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	095036	A. BUILDING _____ B. WING _____	07/13/2006

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F 000	INITIAL COMMENTS An annual re-certification survey, complaint investigation (C-06-072, DC00000966) and complaint/incident investigation (06-067/06-I-1203 , DC00000957/DC00000963) was conducted on July 11 through 13, 2006. The following deficiencies were based on observations, record review and interviews with the facility staff and residents. The sample included 29 sampled residents based on a census of 193 residents on the first day of survey and four (4) supplemental residents.	F 000	**JB Johnson Nursing Center makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/ or executed solely because it is required by Federal and State Law.**	
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by : Based on staff interview and record review for one (1) of 29 sampled residents, facility staff failed to follow the physician's order for releasing a restraint and repositioning the resident for 16 days. Resident #15. The findings include: A review of Resident 15's record revealed a telephone order dated June 26, 2006 at 12:20 [PM] and signed by the physician on July 7, 2006 which directed, "Seatbelt for safety. Staff to release seatbelt q 2 hrs (every two hours) and reposition resident for 15 min [minutes] ..." A review of the June and July 2006 Treatment	F 221	**F 221 483.13 Physical Restraints** **1. During the survey time Resident #15 was released and repositioned as required. The Interdisciplinary team (IDT) re-evaluated the restraint and it was determined that the seatbelt is still needed. The care plan was reviewed. The Treatment Administration Record (TAR) cannot be retrospectively altered for Resident #15 for June 26- June 30 and July 1- July 12. The TAR has been updated to include an on and off time schedule.** **2. All residents on restraints were reviewed. There were no other residents found to be affected by this practice.** **3. Nursing personnel were re-educated on the restraint policy and documentation.** **4. All residents with restraints will be reviewed monthly in the Quality Improvement (QI) sub committee. This is a part of the QI program. Review of the flow sheets (TAR sheets) is a part of nursing comprehensive medical records audit. The findings are reported to the Quality Assurance Committee.**	8/13/06 **08/13/06**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Grace Elvira, RN Acting Administrator for Anne K Price, Adm. from 8/04/06

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

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F 221	Continued From page 1 Administration Record [TAR] revealed, "Staff to release seatbelt and reposition resident q 2 hrs for 15 minutes". The order was dated June 26, 2006. The TAR was not initialed [would indicate that the seatbelt was released every two (2) hours and that the resident was repositioned] for June 26 (3- 11 shift) and 27 through 30, 2006 and July 1 through 12, 2006. A face-to-face interview was conducted on July 12, 2006 at 11:42 AM with the Unit Manager. He/ she acknowledged that the physician's order to release the seatbelt and reposition the resident was not initialed from June 26 (3-11 shift) to July 12, 2006. The record was reviewed on July 12, 2006.	F 221		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled HVAC panel and filters, inoperative water fountains in the hallways, soiled ceiling tiles in residents' rooms and common areas, marred entrance and bathroom doors, excessive personal items on floors and on top of cabinets in residents' rooms, soapy residue on shower walls,	F 253	**F 253 483.15(h) (2) HOUSEKEEPING/MAINTENANCE** **1. The soiled HVAC panels and filters were cleaned immediately by the housekeeping porter during the survey period. Inoperative water fountains in hallways were removed, soiled ceiling tiles in residents rooms and common areas were replaced. Marred entrance and bathroom doors, damaged geri chair armrests, shower room walls and soiled exhaust vents were removed or cleaned. Excessive boxes were removed from the following rooms,200,208,231,300, and 317.** **2. All HVAC panels and filters were cleaned and replaced as needed. All water fountains were inspected and/ or repaired. All residents rooms were inspected for soiled ceiling tiles and replaced as needed. All entrance and bathrooms doors were inspected and painted as needed. All geri chair armrest pads were inspected and repaired as needed. All exhaust vents were inspected and cleaned. All shower walls and rooms were checked on the units for soapy residue and excessive items. No resident was affected by this practice.**	8/28/06

