

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2009
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
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L 000	Initial Comments A Licensure and complaint investigations survey was conducted on April 6 through 9, 2009. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 30 residents based on a census of 273 residents on the first day of survey and 30 supplemental residents.	L 000	Preparation and/or execution of this plan of correction does not constitute admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies (SOD). The plan of correction is prepared and executed solely because it is required under law.	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for six (6) of 30 sampled residents, it was determined that the charge nurse failed to	L 051	L 051 1. Resident #1 5/8/09 scheduled Quarterly MDS was updated to reflect a diagnosis of COPD and obesity. Resident #4 quarterly 4/20/09 MDS was corrected to reflect a fractured hip. Resident #6 annual MDS is coded to Reflect the weight of 108. The 12/09/08 weight was the post dialysis weight dated 12/11/08. Post dialysis weights are used for dialysis patients because it is more accurate. The weight change was within the 7 day assessment window for the MDS and the difference of the admission weight and the MDS weight is due to dialysis treatment. Resident #8 3/23/09 60 days MDS was corrected to reflect a stage II ulcer and Resident #27 3/9/09 annual MDS was corrected to reflect healing ulcer on 5/14/09. Resident #12 2/05/09 significant change MDS was corrected to reflect impaired Vision.	5/14/09 5/14/09 12/11/08 5/14/09 5/14/09

Health Regulation Administration

Janet E. Durham

Executive Director

TITLE

(X6) DATE

5.27.09

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L 051	<p>Continued From page 1</p> <p>accurately code the Minimum Data Set (MDS) for: one (1) resident for diagnoses; one (1) resident for a fall, one (1) resident for weight gain, two (2) residents for pressure ulcers, and one (1) resident for vision. Residents #1, 4, 6, 8, 12 and 27.</p> <p>The findings include:</p> <p>1. The charge nurse failed to accurately code Resident #1's annual MDS completed February 11, 2009 for a diagnosis of COPD [chronic obstructive pulmonary disease] and Morbid Obesity.</p> <p>The annual history and physical assessment completed December 24, 2008 listed working diagnoses: "...COPD and Morbid Obesity."</p> <p>According to the admission Minimum Data Set (MDS) assessment completed February 11, 2009, Section I [Disease Diagnosis] did not include COPD and Morbid Obesity.</p> <p>A face-to-face interview was conducted on April 9, 2009 at 4:15 PM with Employee #6. He/she acknowledged that the diagnoses were not coded in Section I of the MDS. The record was reviewed April 9, 2009.</p> <p>2. The charge nurse failed to accurately code Resident #4 for a fall on the quarterly MDS.</p> <p>A review of the clinical record for Resident #4 revealed the resident sustained a fall on January 7, 2009 with subsequent fracture according to physician 's progress notes dated January 21, 2009. The resident was hospitalized January 10 through 15, 2009 wherein he/she underwent surgical (hemiarthroplasty) repair of the left</p>	L 051	<p>2. The facility MDS Coordinator (MDSC) has conducted a review of residents medical records to ensure MDS is accurately coded as well as a comprehensive assessment of each Resident was completed and MDS's were updated as needed.</p> <p>3. MDS staff was reeducated on the MDS process and the importance of accurate coding on the MDS. MDS Director or designee will do weekly QA to ensure that the correct MDS assessments are completed, timely and coded accurately.</p> <p>4. DON or designee will QA MDS's weekly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>5/22/09</p> <p>5/14/09</p>

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L 051	<p>Continued From page 2</p> <p>femoral neck fracture.</p> <p>A review of the quarterly Minimum Data Set (MDS) completed January 23, 2009, revealed Section J4 (accidents) - " Hip fracture within the last 180 days " was blank.</p> <p>A face-to-face interview was conducted with Employee #6 on April 6, 2009 at 11:30 AM, who acknowledged that the quarterly MDS did not reflect the resident's hip fracture. The record was reviewed April 6, 2009.</p> <p>3. The charge nurse failed to accurately code the Admission MDS for Resident #6.</p> <p>A review of the nursing notes dated December 9, 2008 [admit date] revealed, " ...11-7 shift admission ...wt [weight] 123 lbs [pounds].</p> <p>A review of the " Weight Record " revealed, " December 9, 2008- weight 123 lbs "</p> <p>A review Admission MDS dated December 15, 2008, revealed, " Section K [Height and Weight] ...b. wt (lb.) 108 "</p> <p>A face-to-face interview was conducted on April 7, 2009 at 10:30 AM with Employee #4. He/she acknowledged that the MDS was inaccurately coded for weight. The record was reviewed on April 7, 2009.</p> <p>4. The charge nurse failed to accurately code a pressure sore for Resident #8.</p> <p>A review of Resident #8 ' s record revealed a 60 day Prospective Payment System (PPS) MDS assessment completed March 23, 2009. The</p>	L 051		

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L 051	<p>Continued From page 3</p> <p>Stage I and one (1) Stage III pressure sores.</p> <p>According to a nurse ' s note dated March 19, 2009, at 10:30 AM, " Resident remains in stable condition alert and verbally responsive. Resident ' s sacral pressure ulcer observed with 100% granulation tissue pinpoint area remains small amount serous exudate present without odor ...Observed right heel continues to present with redness ... "</p> <p>The " MDS 2.0 User ' s Manual " page 3-159, "For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a " 2 " for purposes of the MDS assessment. "</p> <p>A face-to-face interview with Employees #11 and #25 was conducted on April 8, 2009 at 9:30 AM. Employee #11 stated, " The resident initially came into the facility with a Stage III wound on [his/her] sacrum. It ' s healing now and it presents as a Stage II, but I am not supposed to down stage the wound. "</p> <p>Employee #25 stated, " I looked at the wound sheets when I code the MDS. The wound sheets coded the sacral pressure sore as a Stage III. It didn ' t say a healing Stage III, just a Stage III. I didn ' t read the nurse ' s note describing the wound. It should have been coded as a Stage II on the MDS. " The record was reviewed April 7, 2009.</p> <p>5. The charge nurse failed to accurately code Resident #12 on MDS for Impaired Vision.</p>	L 051		

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L 051	Continued From page 4 A review of Resident #12's record revealed a Quarterly MDS completed November 11, 2008. Section D1, coded "0" indicating " Adequate Vision, sees fine detail, including regular print in newspaper /books " A review of Resident #12's record revealed Ophthalmology consult for glaucoma dated January 29, 2009 at 9:35 AM. A face-to-face interview with Employee #7 was conducted on April 6, 2009 at 10:00 AM. He/she acknowledge that the resident was recently evaluated for glaucoma and it may be on the next MDS. The record was reviewed April 6, 2009. 6. The charge nurse failed to accurately code Resident #17's for pressure ulcers. A review of nurse ' s progress notes dated December 17, 2008, 2:30 PM, for Resident #27, revealed the resident was readmitted to the facility with three (3) Stage II wounds between the buttocks. Physician ' s orders dated December 17, 2008 directed the administration of wound treatments every third day. The wound treatment orders were discontinued on December 24, 2008 secondary to an assessment that the wound was healed. The annual Minimum Data Set (MDS) completed March 9, 2009, revealed Section M3 (History of Resolved Ulcers) was coded as " 0 " representative of healed ulcers in the last 90 days. A face-to-face interview was conducted with	L 051		

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L 051	<p>Continued From page 5</p> <p>Employee #6 on April 8, 2009 at approximately 12:30 PM. He/she acknowledged that the MDS was not reflective of the resident ' s history of altered skin integrity. The record was reviewed April 8, 2009.</p> <p>B. Based on record review and staff interview for one (1) of 30 resident records reviewed, it was determined that the charge nurse failed to complete an initial Minimum Data Set (MDS) assessment for Resident #30.</p> <p>The findings include:</p> <p>A review of Resident #30 ' s record revealed that the resident was admitted to the facility on October 24, 2008. The resident was admitted as a Medicare participant under the Prospective Payment System (PPS). The initial PPS assessment was completed on October 27, 2008. There was no evidence that an initial OBRA (Omnibus Reconciliation Act) MDS assessment was completed.</p> <p>According to the " MDS User ' s Manual " page 2-1, " The OBRA regulations have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. These are known as " OBRA assessments " ...When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements .. "</p> <p>According to the " MDS 2.0 User ' s Manual " , Page 2-2, " An Admission assessment must be completed within 14 days of admission. This</p>	L 051	<ol style="list-style-type: none"> 1. Resident #30 MDS could not be corrected due to time frame and Resident was discharged to hospital on 1/4/09 and expired. 2. All other new admissions medical records were reviewed for a comprehensive admission MDS assessment to include RAPS and corrected if needed. 3. MDS coordinators were inserviced By Director of Case Mix on the importance of the completion of the admission assessment on all new admissions. The MDS Director or designee will do weekly QA of new admission MDS's to ensure that the correct assessments with RAPS are completed within established guidelines. 4. DON or designee will QA MDS's weekly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months. 	<p>1/4/09</p> <p>5/13/09</p> <p>5/14/09</p>

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L 051	<p>Continued From page 6</p> <p>means that both the MDS and the RAPs [Resident Assessment Protocol] (R2b and VB2 dates) must be completed by day 14. "</p> <p>A full assessment was completed on October 27, 2008 and coded as the Medicare 5 day assessment. However, no RAPS were completed.</p> <p>A face-to-face interview with Employee #25 was conducted on April 10, 2009 at 9:30 AM. He/she acknowledged that the admission assessment with RAPs was missed. The record was reviewed April 10, 2009.</p> <p>C. Based on observation, record review and resident and staff interview for four (4) of 30 sampled residents and one (1) supplemental resident, it was determined that the charge nurse failed to initiate care plans with appropriate goals and approaches for: two (2) residents for the potential adverse interaction for the use of nine (9) or more medications; one (1) resident with hypertension, and incontinence; and one (1) resident for skin condition. Residents #2, 5, 12, 15, and SM2.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #2. <p>A review of the clinical record for Resident #2 revealed physician orders dated and signed, April 5, 2009 that included the following medications:</p> <p>"Ascorbic Acid, Aspirin, Aranesp, Carvedilol, Citalopram, Novolin R, Renagef, Renocaps, Sensipar, Ferrous Sulfate, Diltiazem, Divalproex, Famotidine, Lisinopril, Risperidone, Diazepam, Haldol"</p>	L 051	<ol style="list-style-type: none"> 1. Resident #2 care plan for nine (9) or more medications is in place. Resident #5 care plans for hypertension and incontinence are in place. Resident #15 care plan for dry scaly skin is in place. Resident #SM2 care plan has been updated to include current wound treatments and interventions. The wound assessments and notes pertaining to the wound are found in the Treatment Administration record which is maintained on the unit where it is easily accessible. Resident #12 care plans for nine (9) or more medications is in place. 2. Unit Managers reviewed the records of current residents to ensure that a care plan is in place with appropriate goals and approaches to meet the needs of each Resident. Records found out of compliance were updated to reflect Resident current status. 3. Licensed staff have been educated on the importance of Completing comprehensive Resident assessments and developing comprehensive individualized care plans with appropriate goals and approaches that will effectively address the current needs of each resident. Unit Managers or MDS coordinators will update care plans quarterly and as needed to ensure appropriateness and compliance. Wound nurses will update Residents with 	<p>5/13/09</p> <p>5/13/09</p> <p>5/13/09</p> <p>5/13/09</p> <p>5/13/09</p> <p>5/22/09</p> <p>5/22/09</p>

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L 051	<p>Continued From page 7</p> <p>There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications.</p> <p>On April 6, 2009 at approximately 10:15 PM, a face-to-face interview was conducted with Employee #14. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on April 6, 2009.</p> <p>2. The charge nurse failed to initiate care plans with goals and approaches for, hypertension and incontinence for Resident #5. According to the resident's admission Minimum Data Set (MDS) assessment completed November 28, 2008, and the quarterly MDS assessment completed February 20, 2009, the resident was coded in Section H (Continence in last 14 days) as incontinent of bowel and bladder function, and was coded in Section I (Disease Diagnoses) for Diabetes (DM) and hypertension (HTN). A face-to-face interview was conducted with the resident at approximately 3:00 PM on April 7, 2009. Resident acknowledged that he/she was wet and had to wait to be changed, that he/she does not request to be changed. A review of the resident's care plans lacked evidence that facility staff initiated care plans with appropriate goals and approaches for bowel and bladder incontinence, and hypertension for Resident # 5. A face-to-face interview conducted on April 8, 2009 at approximately 4:15 PM with Employee # 6. He/she reviewed the resident's clinical record and acknowledged that the resident's record</p>	L 051	<p>wounds care plans weekly. Wound care nurses have been instructed to place wound documentation in the treatment administration records. The treatment administration records are maintained on the units. The Unit Managers will QA the treatment administration records to ensure compliance.</p> <p>4. DON or designee will do random QA of care plans and treatment administration records Monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	

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L 051	Continued From page 8 lacked evidence that care plans were initiated for incontinence and hypertension. He/she said, "I will initiate the care plans right away." The record was reviewed on April 8, 2009. 3. The charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #12. A review of the clinical record for Resident #12 revealed physician orders dated and signed March 1, 2009 that included the following medications: "Digoxin, Aricept, Namenda, Aspirin, Lisinopril, Lantus, Enulose, Famotidine, Furosemide, Prednisolone, Simvastatin, Valproic Acid, Metoprolol, Metformin, Novolin R and Tylenol. There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On April 7, 2009 at approximately 11:15 PM, a face-to-face interview was conducted with Employee #7. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. The record was reviewed on April 7, 2009. 4. The charge nurse failed to initiate a care plan to manage the Resident #15's lower extremity skin condition. A review of the clinical record for Resident #15 revealed that the charge nurse failed to initiate a plan of care to manage the resident's lower extremity skin condition. According to the history and physical examination completed by the	L 051	1. Resident #6 care plan has been updated to Reflect current foley size. The bedside urine bag will be taken on every urology appointments and the suprapubic catheter will be changed by the urologist. Resident #11 care plan has been amended To reflect the current wound status. Resident #18 no longer resides in the facility. 2. Unit Managers will complete a comprehensive assessment of each Resident to develop an accurate individualized care plans with appropriate goals and approaches to meet the needs of each Resident. Records that were found out of compliance were updated to reflect Resident current status. 3. Licensed staff has been educated on the importance of Completing comprehensive Resident assessments , developing comprehensive individualized care plans with appropriate goals and approaches as well as reviewing and revising each care plan to reflect and meet the needs of current status of Residents. Unit Managers or MDS coordinators will update care plans quarterly and as needed to ensure appropriateness and compliance. Wound nurses will update Residents with	5/13/09 5/13/09 4/27/09 5/22/09 05/22/09

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L 051	<p>Continued From page 9</p> <p>physician on December 2, 2008, the resident's diagnoses included dementia, peripheral vascular disease, degenerative joint disease, h/o pressure sores, hypertension, feeding dysfunction, asthma and COPD. According to the quarterly Minimum Data Set (MDS) signed February 11, 2009, the resident required maximum assistance with ADL's and was dependent for transfer, positioning and mobility per Section G (Physical Functioning and Structural Problems) and received nutrition and hydration enterally Section K (Oral/Nutritional Status) Hospice services were initiated February 23, 2009 per physician's order dated February 17, 2009.</p> <p>Resident #15 had a history of recurrent altered skin integrity that required wound management. A physician's order dated October 8, 2008 directed the following wound treatment: "Cleanse left anterior foot excoriation with wound cleanser, pat dry, apply a thin layer of Zinc Oxide ointment, leave open to air X 21 days."</p> <p>A nursing progress note dated December 30, 2008, 0900, revealed the wound was healed as follows: "Treatment to left anterior foot excoriation - discontinue due to area closed."</p> <p>A review of the Treatment Administration Records (TAR) for the months of October and December 2008 lacked evidence of the administration of the wound treatments. Facility staff was unable to locate the TAR for November 2008 at the time of this review.</p> <p>A review of the December 2008 TAR revealed the following wound treatment order dated December 9, 2008: "Wash bilateral shins with soap and water, pat dry, apply Zinc Oxide cream daily X 21 days." The TAR was annotated</p>	L 051	<p>wounds care plans weekly. Wound care nurses have been instructed to place wound documentation in the treatment administration records. The treatment administration records are maintained on the units. The Unit Managers will QA the treatment administration records to ensure compliance.</p> <p>4. DON or designee will do random QA of care plans and treatment administration records Monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	

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L 051	<p>Continued From page 10</p> <p>"discontinue" on December 30, 2008.</p> <p>A face-to-face interview was conducted with Employee #4 who acknowledged the TAR lacked evidence of wound treatment to the left anterior foot excoriation.</p> <p>On April 7, 2009 at approximately 11:30 AM, an observation was conducted of Resident #15 ' s lower extremities, dorsal surface of bilateral shins and feet. Upon observation, the dorsal surface of the resident's lower extremities lacked evidence of any open areas, however; the skin appeared very dry and scaly. When queried regarding the management of the resident ' s lower extremities, Employee #4 stated that body lotion was applied during routine ADL care.</p> <p>A review of the care plan for Resident #15 lacked evidence of problem identification, objectives and approaches to care for the skin of the resident ' s lower extremities. Employee #4 stated that a plan of care was developed to address pressure sores, however; acknowledged that the care plan lacked problem identification related to the resident's lower extremity skin condition. The record was reviewed April 7, 2009.</p> <p>5. The charge nurse failed to initiate a plan of care to manage Resident SM2's sacral pressure ulcer from March 7, 2009 until April 8, 2009.</p> <p>Nursing note dated March 7, 2009 [no time indicated] "Resident noted with stage 2 on [his/her] sacral measured 1 X 0.5 cm, red in color MD [Medical Doctor] made aware order given to cleanse area with normal Saline apply exoderm patch Q [every] 3 days and PRN [as needed] Responsible party notify."</p>	L 051		

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L 051	<p>Continued From page 11</p> <p>Nursing note dated March 25, 2009 11:00 AM: "Talked about in PAR [Patients at Risk Meeting], that [he/she] has stage 3 and S/P [special pressure] 3000 mattress ordered for his/her bed and [he/she] go [got] a low bed yesterday."</p> <p>Nursing note dated April 1, 2009 10:00 AM: "PAR-sacral ulcer stage 3 treatment stantyl and special mattress."</p> <p>Plan of Care: Pressure Ulcer Prevention initiated March 8, 2009. High Risk Interventions identified: Evaluate areas of skin where the resident /patient may have impaired sensation Inspect skin daily for signs/symptoms of skin breakdown Bathe with mild soap, rinse and dry thoroughly Moisturize skin with lotion, especially bony prominences Keep skin clean & dry Apply skin prep to elbows and heels for protection Clean skin & apply barrier cream after each episode of incontinence Evaluate bowel and/or bladder continence program as indicated Frequent re-distribution off areas of pressure Provide a pressure reduction surface for bed and/or wheelchair</p> <p>On April 8, 2009 a Comprehensive Plan of Care with problem identified as Resident has a Pressure Area: Stage III Location Sacral was initiated.</p> <p>This writer was unable to locate wound assessments or notes pertaining to the wound in the clinical record.</p> <p>A face-to-face interview was conducted on April 8, 2009 at 1:10 PM with Employee #12. He/she</p>	L 051		

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L 051	<p>Continued From page 12</p> <p>stated, "The wound nurse has separate documentation in a book off the unit. We keep the measurements, the assessments and the progress notes in our books. The unit managers document on the care plans. The record was reviewed April 8, 2009.</p> <p>D. Based on record review, interview and observation for three (3) of 30 sampled residents, it was determined that the charge nurse failed to amend the comprehensive care plan for: one (1) resident with a supra pubic catheter; one (1) resident's current wound status; and behaviors for one (1) resident. Resident # 6, 11 and 18.</p> <p>The findings include:</p> <p>1. The charge nurse failed to update the care plan for Foley catheter care for Resident #6 with a Supra pubic catheter.</p> <p>A review of the " Report of Consultation " dated March 4, 2009 revealed, " Recommendations F/u [follow up] ... Levaquin 250 mg PO [by mouth] daily for 2 day. Bring 18 FR -5cc Foley Catheter and bedside urine bag on every urology follow up."</p> <p>A review of the Care Plan entitled, " Foley Catheter ... " last updated March 20, 2009 lacked evidence that the Foley Catheter size was updated on the care plan and that the resident will have the catheter changed by the urologist for April 2009.</p> <p>A face-to-face interview was conducted on April 7, 2009 at 10:30 AM with Employee# 4. He/she acknowledged that the care plan was not updated to include the Foley catheter and to reflect the urologist changing the SP [supra pubic] Catheter.</p>	L 051			

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L 051	<p>Continued From page 13</p> <p>The record was review on April 7, 2009.</p> <p>2. The charge nurse failed to amend the "Pressure Area" care plan for Resident #11 to reflect the current wound status.</p> <p>A review of the " Skin Grid-Pressure " form last updated on April 3, 2009 revealed, " ...Right ischium [pressure ulcer] Stage III, skin grid initiated on February 16, 2009; Left Calcaneous [pressure ulcer] skin grid initiated on March 6, 2009 ...Stage II; Right Calcaneous [Pressure ulcer] initiated December 19, 2008; and Right Posterior Shin [arterial ulcer] initiated December 19, 2008.</p> <p>A review of the " Pressure Area " care plan last updated February 24, 2009 revealed, " Multiple Wounds pressure ulcers down grade to Stage II ' s ... "</p> <p>The care plan lacked evidence that the stage and location of the Right ischium, left and right calcaneous and right posterior shin ulcers were identified on the care plan.</p> <p>A face-to-face interview was conducted on April 8, 2009 at 1:10 PM with Employee #12. He/she stated, " I was told that the nurse manager is supposed to update the care plan. Additionally he/she acknowledged that the skin care plans were not updated to reflect the resident's current wound status. The record was reviewed on April 8, 2009.</p> <p>3. A review of the clinical record for Resident #18 revealed that the charge nurse failed to amend the plan of care to address the exhibition of recurrent behaviors of the possession and use of incendiary devices.</p>	L 051		

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L 051	Continued From page 14 According to the history and physical examination completed by the physician on February 2, 2009, the resident ' s diagnoses included hypertension, diabetes mellitus, substance abuse and neuropathy. The record revealed three (3) documented accounts of the resident either smoking, in possession of smoking paraphernalia and/or possession of illegal substance(s) in his/her room as follows: per nursing progress notes, January 31, 2009, 2300, " ...resident smoking and having lighter in room; " February 4, 2009, 1520, " ...smoking paraphernalia in room; " April 5, 2009, 11 PM, " ...observed having illegal substance in room.. " A face-to-face interview conducted on April 7, 2009 with Employee #13 revealed that Resident #18 was assigned one (1) staff person to supervise him/her 24-hours daily in accordance with physician ' s orders initiated April 6, 2009; " 1:1 monitoring every shift for safety measures secondary to smoking paraphernalia/illegal drugs ... " A review of the care plan for Resident #18 revealed problem identification, goals and approaches entitled " #11 Behavioral Issues: verbal/physical aggression and resistance to care. " The care plan lacked evidence of amendments/modifications to the goals and approaches developed to address behavioral issues. There was no evidence that the care plan was amended to identify strategies to address the behaviors associated with the possession and use of incendiary devices and illegal substances	L 051		

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L 051	Continued From page 15 within the facility. The record was reviewed April 7, 2009. E. Based on record review and staff interview for 13 of 30 sampled records and two (2) of 30 supplemental residents, it was determined that the charge nurse failed: complete the Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care and the Behavior Data Collection for one (1) resident; to accurately document the behavior monitoring tool for one (1) resident and consistently document the status of a wound, administration of wound treatments for another resident and maintain wound assessment sheets and progress notes for 11 of 30 sampled residents and two (2) of 30 supplemental residents. Residents #1, 5, 6, 8, 10, 11, 13, 15, 16, 18, 24, 28, 29, SM1 and SM2. The findings include: 1. The charge nurse failed to complete the " Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care and the Behavior Data Collection " for Resident #6 on admission. A review of the Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care and the Behavior Data Collection forms dated December 9, 2008 lacked any documentation indicating that the forms were not completed. A face-to-face interview was conducted on April 10, 2009 at 11:00 AM with Employee #4. He/she acknowledged that the evaluations were not completed. The record was reviewed on April 7, 2009.	L 051	1. Facility staff has completed the " Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care form and the Behavior Data Collection form " for Resident #6. Resident #15 clinical record has been updated to reflect the status of the resident 's wound and administration of wound treatments. Facility staff has accurately documented The behavior monitoring tool for Resident # 24. Wound Assessments and progress notes are maintained on the record for current and Closed records. 2. A review of Resident records completed to ensure that the Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care and the Behavior Data Collection forms are completed. Records found out of compliance will be updated. A review of all wound care documentation completed to ensure completion and accuracy Wound care documentation will be maintained in the treatment administration record on the unit available to staff.	5/15/09 5/13/09 5/11/09 5/13/09 5/22/09 5/22/09 5/13/09

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L 051	Continued From page 16 2. A review of the clinical record for Resident #15 revealed the charge nurse failed to consistently document the status of the resident ' s wound and document the administration of wound treatments. Physician ' s orders dated October 8, 2008 directed the following wound treatment: " Cleanse left anterior foot excoriation with wound cleanser, pat dry, apply a thin layer of Zinc Oxide ointment, leave open to air x 21 days. " According to the nurse's progress notes, an entry dated October 8, 2008 revealed the initial identification of " left anterior foot excoriation, unmeasurable due to multiple openings ... " The next entry related to the altered skin integrity of the left anterior foot was October 16, 2008 and the subsequent and final entry, documented greater than 8 weeks later on December 30, 2008, denoted " ...area closed. " A review of the Treatment Administration Records (TAR) for the months of October and December 2008 lacked evidence of daily wound treatments administered to the left anterior foot in accordance with physician ' s orders. A face-to-face interview was conducted with Employee #4 on April 7, 2009 at approximately 11:30 AM. In response to a query regarding the facility ' s practice as it relates to the documentation of wound management, he/she stated that the wound treatment nurse documents the status of a wound on a weekly basis and evidence of wound treatment orders carried out were documented following each treatment on the treatment administration record.	L 051	Staff to complete a record review of all other Residents with behaviors to ensure that the behavior monitoring tool is documented accurately. Wound care nurses have submitted the wound assessments and progress notes to Medical records to be included with closed resident records and have placed the wound assessments and progress notes on the treatment administration record for current resident to be available to staff. 3. Licensed staff have been reeducated on the importance of completing required admission documents to include the Bladder and Bowel Incontinence Evaluation, Discomfort and Pain Identification and Plan of Care and the Behavior Data Collection forms and accurately documenting the behavior monitoring tool. Wound care nurses have been instructed to maintain wound assessments and progress notes on the treatment administration record for current resident to be available to staff. Medical records staff have been instructed of the change to include wound assessments and progress notes in the closed resident records. Unit Managers will QA admission records Daily times 5 days a week to ensure compliance and make random visual rounds and review treatment administration records to ensure compliance. Medical records will be randomly monitored by DON or designee to ensure wound care documentation is kept in the closed record. Behavioral specialist will make random record QA to ensure that the behavior monitoring tools are completed accurately	5/22/09 5/13/09 5/22/09 5/21/09 5/22/09