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F 253	Continued From page 2 damaged geri chair armrests and soiled exhaust vents. These findings were observed in the presence of the Maintenance, Housekeeping and Nursing Staff. The findings include: 1. The interior surfaces of HVAC (Heating Ventilation and Air Conditioning Units) control panels and filters were soiled with accumulated dust in residents' rooms and common areas in the following areas: First Floor Room 102, Day Room and hallway in three (3) of eight (8) observations between 2:35 PM and 4:15 PM on July 11, 2006. Second Floor Rooms 201, 231, Day Room, Dining Room and hallway in five (5) of eight (8) observations between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Day Room and Dining Room in two (2) of six (6) of observations between 2:30 PM and 2:55 PM on July 12, 2006. Fourth Floor Rooms 400, 427, Day Room and Dining Room in four (4) of 10 observations between 3:00 PM and 4:30 PM on July 12, 2006. 2. Water fountains in the hallways were observed to be inoperative when examined on floors one (1) through four (4) in seven (7) of seven (7) observations between 7:55 AM and 4:30 PM on July 12, 2006. 3. Ceiling tiles in residents' rooms were soiled and stained and failed to fit into grids securely in the	F 253	**3. The Director of Engineering reviewed the Prevention Maintenance program and re-Educated staff on expectations. Ceiling tiles, shower walls, resident rooms and geri-chair inspections are included on daily room inspections. The Engineering and Environmental personnel will be in-serviced on these as well.** **4. The Director of Engineering will conduct quarterly audits on the HVAC panels /filters and the exhaust vents. Monthly audits will be conducted on water fountains, soiled ceiling tiles, shower walls, resident rooms, marred entrance and bathroom doors and geri chairs. Findings will be presented at the Quality Assurance meeting.**	**8/28/06**

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F 253	Continued From page 3 following areas: First Floor Room 106 in one (1) of eight (8) observations at approximately 2:45 PM on July 11 , 2006. Second Floor Rooms 201, 222 and janitorial closet in three (3) of six (6) observations between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Rooms 300 and 324 in two (2) of six (6) observations between 2:30 PM and 2:55 PM on July 12, 2006. Fourth Floor Rooms 416, 431 and janitorial closet in three (3) of eight (8) observations between 3:00 PM and 4:30 PM on July 12, 2006. 4. Residents' entrance and bathroom doors and doors jams were marred and splintered on the edges in the following areas: First Floor Rooms 121 and 122 in two (2) of eight (8) observations between 2:35 PM and 4:35 PM on July 12, 2006. Second Floor Rooms 203, 207, 208, 211 and 222 in five (5) of six (6) observations between 7:55 AM and 9:30 AM on July 12, 2006. Third Floor Day Room in one (1) of six (6) observations at approximately 2:45 PM on July 12 , 2006. 5. Excessive personal items were observed in residents' rooms on the floor, in boxes, on top of closets, paper bags and suitcases in rooms 200, 208, 231, 300 and 317 in five (5) of 15	F 253		

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F 253	Continued From page 4 observations between 7:55 AM and 4:30 PM on July 12, 2006. 6. The lower surfaces of shower walls were observed to have a soapy residue in the following areas: Second Floor in four (4) of four (4) observations between 7:55 AM and 9:30 AM on July 11, 2006. 7. Geri chair armrests were marred and damaged in residents' rooms and common areas. Second Floor Room 201 and Day Room in two (2) of five (5) observations between 7:55 AM and 9: 30 AM on July 12, 2006. Fourth Floor Room 424D in one (1) of eight (8) observations between 3:00 PM and 4:30 PM on July 12, 2006. 8. The interior surfaces of exhaust vents were soiled with accumulated dust and debris in residents' rooms and common areas. First Floor Room 106 and soiled linen room in two (2) of eight (8) observations between 2:35 PM and 4:35 PM on July 11, 2006. Second Floor shower room and janitorial closet in two (2) of eight (8) observations between 7:55 AM and 9:30 AM on July 12, 2006.	F 253		