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L 051	<p>Continued From page 17</p> <p>Employee #4 acknowledged inconsistencies in the documentation of the status of the wound and the lack of documentation on the TAR that wound treatments were administered. The record was reviewed April 7, 2009.</p> <p>3. The charge nurse failed to accurately document the behavior monitoring tool for Resident # 24.</p> <p>A review to the history and physical examination completed by the physician December 9, 2008, Resident #24 ' s mental health diagnosis included Bipolar Disorder. According to physician ' s orders signed April 1, 2009, Resident #24 ' s psychotropic medication regimen included Seroquel 150mg po daily and Ativan 2mg every 4 hours as needed (prn) for agitation.</p> <p>A review of the medication administration records (MAR) for February and April 2009, revealed Ativan had been administered on more than ten (10) occasions during each of the months reviewed. A review of the facility ' s behavior monitoring tool entitled " Psychoactive Medication Monitoring Record " for the months of February and April 2009, revealed annotations of zeros with a line drawn through or " N " for " no " and several spaces left blank. The monitoring tool lacked evidence of the behaviors to be monitored. There was no evidence of a correlation between the monitoring tool and the " prn " administration of Ativan.</p> <p>According to facility policy #3.8 Psychopharmacological Medication Use, revised January 15, 2009; Item #3 - " Facility staff should monitor the resident ' s behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents</p>	L 051	<p>4. DON or designee and behavior specialist will randomly QA Resident records to ensure compliance and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	

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L 051	<p>Continued From page 18</p> <p>receiving psychopharmacological drugs for organic mental syndrome with agitated or psychotic behaviors. "</p> <p>A face-to-face interview was conducted with Employee #3 on April 9, 2009 at approximately 3:30 PM who acknowledged the behavior monitoring tool was inaccurately documented. The record was reviewed April 9, 2009.</p> <p>4. The charge nurse failed to maintain Wound Assessments and progress notes on current and closed resident records.</p> <p>A review of clinical records revealed that the records lacked evidence that wound assessments and nursing progress notes were maintained on the record in date order for Residents: 1, 5, 8, 10, 11, 13, 15, 16, 18, 28, 29, SM1 and SM2.</p> <p>A face-to-face interview was conducted on April 8, 2009 at 1:10 PM with Employee #12. He/she stated, "The wound nurse has separate documentation in a book off the unit. We keep the measurements, the assessments and the progress notes in our books."</p>	L 051		
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(h) Proper care to minimize pressure ulcers and</p>	L 052		

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L 052	Continued From page 19 contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral care; and (j) Prompt response to an activated call bell or call for help. A. Based on observation, record review and staff and resident interviews, for three (3) of 30	L 052		

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L 052	<p>Continued From page 20</p> <p>sampled residents and two(2) supplemental residents. it was determined that facility staff failed to give sufficient nursing time to: assess one (1) resident for pain, follow up on a podiatry consult for one (1) resident, follow up on a cardiac consult for one (1) resident, discontinue Risperidone for one (1) resident and administer medication as per physician's orders for one (1) resident. Residents #4, 7, 24, JH2 and S1.</p> <p>The findings include:</p> <p>1. Facility staff failed to give sufficient nursing time to treat Resident S1 ' s complaint of pain.</p> <p>A. Resident S1 was observed sitting in a wheelchair on April 9, 2009 at 3:15 PM requesting pain medication. Employees #26 and 27 were at the medication cart doing the narcotic shift count. Employee #27 reviewed the resident ' s " Controlled Substance Record " and stated, " You received pain medication at 1:15 PM and you get it every four hours. " The resident stated, " I didn ' t have anything for pain today. " After no response from Employee #27, the resident went to his/her room.</p> <p>Employee #27 failed to assess the location, intensity, type and onset of the pain the resident was experiencing when he/she asked for pain medication. There was no attempt to notify the physician that the resident ' s pain was not controlled by the currently prescribed medication.</p> <p>The resident was observed at 3:30 PM in his/her room. lying in bed on the right side, knees drawn up, with facial grimacing. The resident stated, " I hurt. " The resident patted his/her left side.</p> <p>A review of the resident ' s record revealed that</p>	L 052	<p>L 052</p> <p>1. Resident S1 currently receives medication per physician order. Employee #27 is no longer employed at facility.</p> <p>2. Residents who are receiving pain Medication and the pain flow sheets will be reviewed by the Unit Managers to ensure residents receive pain medication per physician orders and have been assessed prior to medication administration and that the documentation is timely and accurate.</p> <p>3. Licensed staff has been reeducated on the importance of pain medication administration process. Unit managers to QA residents MAR's and narcotic flow record daily to ensure appropriate pain medication is administered and documented.</p> <p>4. DON or designee will do random QA of pain medication administration records Monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>4/18/09</p> <p>4/15/09</p> <p>5/22/09</p> <p>5/22/09</p>

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L 052	<p>Continued From page 21</p> <p>the resident had returned from a hospitalization for a splenectomy on April 1, 2009. A physician ' s telephone order dated April 2, 2009 directed, " Darvon 65 mg 1 tab by mouth every 4 hours as needed for abdominal pain. "</p> <p>The " Controlled Substance Record " for Resident S1 documented that a Darvon 65 mg tablet was removed from the narcotics drawer at 1315 (1:15 PM) on April 9, 2009. The narcotic shift count was observed at the time of this review and revealed that 11 tablets had been administered to the resident from April 2 through April 9, 2009 leaving 19 tablets available per the " Controlled Substance Record " . A review of the medication card revealed 20 tablets of Darvon present.</p> <p>Employee #27 was asked if the resident had medication prescribed for break through pain. He/she reviewed the April 2009 MAR and noted that the Darvon 65 mg tablet was not signed indicating that it was administered to the resident for April 9, 2009. The last dose of Darvon the resident received was documented as 10:00 PM on April 8, 2009 (17 hours prior to the resident ' s 3:30 PM request on April 9, 2009).</p> <p>Employee #26 stated, "I must have forgotten to give [Resident S1] the medication. I am very sorry."</p> <p>A second review of the " Controlled Substance Record " revealed that 1555 (3:55 PM) was written over the previous time of 1315 (1:15 PM) as the time the Darvon 65 mg tablet was removed from the narcotic drawer.</p> <p>According to the April 2009 MAR the resident received the medication at 1540 (3:40 PM). On</p>	L 052			

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L 052	<p>Continued From page 22</p> <p>the back of the April 2009 MAR under "Medication Exception and Hold Notes" was an entry dated "4/9/09 at 1428 (2:58 PM) Darvon 65 mg, Reason-c/o (complaint of) abd (abdominal) pain; Result - helpful."</p> <p>A nurse ' s note dated April 9, 2009 at 1515 (3:15 PM) documented, " ...C/o abdominal pain. Medicated with Darvon 65 mg po (orally) at 1545 (3:45 PM) ... "</p> <p>According to the quarterly Minimum Data Set assessment completed December 24, 2008, the resident was coded in Section B (Cognitive Patterns) with no long or short term memory loss with independent cognitive skills for daily decision making. The record was reviewed April 9, 2009.</p> <p>2. A review of the clinical record for Resident #4 revealed that facility staff failed to give sufficient nursing time to follow through on a physician's order to obtain a podiatry consultation.</p> <p>Resident #4 was admitted to the facility October 21, 2008. According to the history and physical examination completed by the physician on October 20, 2008, the resident ' s diagnoses included insulin dependent diabetes mellitus (IDDM), hypertension and dementia.</p> <p>A physician ' s progress noted dated February 14, 2009 revealed the resident sustained a hip fracture and subsequent hemiarthroplasty in January 2009. Additionally, the resident sustained an alteration in the skin integrity of both heels as evidenced by the following order dated March 19, 2009, " wash both heels, pat dry, apply Neutrashield ...elevate residents ' heels at all times on pillows to prevent opening on heels. "</p>	L 052	<ol style="list-style-type: none"> 1. Resident #4 has been seen by the Podiatrist. 2. Unit Managers will conduct a chart review to determine which Residents have not been evaluated by the podiatrist and obtain physician order for all current Residents who have not been evaluated to be evaluated. 3. Licensed staff will be re-educated on The facility process to place new orders in an accordion file for the Unit Managers to daily review. Licensed staff will be reeducated on the facility policy regarding the 24 hour chart review process. The IDT will review in the daily IDT meeting the 24 hour report and new orders to ensure new orders are acted on appropriately. 4. DON or designee will do random chart QA for podiatry visit compliance report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months 	<p>4/09/09</p> <p>5/22/09</p> <p>5/18/09</p>

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L 052	<p>Continued From page 23</p> <p>A review of the physician's orders (POS) from December 2008 through the current orders dated April 1, 2009 directed " podiatry consult/care prn. "</p> <p>A face-to-face interview was conducted with Employee #6 on April 6, 2009. In response to a query regarding the status of an evaluation by the podiatrist. He/she stated that the resident was on the podiatrist's list of resident's to be seen. Employee #6 acknowledged that Resident #4 had not been evaluated as of the date of this review.</p> <p>Resident #4 had a history of IDDM and a history of an alteration in the integrity of skin of both feet in the absence of a podiatry consultation as directed by the physician. The record was reviewed April 6, 2009.</p> <p>3. Facility staff failed to give sufficient nursing time to follow doctor ' s orders to discontinue Risperidone for Resident #7.</p> <p>A review of Resident #7's record revealed a physician ' s order dated October 23, 2008 that directed, "Risperidone F/C 0.5MG Tablet, 1 tab by mouth every 8 PM for Delusional Behavior. "</p> <p>A review of a psychiatrist's progress note dated March 26, 2009, revealed " Reevaluated resident behavior and medication, no behavior management issue in the last three (3) months, may discontinue Risperidone 0.5 MG order. "</p> <p>A review of Physician Order Sheet (POS) revealed that on March 26, 2009 at 10:00 AM, an order was written to "Discontinue Risperidone 0.5 MG."</p> <p>A review of the Medication Administration Record</p>	L 052	<p>1. Resident #7 no longer receives Risperidone.</p> <p>2. Unit Managers will conduct QA of orders written over the past 60 days to ensure compliance. Unit Managers and ADON will continue review new orders daily.</p> <p>3. Licensed staff will be reeducated to place new orders in an accordion file for Unit Managers to complete daily reviews 5 times a week. Licensed staff will be reeducated regarding the 24 hour chart review process and monthly MAR/TAR turnover.</p> <p>4. DON or designee will QA 24 hour chart review process during morning IDT meeting and MAR/TAR turnover monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>4/08/09</p> <p>5/22/09</p> <p>5/22/09</p>	

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L 052	<p>Continued From page 24</p> <p>[MAR] revealed that on March 26, 2009 at 8:00 PM the nurse's initials in the area designated indicated that the last dose of the medication was given and the word "Discontinued" written after the initials.</p> <p>According to the March 2009 MAR, there were no nurse ' s initial in the area designated for March 27, 28, 29, 30 and 31, 2009 indicating that the medication was not administrated to the resident.</p> <p>A review of Physician Order Sheet (POS) of April 2009 revealed no order written to restart Risperidone.</p> <p>A review of April 2009 MAR revealed that the resident received Risperidone 0.5 mg on April 1, 2, 3, 4, 5, 6 and 7, 2009 as evidenced by the nurses' initials in the designated areas documenting that the medication was administered to the resident.</p> <p>A face-to-face interview was conducted with Employee #14 at the time of the findings. He/She acknowledged the above mention medication was discontinued. The record was reviewed March 5, 2009.</p> <p>4. A review of the clinical record for Resident #24 revealed facility staff failed to give sufficient nursing time to follow physician ' s orders to obtain a cardiac consult.</p> <p>According to the hospital discharge summary dated February 20, 2009, Resident #24 ' s diagnoses included cardiomyopathy, hyperlipidemia, chronic obstructive lung disease, hypertension, congestive heart failure and status post myocardial infarction.</p>	L 052	<ol style="list-style-type: none"> 1. Resident #24 cardiology appointment has been rescheduled for 6/02/09. 2. A review has been done to identify Residents with implanted cardiac devices. These Residents charts will have a yellow document stating "Resident has a defibrillator. The document will be located at the front of the chart. The Resident will also have a yellow coordinating wrist band which indicates that the Resident has a defibrillator. Unit Managers will QA Physicians orders to ensure all Residents with Internal cardiac devices (ICD) have been assessed. 3. Licensed staff have been educated Regarding (ICD) Identification. All new Admission with (ICD) implant will be assessed per facility protocol. Unit Managers will monitor the (ICD) process during new admission chart reviews. 4. DON or designee will review (ICD) identification process weekly during care management meeting and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months. 	<p>4/27/09</p> <p>5/07/09</p> <p>5/07/09</p>
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L 052	<p>Continued From page 25</p> <p>He/she was hospitalized February 8 through 20, 2009 secondary to an acute exacerbation of congestive heart failure and underwent placement of an Internal Cardiac Defibrillator (ICD) during the hospitalization.</p> <p>According to the hospital discharge instructions as it relates to the management of the ICD; recommendations included a device and wound surveillance assessment approximately six (6) weeks post implantation and a noninvasive review of the device parameters, function and cardiac events every 3-4 months.</p> <p>Physician ' s readmission orders dated February 20, 2009 and subsequent physician ' s orders signed April 1, 2009 directed " Pacemaker check once monthly. "</p> <p>A face-to-face interview was conducted with Employee #4 on April 9, 2009 at approximately 11 AM. In response to a query regarding the status of Resident #24 ' s ICD device assessment; he/she stated that the assessment would be conducted by the cardiologist and that an appointment was scheduled for April 27, 2009. When queried regarding the physician ' s orders that directed monthly " Pacemaker checks, " he/she stated that the order actually referred to the ICD and that the resident did not have a pacemaker. He/she stated that a clarification of the order would be obtained.</p> <p>Employee #4 acknowledged that the ICD device assessment had not been performed. The resident was greater than six (6) weeks post implantation of the ICD device without evidence of an assessment. The record was reviewed April 9, 2009.</p>	L 052		

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L 052	Continued From page 26 5. Facility staff failed to give sufficient nursing time to ensure that Resident JH2 was free from medication errors. A physician ' s order, signed and dated on April 3, 2009, directed " Magnesium Oxide 400 mg tablet, 1 tablet by mouth every day for supplement ". On April 6, 2009, at approximately 10:50 AM, during the medication pass for Resident JH2, Employee #33 did not administer Magnesium 400 mg tablet to the resident. When the Medication Pass worksheet was compared with Medication Administration Record and the physician ' s orders, the omission was discovered. A face-to-face interview was conducted on April 6, 2009 at approximately 2:30 PM with Employee #33. He/she stated, "I'm not sure if I gave it or not, I thought that I had given it." B. Based on record review, observations and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to give sufficient nursing time to implement interventions to restore bladder function and or initiate an incontinence training program for Resident #27. The findings include: Facility staff failed to give sufficient nursing time to implemented interventions to restore bladder function and or initiate an incontinence training program for Resident #27. A review of the clinical record for Resident #27	L 052	1. Resident # JH2 is receiving medication as ordered. 2. Competencies for medication administration for licensed staff was completed. Unit Managers and pharmacy consultant will do random medication administration assessments (Med Pass review) weekly x 4 weeks to ensure accuracy and consistency. 3 Employee #33 and licensed nurses have been re-educated on medication administration. 4. The DON/ADON/SDC will do monthly medication administration assessments and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months. 1. Resident #27 has a bed/chair alarm in place. Resident #27 has been assessed for the ability to participate in the restorative nursing Bowel and Bladder (B&B) program and was placed on a B&B program. 2. Unit Manager will screen Residents who are incontinent of B& B to determine appropriateness of the B&B training program. Residents who are identified will be placed on a B&B program. 3. Licensed staff re-educated on facility Policy and procedure related to bowel and Bladder management. Staff and Restorative Nursing Team. reeducated on how to assess Resident for B&B program.	4/06/09 5/22/09 5/21/09 3/22/09 5/14/09 5/22/09 5/22/09

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L 052	<p>Continued From page 27</p> <p>revealed that the resident sustained three (3) falls without injury during March 2009. Each of the falls was associated with attempts to mobilize to the bathroom as evidenced by the following nursing progress notes: March 12, 2009, " resident fell onto floor in bedroom, out of bed to go to bathroom; March 19, 2009, resident found sitting on floor near bed, tried to go to the bathroom; March 22, 2009, found sitting on floor mat next to bed, trying to go the bathroom. "</p> <p>According to the comprehensive care plan updated March 11, 2009, the interdisciplinary team identified " incontinent of bowel and bladder " as a problem. Approaches to address the incontinence included " place resident on a q 2 hr toileting program if appropriate. "</p> <p>According to the annual Minimum Data Set assessment completed date March 9, 2009, the resident was coded with no long or short memory problems in Section B (Cognitive Patterns). Additionally, the " Resident Summary " dated March 27, 2009 revealed that Resident #27 was alert, oriented and able to understand information conveyed without difficulty.</p> <p>C. Based on observation, staff interview and record review for three (3) of 11 supplemental residents, it was determined that facility staff failed to give sufficient nursing time to provide necessary services to maintain good personal hygiene for three (3) residents. Residents A1, A2, and A3.</p> <p>The findings include:</p> <p>Facility staff failed to give sufficient nursing time to provide necessary services to maintain good personal hygiene for Residents A1, A2, and A3.</p>	L 052	<p>Restorative nurse will do weekly QA of Residents on bowel and bladder program to evaluated progress.</p> <p>4. DON or designee will random QA B&B program monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	

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L 052	Continued From page 28 1. According to the resident ' s clinical record, the annual Minimum Data Set (MDS) completed on February 5, 2009, Resident A1 was coded in Section G (Physical Functioning and Structural Problems) as being totally dependent for toileting and personal hygiene and unable to attempt test for balance while standing. Resident is incontinent of bowel and bladder function according to Section H (Continence). The resident ' s diagnoses according to Section I (Disease Diagnoses) included missing limb (amputation), stroke, and dementia. On April 8, 2009 at approximately 09:20 AM, Resident A1 was observed seated in wheelchair in his/her room. He/she had a left below the knee amputation. When asked about toileting, the resident responded; " I go to the bathroom by myself but the bathroom in here was being used. I sometimes need help with loose bowel and had to clean myself when the staff failed to respond. Sometimes I can not clean up the mess completely. You do not always get the help when you call for someone so I try to do as much as I can. " According to an incident report of February 23, 2009 at 12:30 PM, the resident was found to be soiled and had not been toileted since the beginning of the shift. 2. According to the resident ' s clinical record, the quarterly MDS completed on March 13, 2009, Resident A2 was coded in Section G (Physical Functioning and Structural Problems) as being totally dependent for toileting and personal hygiene and unable to attempt test for balance while standing. Resident is incontinent of bladder	L 052	1.Residents A1, A2, A3 are receiving timely incontinent care. 2. Review of current residents coded as incontinent on MDS has been completed and assessments initiated as appropriate. 3. Nursing staff has been re-educated on timely incontinent care, repositioning, and answering call lights timely. Unit Managers/Supervisors/Charge Nurses will randomly validate compliance through observation and daily rounds. 4. DON or designee will QA random timely incontinent care, repositioning, and answering call lights timely report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.	5/22/09 5/22/09 5/22/09

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L 052	<p>Continued From page 29</p> <p>function according to Section H (Continence). The resident ' s diagnoses according to Section I (Disease Diagnoses) included stroke, and hemiplegia / hemiparesis.</p> <p>On April 8, 2009 at approximately 1:30 PM, Resident A2 was observed seated in a wheelchair in the day room across from the nursing station. A face-to-face interview was conducted with Resident A2 on April 8, 2009 at approximately 1:45 PM. He/she said, " I was changed at 8:00 AM by the morning shift, I am wet right now and will be changed after lunch. I do need help with toileting. "</p> <p>3. According to the resident ' s clinical record, the annual Minimum Data Set (MDS) completed on March 16, 2009, Resident A3 was coded in Section G (Physical Functioning and Structural Problems) as being totally dependent for toileting and personal hygiene and unable to attempt test for balance while standing. Resident is incontinent of bowel and bladder function according to Section H (Continence). The resident ' s diagnoses according to Section I (Disease Diagnoses) included arthritis, stroke, glaucoma and dementia.</p> <p>On April 7, 2009 at approximately 8:00 AM, Resident A3 was observed seated in a gerichair in the day room across from the nursing station from 8:00 AM to 1:30 PM. During the observation period, the resident was not offered incontinent care including checking for wet/soiled diaper. A review of the resident ' s clinical record revealed a " Bowel Incontinence Evaluation " last reviewed on December 11, 2008. According to the " Bowel Incontinence Evaluation " the resident have history of incontinence related</p>	L 052		

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L 052	<p>Continued From page 30</p> <p>to cognitive impairment, unable to transfer to toilet/commode, and unable to consistently communicate urge to eliminate.</p> <p>A face-to-face interview was conducted with Resident A3 on April 8, 2009 at approximately 2:45 PM. He/she was unable to respond. There was no evidence that facility staff give sufficient nursing time to consistently offered incontinent services necessary to maintain good personal hygiene for Residents A1, A2, and A3.</p> <p>A face-to face interview was conducted with Employee #23 on April 8, 2009 at approximately 3:10 PM. Employee #23 said, " My residents are given incontinent care by the night nurses in the AM. I give them PM care after lunch when I put them in bed just before my shift ends. When ask the frequency of incontinent care Employee # 23 said, I do not know. "</p> <p>A face-to-face interview was conducted with Employee #24 on April 8, 2009 at approximately 1:10 PM. When asked the frequency of incontinent care for Resident A2, Employee #24 responded, " I give incontinent care in the AM and before lunch. The resident was supposed to call for help but he/she was not wet. " The records were reviewed April 8, 2009.</p> <p>D. Based on observations of two (2) of three (3) wound treatments, it was determined that facility staff failed to give sufficient nursing time to maintain clean technique during the wound treatments for Residents #3 and 8.</p> <p>The findings include:</p> <p>1. Clean technique was not maintained for a wound treatment for Resident #3.</p> <p>A wound treatment observation was conducted</p>	L 052	<p>1. Resident #3 and 8 did not sustain adverse effect. Employee #11 and #12 have been reeducated on clean technique, hand washing and infection control.</p> <p>2. The infection control nurse and the Unit mangers will assess the knowledge, skills and abilities of licensed staff regarding inflection control, clean technique and proper hand washing.</p> <p>3. Licensed staff will be reeducated on the importance of practicing the clean technique when providing wound care, hand washing, and infection control. Return demonstration will be required during retraining. Unit Managers or designee will make rounds weekly with wound care nurses/licensed staff to observe for compliance.</p> <p>4. DON or designee will do random QA Of clean technique when providing wound care, hand washing, and infection control weekly during wound care rounds and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>5/14/09</p> <p>5/22/09</p> <p>5/22/09</p>