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F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by : Based on record review for one (1) of 29 sampled residents, facility staff failed to complete a significant change Minimum Data Set (MDS) within 14 days. Resident #6. The findings include: According to a nurse's note dated February 15, 2006 at 4:20 PM, " X-ray showed fracture of the left fourth middle phalanx". The resident's finger was immobilized on February 16, 2006. The facility completed a significant change MDS on March 20, 2006 based on the fracture of the left fourth finger. The significant change MDS was completed 32 days after the facility determined that the resident experienced a change in status. The record was reviewed July 12, 2006.	F 274	**F 274 483.20(B)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED** **1. The Minimum Data Set (MDS) for resident #16 was transmitted to reflect a significant change.** **2. All Minimum Data Sets (MDS)/ Resident Assessment Instrument (RAI) for residents with fractures were reviewed. There were no other residents found to be affected by this practice.** **3. The MDS Coordinator, RCC, and Nurse Managers were re-educated on the MDS/RAI.** **4. The MDS audit is a part of the Quality Improvement program and is presented at the Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for three (3) of 29 sampled residents, it was determined that facility staff failed to include all diagnoses on the Minimum Data Set (MDS) for two (2) residents and code one (1) resident for	F 278	**F 278 483.20(g) -(j) RESIDENT ASSESSMENT** **1. Residents #8, 10, and 16 significant corrections on the MDS were completed to reflect Glaucoma diagnosis, behavior symptoms and Peripheral Vascular Disease (PVD) respectively.** **2. An MDS audit was conducted to ensure that significant changes such as glaucoma, behavioral symptoms, and PVD are captured.** **3. The MDS Coordinator, RCC, and Nurse Managers have been re-educated on the resident assessment instrument.** **4. The MDS audit is a part of the Quality Improvement program and is presented at the Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 278	Continued From page 7 behavioral symptoms. Residents #8, 10 and 16. The findings include: 1. Facility staff failed to code Resident #8 for Glaucoma in Section I on the annual MDS completed March 22, 2006. A review of Resident #8's record revealed an ophthalmology consult dated July 21, 2005 the resident was diagnosed with Glaucoma. An order for Lumigan eye drops for Glaucoma, administered daily, was initiated July 25, 2005 and most recently renewed May 4, 2006. A diagnosis of Glaucoma was not included in Section I on the annual MDS completed March 22 , 2006. A face-to-face interview was conducted with the unit manager on July 11, 2006 at 2:30 PM. He/ she acknowledged that a diagnosis of Glaucoma was not included on the annual MDS. The record was reviewed July 11, 2006. 2. Facility staff failed to accurately code Resident #10 for behaviors on the quarterly MDS. The quarterly MDS dated May 25, 2006 revealed that Resident #10 was not coded for behaviors in Section E1 (Indicators of Depression, Anxiety, Sad Mood). The assessment period for this section is 30 days prior to the Assessment Reference Date (ARD) which was May 25, 2006. The facility initiated observations of delusional behaviors on May 2, 2006 and crying behaviors on May 7, 2006 recorded on the " Behavior Monitoring Sheet. " The resident was coded for	F 278		

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F 278	Continued From page 8 delusional behaviors daily from May 2 through May 25, 2006. The resident was coded for crying from May 7 thorough May 15, 2006 and May 16 through May 25, 2006. There was no explanation of the behaviors in the nurses' notes. Facility staff failed to accurately code Resident # 10 for behaviors. The record was reviewed on July 11, 2006. 3. Facility staff failed to code all pertinent diagnoses for Resident #16 on the annual MDS. A review of Resident #16's record revealed an annual MDS dated January 11, 2006 which included the following diagnoses in Section I: Parkinson's Disease, Seizure Disorder, Schizophrenia, Cataracts and Allergies. The History and Physical dated February 19, 2006 listed the following: "...Interim History: 70 years old [sex] with H/O (History Of) Parkinsons Disease, Severe Peripheral Vascular Disease, S/P (Status Post) Depression ..." A face-to-face interview was conducted with the RCC (Resident Care Coordinator) on July 12, 2006 at 8:20 AM. He/She acknowledged that the diagnosis of PVD was missing from the MDS and stated, "PVD (Peripheral Vascular Disease) was on the other MDS." The record was reviewed on July 11, 2006.	F 278		