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L 052	<p>Continued From page 31</p> <p>on April 7, 2009 at 2:30 PM to Resident #3 ' s left arm. Employee #12 failed to wash off the bedside table prior to establishing a clean field. A non-pemeable barrier was placed on the bedside table and wound care items were assembled.</p> <p>The resident was sitting on the bed, feet on the floor and head resting on a pillow placed towards the foot of the bed. The resident ' s left arm was resting on the bed.</p> <p>Employee #12 failed to place a barrier under the resident ' s left arm on top of the bedspread. Employee #12 removed a scissors from his/her pocket, did not clean the scissors, cut the gauze wrapped around the resident ' s arm and replaced the scissors into his/her pocket.</p> <p>The dressing was stuck to the resident ' s wound and Employee #12 sprayed " Skin Integrity " wound cleanser on the wound to loosen the dressing. A wet spot was observed on the bedspread underneath the resident ' s left arm after the wound dressing was removed. The soiled dressing was observed with a small amount of serous drainage on it.</p> <p>During the wound treatment, Employee #12 changed gloves four (4) times and failed to wash hands between glove changes.</p> <p>2. A wound dressing change was observed for Resident #8 ' s sacral wound on April 8, 2009 at 8:35 AM with Employee #11.</p> <p>Employee #11 completed the wound treatment with five (5) glove changes. Hands were not washed between glove changes.</p> <p>Employee #11 was asked why he/she did not</p>	L 052		
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L 052	<p>Continued From page 32</p> <p>wash hands between glove changes immediately after the wound treatment observation. Employee #11 replied, " I forgot to take in the hand sanitizer. "</p> <p>E. Based on observations, record review and staff interviews for two (2) of 30 sampled residents, it was determined that facility staff failed to give sufficient nursing time to provide appropriate services to residents identified with a decline in function for Residents #1 and 13.</p> <p>The findings include:</p> <p>1. Facility staff failed to give sufficient nursing time to provide rehabilitation services for Resident #1 after a noted decline in activities of daily living [ADLs] and Range of Motion [ROM].</p> <p>A review and comparison of the last quarterly and annual Minimum Data Set assessments revealed the following:</p> <p>Quarterly MDS completed November 11, 2008: Section G1 [ADL self performance] coded resident as requiring limited assistance in bed mobility, personal hygiene and no set up help for eating. Section G 4 [Functional Limitation in Range of Motion] leg and foot were coded as limitation on one side and partial loss.</p> <p>Annual MDS completed February 12, 2009 Section G1 coded resident as total dependence in bed mobility, extensive assistance in personal hygiene and supervision while eating. Section G 4 leg and foot were coded as limitation on both sides and partial loss.</p> <p>The record lacked evidence that the resident had been screened by the physical or occupational</p>	L 052	<p>1. Resident #1 and #13 were referred to therapy for screen by PT/OT/ST.</p> <p>2. A review of QI report indicating Residents with ADL need for help increases and decreases in Range of Motion was completed and list given to therapy for appropriate screening.</p> <p>3. MDS Coordinator, Unit Manager, and nursing staff was reeducated on the importance of following appropriate procedure for referral to therapy when declines in functioning and change in clinical status of a resident occurs. Unit Managers will review resident status changes during daily rounds 5 times a week and ADON or designee will review those changes at the morning meeting with the management team.</p> <p>4. DON or designee will review the QI report with the list of therapy screens monthly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>5/22/09</p> <p>5/22/09</p> <p>5/22/09</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2009
NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
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L 052	<p>Continued From page 33</p> <p>therapist or the speech language pathologist after a functional decline was identified.</p> <p>A face-to-face interview was conducted on April 9, 2009 at 2:55 PM with Employee #16. He/she stated that [he/she] was not aware of the decline in the ADL 's and ROM and acknowledged that the resident was not seen by the rehabilitation department after the noted decline on the annual MDS. The record was reviewed on April 9, 2009.</p> <p>2. Facility staff failed to give sufficient nursing time to provide rehabilitation services for Resident #13, who was identified with a decline in functional ability.</p> <p>According to a quarterly Minimum Data Set (MDS) assessment completed November 28, 2008, Resident #13 was coded in Section G (Physical Functioning and Structural Problems) as requiring limited assistance with bed mobility and transfers and extensive assistance with eating, toileting and personal hygiene.</p> <p>A significant change MDS was completed on February 23, 2009 and coded the resident in Section G as being totally dependent for bed mobility, transfers, eating, toileting and personal hygiene.</p> <p>There was no evidence that the resident had been screened by the physical, occupational or speech-language therapists for rehabilitative services after the functional decline was identified.</p> <p>Resident #13 was observed lying in bed on April 6, 2009 at 11:30 AM. He/she was not able to turn on his/her side when requested.</p>	L 052			

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L 052	<p>Continued From page 34</p> <p>A face-to-face interview was conducted on April 6, 2009 at 2:00 PM with Employee #22. He/she acknowledged that there was no rehabilitation screen completed or rehabilitative services provided for Resident #13 after a decline in function was identified. The record was reviewed April 6, 2009.</p> <p>F. Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to give sufficient nursing time to address Resident # 1's intended weight loss.</p> <p>The findings include:</p> <p>A review of Resident # 1's " Individual Monthly Weight Report ..." dated March 27, 2009 revealed the following: Weight date 11/01/08 weight 330.9 # [pounds] Weight date-12/01/08 weight 339.0 # Weight date-01/01/09 weight 0.0 # Weight date-02/01/09 weight 313.0 # Weight date-03/06/09 weight 312.8 # Weight date-01/01/09 weight 0.0 # - refused Weight date-02/01/09 weight 313.0 # - rewt [re-weight] 310.5 #</p> <p>The resident lost 28.5 # from December 1, 2008 and February 1, 2009.</p> <p>A review of the nutritional assessment last updated December 29, 2008, revealed that Resident #1 's weight was 339 #.</p> <p>There was no evidence in the record that the dietitian reviewed/assessed the resident's weight loss of 28.5 pounds between December 1, 2008 and February 1, 2009.</p>	L 052	<ol style="list-style-type: none"> 1. Dietician for that unit during that time is no longer employed at facility. Current Dietician wrote a nutritional note for Resident #1 nutrition on 4/6/09 and 4/15/09 Regarding the significant weight loss which was desired. Part of the weight loss was due to fluid loss as Resident #1 continues to receive 40 mg of lasix and the antipsychotic drug is indicated for weight loss as a side affect. 2. Dietician has reviewed the records of all Residents with significant weight loss and found no other infractions. 3. Licensed staff reeducated on importance of communicating weight changes to the dietician and physician. Weight team has been reeducated on the importance of completing Resident weights per physician order and recording them in the record. Physicians have been re-educated on the importance of following through on all weight changes. During quality rounds Unit Managers will review 24 hour reports to identify weight changes and initiate follow up process. Unit Manager will QA charts daily 5 times a week to ensure that recommendations are carried out per physician orders. Dietician will review and address the records of all Residents with weight changes. 4. DON or designee and Dietician will QA Resident records to ensure consults and recommendations are completed by the disciplines involved and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months. 	<p>1/01/09</p> <p>5/22/09</p> <p>5/22/09</p>
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L 052	<p>Continued From page 35</p> <p>A review of the physician ' s progress note signed by the physician on March 4, 2009 revealed, " ...Examination: ...Wt [weight] - 310.5 lbs ... Review of Systems - Weight - stable ... "</p> <p>There was no evidence on the record that the physician addressed the intended weight loss on his/her progress note.</p> <p>According to the Report of Consultation dated December 16, 2008 , " ...Has gained more weight up to 330, Not able to lose weight ... Recommendations: Will try Topamax for neuropathy pain and weight loss...Strict 1800 calorie / day diet. No visitor food. No snack, no soda or juice." The consult was signed on December 28, 2008 by the attending physician.</p> <p>The physician ' s orders last signed March 4, 2009 revealed, " Dietary- NAS, NCS, Low Fat/cholesterol diet ..."</p> <p>The record lacked evidence that the physician or dietitian acknowledged the recommendation for the strict 1800 calorie.</p> <p>According to the Report of Consultation dated February 13, 2009 revealed, " Findings- Pt [patient] with morbid obesity ...says has lost 40 lb. (310 now) ...be sure pt ' s [patient ' s] diet is observed and no food allowed from outside. "</p> <p>A face-to-face interview was conducted with Employee #6 at approximately 3:30 PM on April 6, 2009. He/she stated, "The dietitian was no longer at [facility]. He/she left around the being of this year. He/she also stated, " [The Resident] is on Lasix. Employee #6 acknowledged that there was no follow up to the intended weight loss. The record was reviewed on April 9, 2009.</p>	L 052		

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L 091	<p>3217.6 Nursing Facilities</p> <p>The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: A. Based on observation and interview it was determined that the facility failed to implement an infection control program in which it investigates infections in the facility and failed to maintain records of incidents and corrective actions related to infections.</p> <p>The findings Include:</p> <p>Facility policies: "Infection Prevention and Control Program 1.1, Original Date 8/04, Revised Date 2/09 stipulated, " ...The Program includes a system to monitor and investigate infection trends. " Infection Surveillance 8.4, Original Date 8/04, Revised Date 2/09 stipulated, " The facility will use a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determining factors of a given disease event ...The facility will have baseline surveillance data on the incidence of nosocomial infections in order to identify outbreaks ... Procedure: 1. Gather Information from each unit at least once per week. 2. Initiate a resident/patient specific Infection Surveillance Worksheet ...3. Summarize information from the Infection Surveillance Worksheet on the Monthly Line Listing Report...4. Tabulate infection data ...and document on the Annual Infection Rate Summary...5. Calculate incidence rates and compare to previous rates ...7. Develop conclusions, recommendations, actions and</p>	L 091	<p>L 091</p> <p>1. New Infection control nurse completed Infection control policy review and training.</p> <p>Floor mats in rooms 213, 229 and 311 have been cleaned and sanitized.</p> <p>The interior surfaces of the ice machine water and ice chutes and trays were cleaned of the accumulated mineral deposits, rust and other debris in nourishment rooms on the Units 2nd North, 2 South and 4 North.</p> <p>2. Hired Infection control nurse to oversee, implement and maintain the infection control program. Floor mats in all other Resident rooms have been cleaned and sanitized. Ice machines on all other units have been cleaned and sanitized.</p> <p>3. Infection control nurse has been trained and oriented to infection control program and the importance of investigating and monitoring infections in the facility; maintaining a record of incidents and corrective actions related to infections; and adhering to the facility's Infection Control Policies and Procedures. Housekeeping manager and staff has been inserviced on the importance of cleaning and sanitizing the floor mats daily and ice machines weekly. The interior surfaces of the ice machine water and ice chutes and trays will be cleaned weekly of the accumulated mineral deposits, rust and other debris in nourishment rooms on the Units. Housekeeping manager will monitor compliance 5 times a week. DON or designee will QA weekly infection Control logs to ensure proper tracking and</p>	<p>4/07/09</p> <p>4/06/09</p> <p>4/06/09</p> <p>4/06/09</p> <p>4/07/09</p>

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L 091	<p>Continued From page 37</p> <p>follow-up...</p> <p>An Infection Control interview was held with Employee # 28 on April 9, 2009 at 1:10 PM. Employee #28 was asked about infection control data collected since the last survey. Employee #28 stated that he/she had only been at the facility for 32 days and was just starting to implement the infection control policies and procedures. Employee #28 reviewed the forms for the Infection Control program with the surveyor and presented forms that he/she had used to collect data as of March 2009.</p> <p>A sheet entitled " Monthly Line Listing Report " dated March 2009 was reviewed at the time of this interview. The listing contained 27 entries but the type, site or source of the infection was not documented on the form. When asked how many UTIs [Urinary Tract Infections] did you have based on your listing. Employee #28 stated he/she would have to review the Individual Infection Surveillance Worksheets as the line listing did not identify the type, site or source of infection.</p> <p>Employee # 28 was unable to provide the Annual Infection Rate Summary form or evidence that incidence rates had been calculated and compared to previous rates within the facility. Employee #28 was unable to produce documentation that the facility followed it ' s policies regarding infection control in monitoring and investigation of infection trends.</p> <p>Employees #2 and 3 were asked to provide data on the monitoring of infections in the facility since Employee #28 was new, but no additional data was provided by to the surveyor by the end of the survey.</p>	L 091	<p>trending is completed.</p> <p>4. Housekeeping manager will monitor Floor mat cleaning compliance 5 times a Week and Ice machines weekly. DON or designee will monitor progress Of infection control program weekly. Both will report findings to the faciliity Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	

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L 091	Continued From page 38 There was no evidence that the Infection Control Committee investigated and monitored infections in the facility; maintained a record of incidents and corrective actions related to infections; and adhered to the facility's Infection Control Policies and Procedures. B. Based on observations during the environmental tour on April 6, 2009 between 9:30 AM and 5:45 PM, it was determined that three (3) of 51 resident rooms with protective mats stored on floors and along walls were soiled with spillages and three (3) of eight (8) ice machine chutes and trays were soiled with mineral deposits and other debris. These findings were observed in the presence of Employees #15 and 32 who acknowledged the findings at the time of the observations. The findings include: 1. Floor mats used to protect residents who were subject to falls were observed on floor surfaces beside resident beds and along wall surfaces were soiled with debris on the bottom and top surfaces in rooms 213, 229 and 311 in three (3) of 51 resident rooms with protective floor mats observed. 2. The interior surfaces of the ice machine water and ice chutes and trays were soiled accumulated mineral deposits, rust and other debris in nourishments rooms on the Units 2nd North, 2 South and 4 North in three (3) of eight (8) ice machines observed.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free	L 099		

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L 099	Continued From page 39 from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the tour of the main kitchen, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: 16 of 18 hotel pans stored soiled and wet and ready for reuse, four (4) of four (4) drains with no air gap above the drain, four (4) of four (4) incorrect size scoops used for plating the breakfast meal on April 6, 2009, food temperatures on the tray line with three (3) of seven (7) hot foods below 140 Fahrenheit (F) and one (1) of two (2) cold foods above 40 F, five (5) of five (5) opened items undated in the dry storage area, and one (1) of six (6) line servers used gloved hands to serve pancakes and sausages and touched counter, cabinet handles with same gloved hands. The tour of the main kitchen was conducted on April 6, 2009 from 7:35 AM through 9:45 AM in the presence of Employee #21, who acknowledged the findings at the time of the observations. The findings include: 1. 16 of 18 hotel pans were observed soiled and/or wet and stored ready for reuse as follows: Five (5) of seven (7) 2 " hotel pans Five (5) of five (5) 4 " hotel pans Four (4) of four (4) 6 " hotel pans Two (2) of two (2) baking pans 2. No air gaps were observed above the drains in the following areas: one (1) drain near the tray	L 099	L 099 1. All of the hotel pans are stored clean and dry and ready for reuse. 1a. Drain caps have air gaps per regulation. 1b. Correct scoop sizes are used during serving all meals. 1c. Hot foods are served at 140 Fahrenheit. 1d. Cold foods are served at 40 Fahrenheit. 1e. Opened items are labeled and dated. 1f. Servers are practicing sanitary conditions while serving. 2. A comprehensive environmental walk through was done in the kitchen to identify areas of sanitary non compliance and that equipment is in good working order. Deficient practices are resolved. 3. Dietary Manager inserviced staff on proper way of washing, rinsing, sanitizing, stacking and drying hotel pans as well as the proper use of general sanitation practices while serving, storage and cleaning the kitchen. Staff was also re-educated on use of proper scoop sizes for portion control, infection control and storage procedures. Dietary Manager or designee will observe tray line during each meal to monitor accuracy of the diet orders sanitation practices and food temperatures 4. Administrator or designee will make random observation of tray line and environmental rounds in the kitchen to ensure sanitary practices are in compliance and that equipment is in good working order and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 Months.	4/06/09 5/22/09 4/07/09 4/07/09 4/06/09