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483. 25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483. 10(b)(4). This REQUIREMENT is not met as evidenced by : Based on observation and record review for three (3) of 29 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches for one (1) resident with a new gastrostomy tube (G-tube), one (1) resident with an amputated limb and one (1) resident with an orthotic device. Residents #4, 7 and W2. The findings include: 1. Facility staff failed to develop a care plan for Resident #4 who went to the hospital and returned with a G-tube.	F 279	**F 279 483.20(K)(1) COMPREHENSIVE CARE PLANS** **1. Resident #4 has been reviewed by dietary and nursing and a care plan was updated to address the G-Tube. Resident #7 and W2 were re-assessed and the care plans were adjusted to reflect the amputation and the management of the orthotic device respectively.** **2. Nurse Managers and/ or designee will review resident records for accuracy and timeliness of care plans. Additionally all care plans for admission and re-admission will be reviewed for accuracy and updated as needed.** **3. The interdisciplinary team was re-educated on the care planning process.** **4. Review of the care plan and its accuracy is a part of the nursing comprehensive medical record audit and is presented at the Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 279	Continued From page 10 According to a nurse's readmission note dated June 2, 2006, Resident #4 was transferred to the hospital on May 25, 2006 for respiratory distress and lethargy. He/she returned to the facility on June 2, 2006 with a G-tube inserted. The review of the current care plan was dated April 20, 2006. The care plan did not include goals and approaches for the care of the a G-tube. The record was reviewed on July 11, 2006. 2. Facility staff failed to develop a care plan for Resident #7 who was admitted to the facility with an amputation of the left foot. A review of Resident 7's record revealed admission orders dated March 24, 2006 which included the following diagnoses: Diabetes Mellitus, Lethargy, Altered Mental Status, Sepsis, Pneumonia, Diabetic Ketoacidosis, Pleural Effusion, Renal Insufficiency and Left Foot Stump . The admission MDS (Minimum Data Set) dated April 6, 2006 at Section I (Disease Diagnoses) included "missing limb." A podiatrist's progress note dated March 30, 2006 revealed the following: "...Prior Transmetatarsal amputation left ..." The care plan was reviewed and lacked evidence of an identified problem for the missing limb with goals approaches for care. The record was reviewed on July 11, 2006. 3. Facility staff failed to develop a care plan for	F 279		

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F 279	Continued From page 11 the management of Resident W2's orthotic device . A review of Resident W2's record revealed a current Physician's Order Form which indicated the following: "April 28, 2006 [initial order], Palm protector to right hand." The resident was observed seated in the lounge on July 13, 2006 at 7:55 AM with the palm protector on the right hand. The care plan was reviewed and lacked evidence of an identified problem with goals and approaches for contracture management of the right hand. The record was reviewed on July 13, 2006.	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by : Based on observation and record review for one (1) supplemental resident, it was determined that facility staff failed to update Resident W1's care plan for contracture management. The findings include: A review of Resident W1's record revealed a " Contracture Management Interdisciplinary Care Plan" which was initiated on July 15, 2005 by the physical therapist. The identified problem was an upper extremity contracture. The resident was observed on July 13, 2006 at 7: 56 AM with a splint on the left hand. The care	F 280	**F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS** **1. The care plan for resident #W1 was updated to reflect contracture management.** **2. Care plans of all residents with splints were reviewed. There were no other residents found to be affected by this practice.** **3. The Interdisciplinary Team (IDT) team was re-educated on updating care plans.** **4. The care plan audit update is a part of the Quality Improvement program and presented at the Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 280	Continued From page 13 plan had not been reviewed or updated since it was developed. The record was reviewed on July 13, 2006.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for two (2) of 29 sampled residents, it was determined that facility staff failed to: clarify the strength of a medication for one (1) resident and ensure that one (1) resident consumed all medications. Residents #20 and J1. The findings include: 1. Facility staff failed to clarify the strength for Haldol Decanoate for Resident #20. A review of Resident #20's record revealed a physician's order dated April 12, 2006, "Haldol Dec IM (intramuscular) every 2 weeks." There was no strength indicated. According to the manufacturer, Haldol Decanoate comes in 50 mg and 100 mg strengths. The facility's policy, "New Schedule III-V controlled Substance Medication and non Controlled Substance Medication Orders," #4.3, effective August 1, 2002, page 1, under "Process: 1.1.1 New Order must include ...1.1.3	F 281	**F 281 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS** **1. The Psychiatrist clarified the strength for Haldol Deconnate for Resident #20. The facility is unable to retrospectively correct the administration of potassium for resident J1, however a potassium (K+) level is scheduled to be drawn.** **2. The charts of all residents on Haldol Deconnate was reviewed for strength of medication and clarified as needed. The residents on potassium liquid are monitored for full consumption of medication. There were no other residents found to be affected by this practice.** **3. Staff was re-educated on clarification of physician orders and medication pass of liquid medications.** **4. An audit of the MAR is a part of the nursing management tool and medication pass observation is presented at the Quality Assurance Committee meeting.**	8/28/06 **08/28/06**