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L 099	Continued From page 40 line, one (1) near the pot and pan wash area, one (1) near the cook ' s preparation area and one (1) near the dish machine. 3. The incorrect scoop size was observed for the following foods for the breakfast meal on Monday, April 6, 2009 at 7:40 AM: Pureed bread: a 1 3/8 ounce scoop was used and a 2 ounce serving was indicated on the production sheet. Chopped Meat: a 1 1/3 ounce scoop was used and a 2 ounce serving was indicated on the production sheet. Pureed Meat: a 1 1/3 ounce scoop was used and a 2 ounce serving was indicated on the production sheet. Scrambled Eggs: a 2 ounce scoop was used. However, scrambled eggs did not appear on the production sheet. 4. Food temperatures on the tray line for hot food holding were below 140 F and cold foods above 41 F for the breakfast meal were observed on Monday, April 6, 2009 at 7:45 AM as follows: Sausage link: 122 F Pancakes: 120 F Turkey Bacon: 120 F Cranberry Juice: 70 F 5. The following opened undated items were observed in the dry storage areas: 1 (one) gallon bottle of vinegar 1 (one) gallon bottle of Worcestershire sauce 1 (one) package of dry spaghetti 1 (one) package of dry macaroni	L 099		

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L 099	Continued From page 41 1 (one) package of dry three colored past 6. During the breakfast meal, the following observation was made of Employee #20. Employee #20 was observed plating pancakes and sausage links with a gloved hand. His/her gloved palms were observed placed on the steam table, opening the steam table cabinet to retrieve warmed plates, and opening packages of warmed pancakes that were handed to him/her by another employee with ungloved hands.	L 099			
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is	L 128			

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L 128	Continued From page 42 maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview for six (6) of 30 sampled residents and eight (8) supplemental residents, it was determined that the pharmacist failed to notify the facility that a dose reduction was not attempted for two (2) residents receiving antipsychotic medications. the facility failed to act upon the pharmacist's recommendations for 13 residents and facility staff failed to consistently the Medication Administration Record for the administration of controlled substances for one (1) resident. Residents #3, 6, 7,11, 13, 14, JH2, JH6, JH7, JH8, JH9, JH10, JH11 and JH12. The findings include: 1. The pharmacist failed to notify the facility that a gradual dose reduction for Resident #3 who was prescribed antipsychotic medications. A review of Resident #3 ' s record revealed the following physician ' s orders: " Remeron 15mg at bedtime by mouth " initiated May 16, 2008. " Seroquel 50 mg twice daily by mouth " initiated June 19, 2008. " Ativan 2 mg every 8 hours as needed by mouth for agitation " for agitation initiated April 11, 2008. Ativan was discontinued October 13, 2008. " Xanax 0.25 mg every 8 hours as needed for agitation " initiated October 14, 2008. " Ambien 5 mg at bedtime by mouth for insomnia " initiated June 22, 2008. The above medications were renewed on July 29, September 2, October 14 and December 1, 2008 and January 1 and February 22, 2009.	L 128	L 128 1. The Pharmacist wrote recommendation for gradual dose reduction for Residents #3 who were prescribed antipsychotic medications and notified Psychiatrist of the recommendation. Recommendation initiated. The facility has acted upon the Pharmacist's recommendations for the 13 residents and #3, 6, 7,11, 13, 14, JH2, JH6, JH7, JH8, JH9, JH10, JH11 and JH12. 2.A chart review of all Resident records was done to ensure pharmacist recommendation were completed consistently and timely. Records that were found out of compliance were updated to reflect Pharmacist current recommendations. 3.Unit managers have been reeducated on the importance of acting upon Pharmacist recommendations consistently and timely. Pharmacist has been reeducated on the importance of communicating recommendations to the facility in a timely manner. Pharmacist will communicate recommendations with Unit Managers during consultation visit and provide the actual report of recommendation to the facility within one week of visit. Unit manager will review recommendations and ensure implementation within 72 hours of notification.	5/13/09 5/22/09 5/22/09 5/22/09

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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
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L 128	<p>Continued From page 43</p> <p>The resident received no Xanax according to the October, November, and December 2008 and January, February March and April 2009 Medication Administration Records.</p> <p>The pharmacist reviewed the resident ' s medications on April 5, May 14, June 9, July 23, August 20, September 23, October 31, November 12 and December 12, 2008 and January 21, February 10, and March 5, 2009. There was no evidence that the pharmacist recommended an attempted dose reduction for the above cited antipsychotic medications.</p> <p>A " Consultation Report " from the pharmacist dated March 9, 2009, recommended, " [Resident #3] has been taking Remeron 15 mg q hs (at bedtime) for depression, Risperidone 1 mg bid (twice daily) for psychotic disorder, Seroquel 50 mg bide for psychotic disorder and Zolpidem (Ambien) 5 mg q hs for insomnia.</p> <p>Suggest obtain a psych consult at this time to consider a gradual dose reduction of the above medications. If therapy is to continue at the current dose, please provide rationale describing a dose reduction as clinically contraindicated. " There was no evidence that a prior recommendation was made by the pharmacist.</p> <p>A face-to-face interview with Employee #3 was conducted on April 6, 2009 at 3:30 PM. He/she acknowledged the above cited information. The record was reviewed April 6, 2009.</p> <p>2. Facility staff failed to consistently act upon the Pharmacist's recommendations in a timely manner for Resident #6.</p> <p>A review of the consultant pharmacist</p>	L 128	4.DON or designee, Behavioral Specialist and Pharmacy consultant will randomly QA latest recommendations to ensure timely and consistent implementation and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.	

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L 128	<p>Continued From page 44</p> <p>recommendations dated February 10, 2009 revealed, "Comment: ...takes Lipitor and Zetia. Recommendation: Please consider monitoring a fasting lipid panel and hepatic function panel on the next convenient lab day and every six months thereafter. Rational for Recommendation: ...monitor a fasting lipid panel and hepatic function panel 12 weeks after initiation of therapy or following any dosage increase, and periodically thereafter to monitor efficacy and toxicity of this therapy."</p> <p>The record lacked evidence that a fasting lipid and hepatic function panel were obtained and/or any laboratory results obtained from dialysis were used and reviewed at the time of this review.</p> <p>A face-to-face interview was conducted on April 10, 2009 at 11:00 AM with Employee #4. He/she stated, "The report was in my box [mail box] on Monday morning and I started working on the recommendations. Some of the recommendations were done." The record was reviewed on April 10, 2009.</p> <p>3. Facility staff failed to consistently sign the Controlled Medication Utilization Record and the Medication Administration Record (MAR) when administering controlled substances to Resident #7.</p> <p>A review of Resident #7's record revealed a physician's order dated January 7, 2009 that directed, "Tylenol w/ codeine #3 300-30 mg tablet, 2 tab by mouth every four hours as needed for pain."</p> <p>Tylenol #3 was signed on the Resident Controlled Substance Record for February 27, 2009 at 6:00 PM, March 2 at 6:00 AM and 6:00 PM, March 4 at</p>	L 128			

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L 128	<p>Continued From page 45</p> <p>11:20 AM and 5:30 PM, March 7 at 9:00 PM and March 16, 2009 at 3:00 PM, April 6, 2009 at 12:00 AM as being removed from the narcotics drawer.</p> <p>According to the February 2009, March 2009 and April 2009 MAR, there were no nurse ' s initials in the area designated for February 27, 2009, March 2, 4, 7, 16, 2009 and April 6, 2009 and no time mentioned above indicating that the medication was administrated to the resident. There was no documentation on the back of the MAR under "Comments /Progress Notes" documenting the administration of medication or the effectiveness of the medication for the above cited dates and times.</p> <p>There was no evidence in the nurse's notes that documented that the medication was administered to the resident for the above dates and times.</p> <p>A face-to-face interview was conducted with Employee #14 at the time of the findings. He/She acknowledged the above findings. The record was reviewed April 7, 2009.</p> <p>4. Facility staff failed to consistently act upon the Pharmacist's recommendations in a timely manner for Resident #11.</p> <p>On April 8, 2009 it was noted that the consultant pharmacist wrote recommendations for the medical and nursing staff dated October 1, 2008 and March 1, 2009 for Resident #11.</p> <p>A face-to-face interview was conducted on April 8, 2009 at 12:00 PM with Employee #14. He/she acknowledged that the consultant pharmacist recommendations were not act upon.</p>	L 128		

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L 128	<p>Continued From page 46</p> <p>5. The pharmacist failed to notify the facility that a gradual dose reduction for Resident #13 who was prescribed antipsychotic medications.</p> <p>A review of Resident #13 ' s record revealed the following physician ' s orders: " Haldol 2 mg concentrate every 6 hours for agitation as needed " initiated on April 28, 2008. " Risperdal 0.5 mg daily by mouth " initiated July 14, 2008.</p> <p>The above medications were renewed June 24, August 28, September 28, November 7, and December 30, 2008 and February 5 and 27 and March 24, 2009.</p> <p>An observation of the bottle of Haldol was conducted on April 6, 2009 at 1:30 PM and revealed that the bottle was unopened. The resident had received no doses of Haldol since the initial order of April 28, 2008.</p> <p>The pharmacist visited the resident on May 14, June 6, July 5, August 24, September 7, October 22, November 12, and December 12, 2008 and January 21, February 20 and March 9, 2009. There was no evidence that the pharmacist recommended an attempted dose reduction for the above cited antipsychotic medications or to discontinue the Haldol.</p> <p>A face-to-face interview was conducted with Employee #3 on April 6, 2009 at 2:00 PM. He/she acknowledged the above cited information. The record was reviewed April 6, 2009.</p> <p>6. Facility staff failed to act upon the Pharmacist's recommendations in a timely manner for</p>	L 128		

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L 128	<p>Continued From page 47</p> <p>Resident #14.</p> <p>A review of the consultant pharmacist recommendations for the medical and nursing staff dated February 26, 2009 for Resident #14 revealed, " ...Comment: The pharmacy recommendation(s) for [resident name] from November 24, 2008 and December 29, 2008 have not been acted upon by the intended recipient of the recommendation in accordance with the State Operations Manual guidelines. Recommendation: ...1) ...discharge summary stated to resume all preadmission medications and to increase the Coreg 12.5 mg po bid. Please review for a possible need to increase [resident] Coreg dose. Discussed with charge nurse. 2) ...has been taking Remeron 30 mg daily for management of major depressive disorder. Please consider documenting that GDR (gradual dose reduction) attempts are clinically contraindicated in this individual with major depressive disorder ...Resubmitted February 26, 2009. "</p> <p>The record lacked evidence that the pharmacy recommendations had been acted upon.</p> <p>A face-to-face interview was conducted on April 7, 2009 at 1:48 PM with Employee #9. He/she acknowledged that the pharmacy recommendations have not been acted upon. The record was reviewed on April 7, 2009.</p> <p>7. Facility staff failed to consistently act upon the Pharmacist's recommendations.</p> <p>On April 7, 2009, at approximately 1:30 PM, it was noted that the consultant pharmacist wrote recommendations for the medical and nursing staff dated March 6, 2009, summarizing reported</p>	L 128			

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L 128	<p>Continued From page 48</p> <p>recommendations that had not been acted upon for the following residents:</p> <table border="0"> <tr> <td>Resident</td> <td>Recommendation dates</td> </tr> <tr> <td>Resident #3</td> <td>12/12/2008</td> </tr> <tr> <td>Resident JH2</td> <td>11/5/2008 and 1/12/2009</td> </tr> <tr> <td>Resident JH6</td> <td>11/12/2008</td> </tr> <tr> <td>Resident JH7</td> <td>12/29/2008</td> </tr> <tr> <td>Resident JH8</td> <td>11/19/2008</td> </tr> <tr> <td>Resident JH9</td> <td>11/21/2008</td> </tr> <tr> <td>Resident JH10</td> <td>9/17/2008 and 11/21/2008</td> </tr> <tr> <td>Resident JH11</td> <td>12/12/2008</td> </tr> <tr> <td>Resident JH12</td> <td>1/12/2009</td> </tr> </table> <p>A telephone interview was conducted on April 7, 2009 at approximately 1:10 PM with Employee #35. He/she stated that the consultant pharmacist was on vacation at the time of the survey.</p> <p>A face-to-face interview was conducted on April 8, 2009 at 4:30 PM with Employee #3. He/she stated that the consultant pharmacist reports arrive at the end of each month and are distributed to the unit managers for follow-up.</p> <p>A face-to-face interview was conducted on April 9, 2009 with Employee #3. He/she stated, "We identified that the drug regimen reviews were not being submitted and we [the facility] discussed the concern in the January 2009 Quality Assurance meeting. Follow up was done. The pharmacist had a problem with his/her computer/laptop over the last month and a half. When I received the reports they were due back to the Director of Nursing by April 6, 2009."</p> <p>There was no evidence that additional interventions were taken and/or initiated to</p>	Resident	Recommendation dates	Resident #3	12/12/2008	Resident JH2	11/5/2008 and 1/12/2009	Resident JH6	11/12/2008	Resident JH7	12/29/2008	Resident JH8	11/19/2008	Resident JH9	11/21/2008	Resident JH10	9/17/2008 and 11/21/2008	Resident JH11	12/12/2008	Resident JH12	1/12/2009	L 128		
Resident	Recommendation dates																							
Resident #3	12/12/2008																							
Resident JH2	11/5/2008 and 1/12/2009																							
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L 128	Continued From page 49 ensure that the pharmacist reports were received in a timely manner.	L 128	L 161 1.The facility staff has removed all expired medications from the currently dated medications in the narcotic interim box and emergency boxes on Units 2 North and 4 South. The lock box has been replenished.	4/8/09
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations of two (2) of eight (8) medication rooms, and staff interviews, it was determined that the facility staff failed to remove expired medication from the currently dated medications in the narcotic interim box and emergency boxes on Units 2 North and 4 South. The findings include: 1. The facility staff failed to remove expired medication from usage from the narcotic interim box and the emergency boxes on 2 North and 4 South. A. On April 8, 2009 between 10:00 AM and 3: 00 PM. during the inspection of the medication storage areas, the narcotic interim box located in the nursing supervisor ' s office contained four (4) of seven (7) narcotic blister package medications that were observed expired along with stock that was current. The expired drugs included: Oxycodone IR 5mg, Expired 2/28/2009 Oxycodone IR 5mg, Expired 1/31/2009 Morphine ER 30 mg, Expired 2/2009 Morphine ER 30 mg, Expired 2/2009 B. The emergency box on 2 North contained four (4) Epinephrine 1:1000 (1mg/ml), 1 ml ampoules which expired March 1, 2009. The expiration date documented on the exterior of the box was March 1, 2009.	L 161	2.Unit Managers have checked all other narcotics boxes for expired medication and discarded any found. The narcotic and lock boxes were replenished. 3.Unit Managers have been reeducated on the importance of discarding expired medications Unit managers will check medications on the carts, the narcotic boxes, lock boxes and refrigerators on a weekly basis and discard those that are expired. Narcotics will be destroyed monthly and reported to DEA. DON will review narcotic box in nursing office weekly and discard those that are expired . Consulting pharmacist will review interim medication and narcotic boxes monthly to ensure compliance and discard those that are expired. 4.DON or designee and Pharmacy consultant will randomly QA medications process to ensure expired medications are removed from the carts, narcotic boxes, lock boxes and refrigerators and discarded per facility practice and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.	4/08/09 4/08/09

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L 161	Continued From page 50 The emergency box on 4 South contained two (2) Vitamin K 10mg/ml, 1ml ampoule and Atropine sulfate syringe, 0.5mg (0.1mg/ml, 5 ml syringe), which both expired April 1, 2009. The expiration date documented on the exterior of the box was April 1, 2009. A face-to-face interview was conducted at the time of the observation with Employees #9 and 10. They acknowledged that the medications were expired.	L 161	L 214 1. Resident #9 has been referred to the facility's behavioral specialist. Resident #9 has agreed to participate in the A.A. program. The toilet in the male shower room on unit 3 South was secured to floor surfaces and no longer tilt back and forth. The fire emergency double door closure mechanism lacked a cover to conceal exposed electrical wiring on unit 3 North near room 336 and 536.	5/15/09 5/22/09 5/22/09	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to provide adequate supervision for Residents #3 and 9 who had multiple falls, one with subsequent injuries. Additionally, facility staff failed to secure one (1) of eight (8) toilets in shower rooms observed and cover the electrical wires on one (1) of eight (8) unit entrance double doors. Residents #3 and 9. The findings include: 1. Facility staff failed to provide adequate supervision for Resident #3 who had multiple falls and subsequent injury. A review of Resident #3 's record revealed a nurse 's note dated December 10, 2008 at 10:00 AM, " Resident observed on the floor in a sitting	L 214	2. Unit Managers will review care plans of each resident with incidents and accidents to ensure appropriate goals and approaches are established to help minimize the occasion of incidents and accidents for each Resident. Records that are found out of compliance will be updated to reflect Resident current needs. 3. Falls are evaluated daily by the Interdisciplinary team during daily stand up Meetings five times a week. During those meetings referrals are made to therapy services. An analysis of the events is done and appropriate interventions are implemented. Interventions are reviewed weekly by the interdisciplinary team until resolved and care plan goals and approaches are updated as needed. 4. DON or designee will do random QA Of fall process during weekly care management meeting weekly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.	5/22/09 5/13/09	

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L 214	<p>Continued From page 51</p> <p>position in [another resident ' s room]. Range of motion to upper and lower extremities without difficulty or complaint of pain. No skin abrasions, bruises noted at this time ... "</p> <p>A care plan entitled, " Resident at risk for FALLS " was reviewed by facility staff on December 11, 2008. Under the column " Status/Date " was hand written " Cont [continue]. "</p> <p>There was no evidence that additional interventions were initiated after the resident fell on December 10, 2008.</p> <p>An " Interdisciplinary Functional Status Form " was completed by the occupational therapist on December 11, 2008. The comment on the form was, " Patient recently treated with OT/PT (occupational and physical therapy): reached max potential. "</p> <p>An " Interdisciplinary Functional Status Form " was completed by the physical therapist on December 15, 2008. The comment on the form was, " No injuries noted. Patient has increased trunk flexion but ambulating with limit assist. Has visual impairment. No change since [unable to read] treatment. "</p> <p>According to the quarterly Minimum Data Set assessment completed December 8, 2008, the resident was coded in Section G (Physical Functioning and Structural Problems) as being independent in walking in the room and corridor.</p> <p>A face-to-face interview conducted on April 6, 2009 at 3:30 PM with Employee #3. He/she stated, " Resident #3 has always wandered around the unit by [him/herself]. Sometimes [he/she] wanders into other residents ' rooms</p>	L 214	<p>1. Resident #3 is participating in more recreational therapy programs to assist with closer monitoring.</p> <p>2. Unit Managers will review care plans of each resident with incidents and accidents to ensure appropriate goals and approaches are established to help minimize the occasion of incidents and accidents for each Resident. Records that are found out of compliance will be updated to reflect Resident current needs.</p> <p>3. Falls are evaluated daily by the Interdisciplinary team during daily stand up Meetings five times a week. During those meetings referrals are made to therapy services. An analysis of the events is done and appropriate interventions are implemented. Interventions are reviewed weekly by the interdisciplinary team until resolved and care plan goals and approaches are updated as needed.</p> <p>4. DON or designee will do random QA Of fall process during weekly care management meeting weekly and report findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	<p>5/15/09</p> <p>5/22/09</p> <p>5/13/09</p>	

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L 214	<p>Continued From page 52 and needs to be redirected. "</p> <p>A nurse ' s note dated March 25, 2009 at 8:00 AM documented, " Resident observed sitting on the floor next to the wall near [his/her] bed. Blood at this time was seen on left side of face ...laceration was observed about 3 cm long on left side of around eye region ...MD made aware and gave orders to transfer resident to the nearest ER via 911 ... "</p> <p>The resident was hospitalized from March 25 through March 30, 2009 and returned to the facility with a diagnosis of orbital fracture.</p> <p>Resident #3 was observed on April 6, 2009 at 10:00 AM wandering on the nursing unit. The resident walked around the day room and up and down the corridors without assistance. The resident had a blue-yellow discoloration beneath the left eye.</p> <p>A face-to-face interview was conducted with Employee #3 on April 6, 2009, who acknowledged that there was no evidence that interventions were initiated after the fall on December 10, 2008 or that the resident received limited assistance while ambulating on the unit as identified by the physical therapist. The record was reviewed April 6, 2009.</p> <p>2. Facility staff failed to supervise Resident #9 who had multiple falls without injury. Resident #9 ' s diagnoses included Diabetes Mellitus and bilateral above the knee amputations according to Section I (Disease Diagnoses) of the admission Minimum Data Set assessment completed June 27, 2008.. He/she was non-ambulatory, required extensive assistance for transfer and self-propelled via wheelchair for</p>	L 214		

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L 214	<p>Continued From page 53</p> <p>mobilization as coded in Section G (Physical Functioning and Structural Problems) of the same MDS.</p> <p>The resident sustained the following fall-related accidents according to documentation reviewed in the comprehensive care plan September 8, 2009 revealed, " actual fall - observed on the floor. "</p> <p>According to following nurses' progress notes: September 29, 2008, 2300, " observed on the floor at 11:00 PM; " November 14, 2008, 2330, " ...fell on the ground in a sitting position ...; " November 22, 2008, 2200, documented, " observed lying on stomach in front of the elevator intoxicated with alcohol; " March 23, 2009, 2000, " observed sliding out of chair ...helped, accompanied resident into sitting position on the floor. "</p> <p>A review of the resident ' s comprehensive care plan, as it related to falls, revealed that facility staff implemented monitoring for alcohol use on September 29, 2008 and monitoring every 2 hours while off the unit on November 14, 2008 as documented under problem # " 2. "</p> <p>The resident continued to sustain fall related accidents and facility staff failed to implement any additional interventions or screenings related to the resident ' s functional status.</p> <p>A face-to-face interview was conducted with Employee #16 on April 9, 2009 at approximately 2:30 PM. In response to a query regarding the role of rehabilitative (rehab) services as it relates to residents who sustain falls in the facility, he/she responded, "Meetings are held every morning to overview the unusual incidents that occurred the day prior, inclusive of those related</p>	L 214		
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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(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) COMPLETE DATE
L 214	Continued From page 54 to falls. Staff from the rehabilitative services division conduct screening assessments on residents who sustain falls within 24-hours of the fall incident and document comments/recommendations accordingly." Employee #16 provided a document entitled " Interdisciplinary Functional Status Form. " He/she stated that a rehabilitation screening was conducted on 11/28/09 (this document was not observed in the clinical record) for Resident #9. According to Employee #16, the rehabilitation services division was not aware of the other falls sustained by Resident #9. The record was reviewed April 6, 2009. The following observations were made during the environmental survey on April 7, 2009 between 9:20 AM and 6:00 PM, in the presence of Employees #15 and 32 who acknowledged the findings at the time of the observations. 3. The toilet in the male shower room on unit 3 South was not secured to floor surfaces and tilted back and forth, when examined in one (1) of eight (8) toilets observed in shower rooms. 4. The fire emergency double door closure mechanism lacked a cover to conceal exposed electrical wiring on unit 3 North near room 336 and 536 in one (1) of eight (8) unit entrance double doors observed.	L 214	L 245 1. Boilers and mixing valves were adjusted to maintain hot water temperatures below 110 and degrees Fahrenheit (F) in resident rooms and common areas 2nd Floor Shower Room blue side, 2nd Floor Shower Room-pink side , Room 213, Room 228 Room 229 and Rehabilitation Department Fire safety entry door for room 429 has been repaired and in safe operation. The smoke alarm is also working properly. 2. Administration has developed and is strategically implementing a plan to address the overall environmental issues of the facility. 3. Maintenance Director has obtained quotes for environmental repairs and have submitted them for approval. Contractors are called in to make repairs as needed. Daily issues are identified and addressed within 24- 72 hours. Maintenance staff has been authorized to work more hours when needed to address issues. Anticipated completion of identified major projects is August 30, 2009. Maintenance staff has been educated on the importance of maintaining all essential mechanical, electrical, and patient care equipment in safe operating condition. Maintenance staff take water temps daily times 5 days a week. Maintenance Director will ensure that facility essential mechanical, electrical, and patient care equipment is in safe operating condition during environmental rounds daily times 5 days a week to ensure compliance.	4/06/09 Ongoing 5/22/09 Ongoing 08/30/09
L 245	3238.1 Nursing Facilities Each piece of heating and air conditioning equipment and its installation shall comply with	L 245		

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L 245	<p>Continued From page 55</p> <p>the 1996 BOCA International Mechanical Code (Heating, Air Conditioning and Refrigeration), and all applicable District laws and regulations. This Statute is not met as evidenced by:</p> <p>Based on observations during the environmental tour conducted on April 6, 2009 between 9:30 AM and 6:00 PM, it was determined that boilers and mixing valves were not adjusted to maintain hot water temperatures below 110 degrees Fahrenheit (F) in resident rooms and common areas as evidenced by elevated temperatures in five (5) of 51 resident rooms and common areas observed and facility staff failed to ensure the safe operation of a fire safety door and smoke alarm for one (1) of 51 resident rooms observed.</p> <p>The findings include:</p> <p>1. Boilers and mixing valves were not adjusted properly to ensure that domestic hot water temperatures were below 110 degrees F as follows:</p> <p>2nd Floor Shower Room, blue side-134 F 2nd Floor Shower Room, pink side - 124 F Room 213-120 F Room 228-112 F Room 229-112 F Rehabilitation Department - 125 F</p> <p>These findings were observed in the presence Employees #15 and 32 who acknowledged the findings at the time of the observations.</p> <p>2. During an initial tour of the facility on April 6, 2009 at approximately 9:00 AM, it was determined that facility staff failed to ensure the safe operation of the entry door of resident room 429. These findings were observed in the</p>	L 245	<p>4. Administrator or designee will monitor facility essential mechanical, electrical, and patient care equipment in safe operating condition daily times 5 days a week to ensure compliance and report findings to the findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.</p>	
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L 245	Continued From page 56 presence of Employee #4 who acknowledged the findings at the time of the observations. An observation of the entry door of resident room 429 revealed the door was held open with plastic trash bags tied to an interior door inside the room. A smoke alarm was observed in the ceiling of room 429 and periodically emitted an audible alarm. Four (4) residents resided in the room. In response to a query regarding the reason for the door being held open with plastic bags, the staff person stated that the door would not remain in an open position without the plastic bags. Employee #4 removed the plastic bags from the door. Subsequently, the door closed and did not remain open without props. Employee #4 made a verbal request to the facility 's maintenance staff for the door to be repaired and placed a chair in front of the door to keep it open. A face-to-face interview was conducted with Employee #15, on April 7, 2009 at approximately 10:00 AM. He/she stated that the door was in the process of being repaired, however, a part was ordered and scheduled for delivery on April 8, 2009. The door was designated as a fire safety door and in turn periodically triggered the smoke alarm due to its malfunctioning.	L 245		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observation during the environmental tour of the of the facility on April 6, 2009 from	L 410		

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L 410	<p>Continued From page 57</p> <p>9:20 AM through 5:45 PM, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by the following observations: damaged wall surfaces in 11 of 51 walls, damaged and marred doors in 18 of 51 doors in resident rooms and common area, soiled exhaust vents in six (6) of 25 exhaust vents in resident bathrooms and common areas, air supply vents and louvers in two (2) of two (2) air supply vents in the laundry, damaged floor tiles in four (4) of four (4) areas in the laundry, the top surfaces of washers were soiled in four (4) of four (4) washers in the laundry, dining room threshold missing in one (1) of five (5) resident dining rooms, missing insulation on the main entrance door in one (1) of two (2) sliding glass entrance doors, soiled and damaged ceiling tiles in 16 of 51 ceilings in resident rooms and common areas, damaged floor surfaces in six (6) of 12 floor surfaces in resident shower rooms and the laundry, soiled sprinkler heads in eight (8) of 30 sprinkler heads in resident rooms and common areas, soiled and stained privacy curtains in four (4) of 30 privacy curtains in resident rooms, soiled bed frames in five (5) of 25 bed frames in resident rooms, soiled and unsecured chair seats in two (2) of five (5) resident dining rooms, marred elevator jams and doors in three (3) of three (3) elevators, soiled lamp covers in two (2) of 25 lamp covers in resident rooms and common areas, six (6) of eight (8) damaged lamp covers in the Rehabilitation Department, boxes improperly stored on the floor in one (1) of eight (8) storage areas, and personal items stored on floor surfaces in one (1) of 50 resident rooms.</p> <p>These observations were made in the presence of Employees #15 and 32. These findings were</p>	L 410	<p>L 410</p> <p>1. Marred wall surfaces were repaired and wall paper repaired that was separating from surfaces adjacent to windows in resident rooms and common areas in rooms 203, 318, 335, 421, 3 South Lounge, 2 South Day Room, Clean and Soiled Sides of the Main Laundry Room, Rehabilitation Department, 3rd floor Soiled Linen Room, and 4th Floor Shower Room.</p> <p>The frontal and edge surfaces of resident entrance and bathroom doors were repaired in rooms 203, 220, 229, Nourishment Room, 2nd Floor Janitorial Closet, 305, 311, 314, 319, 325, 330, 515, 520, 529, 3rd Training Toilet, 3rd Floor Soiled Linen Room, 4th South Shower Room and 5th Floor Shower Room.</p> <p>The interior surfaces of exhaust vents in resident bathrooms and common areas were cleaned in the Clean and Soiled Sides of the Main Laundry, Laundry Storage Room, 305, 309 and 428 in six (6) of 25 exhaust vents observed.</p> <p>The air supply vent and louvers in the folding area of the Laundry Room and soiled receiving area were repaired</p> <p>Floor tiles were replaced in the folding, dryer, storage and soiled laundry areas of the main Laundry Room.</p> <p>The top surfaces of 4 washers in the main Laundry Room were cleaned.</p> <p>The threshold was repaired at the entrance to the dining room on the first floor.</p>	5/22/09

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L 410	<p>Continued From page 58</p> <p>acknowledged at the time of these observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Wall surfaces were marred and wall paper was separating from surfaces adjacent to windows in resident rooms and common areas in rooms 203, 318, 335, 421, 3 South Lounge, 2 South Day Room, Clean and Soiled Sides of the Main Laundry Room, Rehabilitation Department, 3rd floor Soiled Linen Room, 4th Floor Shower Room in 10 of 51 walls observed.. 2. The frontal and edge surfaces of resident entrance and bathroom doors were marred, scarred and splintered on the edges in rooms 203, 220, 229, Nourishment Room, 2nd Floor Janitorial Closet, 305, 311, 314, 319, 325, 330, 515, 520, 529, 3rd Training Toilet, 3rd Floor Soiled Linen Room, 4th South Shower Room and 5th Floor Shower Room in 18 of 51 doors observed. 3. The interior surfaces of exhaust vents in resident bathrooms and common areas were soiled with accumulated dust in the Clean and Soiled Sides of the Main Laundry, Laundry Storage Room, 305, 309 and 428 in six (6) of 25 exhaust vents observed. 4. The air supply vent and louvers in the folding area of the Laundry Room and soiled receiving area were damaged in two (2) of two (2) air supply vent and louvers observed. 5. Floor tiles were damaged and sections of tile were missing in the folding, dryer, storage and soiled areas of the main Laundry Room in four (4) of four (4) areas observed. 	L 410	<p>The insulation on the frontal edges of double sliding entrance doors were repaired.</p> <p>Ceiling tiles in residents' rooms and common areas were replaced in Rooms 203, 209, 322, 409, 421, 511, 515, 520, 533, South Lounge, Folding and Soiled Laundry Areas of the Main Laundry Room, Physical Therapy, 3rd Floor Clean Utility Room, 3rd Floor Nourishment Room, 3rd Floor Soiled Linen Room and 3rd Floor Nourishment Room.</p> <p>Painted floor surfaces in the 2 South and 2 North Showers, 4 North and 4 South Showers, 5th Floor Shower room and washer and soiled areas of the Laundry Room were repaired and painted.</p> <p>Sprinkler heads were cleaned in residents rooms and common areas in Rooms 228, 311, 314, 318, 2nd Floor Storage Room, 3rd Floor Soiled Utility Room, Folding , Dryer and Washer Areas of the Laundry Rooms.</p> <p>Privacy curtains in resident rooms were cleaned and hooks were reattached in rooms 209, 220, Rehabilitation Therapy and 304.</p> <p>The horizontal surfaces of resident beds were dusted and cleaned in Rooms 209, 220, 228, 229 and 305 in five (5) of 25 beds observed.</p> <p>The seat surfaces of straight back chairs in Day Rooms/Dining rooms were cleaned and unsecure chairs were removed, 2nd Floor two (2) of six (6) chairs and 3rd Floor one (1) of six (6) chairs.</p>	

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L 410	Continued From page 59 6. The top surfaces of washers in the main Laundry Room were soiled with dust accumulation in four (4) of four (4) washers observed. 7. The threshold at the entrance to the dining room on the first floor was missing in one (1) of five (5) dining rooms observed. 8. The insulation on the frontal edges of double sliding entrance doors were damaged and separated from door surfaces in one (1) of two (2) sliding glass entrance doors observed. 9. Ceiling tiles in residents rooms and common areas were soiled, stained and failed to fit securely into grids in Rooms 203, 209, 322, 409, 421, 511, 515, 520, 533, South Lounge, Folding and Soiled Areas of the Main Laundry Room, Physical Therapy, 3rd Floor Clean Utility Room, 3rd Floor Nourishment Room, 3rd Floor Soiled Linen Room and 3rd Floor Nourishment Room in 16 of 51 ceiling tiles observed. 10. Painted floor surfaces in the 2 South and 2 North Showers, 4 North and 4 South Showers, 5th Floor Shower room and washer and soiled areas of the Laundry Room were damaged and paint was peeling in six (6) of 12 painted floor surfaces observed. 11. Sprinkler heads were soiled with accumulated dust in residents rooms and common areas were soiled with dust in Rooms 228, 311, 314, 318, 2nd Floor Storage Room, 3rd Floor Soiled Utility Room, Folding, Dryer and Washer Areas of the Laundry Rooms in nine (9) of 30 sprinkler heads observed. 12. Privacy curtains in resident rooms were soiled	L 410	Elevator jams and doors were repaired in the basement and first floor areas. The interior surfaces of lamp covers in resident rooms and common areas were cleaned in room 209 and the Laundry Room. Lamp covers in Rehabilitation Department were repaired in six (6) of eight (8) lamp covers in the Rehabilitation Department. Storage area on 4 south is neatly packed and within storage guidelines. The five (5) boxes and bags of personal belongings in room 229 are properly stored. 2. Rounds will be conducted to identify environmental issues that are in need of resolution such as marred and damaged doors and walls, soiled exhaust and air vents, damaged floors, soiled equipment, proper functioning doors, missing insulation, damaged ceiling tiles, soiled bed frames, damaged lamp covers, items are being properly stored and the like. A master list will be maintained by the environmental staff and items from that list will be completed daily.	5/22/09

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L 410	Continued From page 60 with grease and hooks were detached in rooms 209, 220, Rehabilitation Therapy and 304 in four (4) of 30 privacy curtains observed. 13. The horizontal surfaces of resident beds were soiled with dust in Rooms 209, 220, 228, 229 and 305 in five (5) of 25 beds observed. 14. The seat surfaces of straight back chairs in Day Rooms/Dining rooms were soiled and chairs were not secure when examined, 2nd Floor two (2) of six (6) chairs and 3rd Floor in one (1) of six (6) chairs in two (2) of five (5) dining rooms observed. 15. Elevator jams and doors were marred and scarred on the frontal surfaces in the basement and first floor areas in three (3) of three (3) observations. 16. The interior surfaces of lamp covers in resident rooms and common areas were observed to be soiled in room 209 and the clean soiled area of the Laundry Room in two (2) of 25 lamps observed. 17. Lamp covers in Rehabilitation Department were damaged and were not secured to fixtures in six (6) of eight (8) lamp covers in the Rehabilitation Department. 18. Three (3) of three (3) boxes of supplies were stored directly on floor surfaces in the Storage Room on unit 4 South in one (1) of eight (8) storage areas. 19. Five (5) boxes and bags of personal belongings were stored on floor surfaces in room 229 in one (1) of 50 resident rooms observed.	L 410	3. A preventative maintenance process was developed to ensure that the facility will provide adequate housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Environmental staff has been in-serviced On how to make quality environmental rounds as well as the importance of making the environmental rounds. Maintenance and Housekeeping/Laundry shift leaders will make rounds daily to ensure that preventative maintenance is done daily. 4. Maintenance and Housekeeping/ Laundry Managers will make rounds 5 days a week to ensure that preventative maintenance is done daily and will report findings monthly to the facility Risk Management/ Quality Improvement Committee monthly X 12 months.	05/21/09

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L 426	Continued From page 61	L 426	L426	
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the survey conducted on April 6, 2009 between 9:20 AM and 6:00 PM, it was determined that flying insects were observed in two (2) of eight (8) nourishment rooms and roaches crawling on floor surfaces in one (1) of 50 resident rooms observed and one (1) of one (1) laundry room observed. These observations were observed in the presence Employees #4, 15 and 32 who acknowledged the findings at the time of the observations. The findings include: 1. Gnats were observed flying in the Nourishment Room on the Unit 3 North and room 420 in two (2) of eight (8) nourishment rooms observed. 2. Roaches were observed crawling on floor surfaces adjacent to washers in the Laundry Room in one (1) of one (1) laundry room observed and crawling along the wall and vanity surfaces of resident room 410 in one (1) of 50 resident rooms observed.	L 426	1.The facility maintains an effective pest control program so that the facility is free of pests and rodents. Nourishment Room on the Unit 3 North, room 420, Laundry Room, vanity surfaces of resident room 410 were cleaned and treated. 2.Pest Control company evaluated property and did appropriate treatment of facility. 3.Staff reeducated on the importance of reporting sightings of pest in facility. A pest control log is in each department for staff use. The pest control company is to review and sign the logs on each visit to ensure the facility is properly treated upon each visit. Pest control company will be called in when needed to avoid infestations. Residents, staff and visitors informed of proper food storage and to dispose of trash properly. 4.Maintenance Director will monitor facility and Pest control logs daily times 5 days a week to ensure compliance and report findings to the findings to the facility Risk Management/ Quality Improvement Committee monthly X 12 months	5/22/09 5/21/09 5/22/09