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F 281	Continued From page 14 Drug name, strength, dosage ..." A face-to-face interview was conducted with the charge nurse on July 112, 2006 at 1:10 PM. He/ she stated, "We called the pharmacy and they told us that the Haldol only comes in one strength . We didn't call the doctor, we believed the pharmacy." The record was reviewed July 12, 2006. 2. The nurse failed to ensure that Resident #J1 consumed his/her medication. The facility's Policy # 6.0, § 4.8 "General Dose Preparation and Medication Administration" stipulates, " Medication Administration: Observe the customer's consumption of the medication(s)." During observation of medication pass on July 12, 2006 at approximately 9:20 AM, a nurse administered a mixture of orange juice and Potassium Chloride (KCl) 20meq/ 15ml liquid to Resident #J1. The nurse walked out of the resident 's room before the resident finished the medication and signed the medication as given on the Medication Administration Record.	F 281		

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F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on record review, observations and staff interviews for six (6) of 29 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to provide the necessary care and treatment as evidenced by failure to: administer a supplement and sliding scale insulin as ordered for one (1) resident; follow up on recommendations to discontinue a supplement and change a diet for one (1) resident; elevate one (1) resident ' s feet as ordered; consistently administer orange juice to one (1) resident as ordered; obtain a current order for palm protectors and review and discontinue orders not currently in use for one (1) resident; and obtain an order for bilateral hand orthotics. Residents # 5, 9, 16, 21, 26 and W1 The findings include: 1. Facility staff failed to administer Prosource and administer insulin per physician's orders for Resident #5. A. A review of Resident #5's record revealed a physician's order signed May 2, 2006, "Prosource 30ml three times daily."	F 309	**F 309 483.25 QUALITY OF CARE** **1. The facility cannot retrospectively administer pro-source or insulin for Resident #5; the insulin order was clarified. Resident # 9 is now on a Carbohydrate Controlled Mechanical Soft diet and the dietary supplement Med Pass 2.0 120cc. BID orders have been discontinued. Resident #16 feet were elevated immediately. Resident #21 was reassessed by the clinical team in consultation with the MD and orders were clarified if indicated. The facility cannot retrospectively administer Orange Juice. This resident has not exhibited any signs/symptoms of hypoglycemia. Resident #26 and W1 were re-assessed by the clinical team. In consultation with the MD, the orthotic device and palm protector were clarified to meet the needs of the residents respectively.** **2. All residents in the facility with orders to elevate feet, diabetics with sliding scale, and orthotic devices were reviewed to ensure compliance. The dieticians have reviewed diet order changes to ensure full compliance. The 11-7 shift will be responsible for checking orders on a nightly basis. They will ensure the accuracy of the orders as well as ensure that new orders have been transcribed accurately. There were no other residents found to be affected by this practice.**	8/13/06

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F 309	Continued From page 16 A review of the May, June and July Medication Administration Records (MAR) revealed that the order for the Prosource had not been transcribed or administered to the resident. A face-to-face interview was conducted with the charge nurse on July 11, 2006 at 12:25 PM. He/ she acknowledged that the Prosource had not been transcribed or administered to the resident. B. A review of Resident #5's record revealed a physician's order signed May 2, 2006, "Insulin coverage: [For blood sugar] 51-100 =8 oz of orange juice. 101-150 =0 units, 151-200= 2 units [insulin]. 201-250=4 units...twice daily." A review of the June and July MAR revealed the following: "51-100 = 8 ounces of orange juice. 101-151=200=2 units ..." There was no evidence in the record that the physician had changed the insulin order. There was no evidence in the record that facility staff clarified the above order for June 2006. On the July 2006 MAR was a hand written clarification," 101-150 - 0 units; 151-200 = 2 units." Two (2) units of insulin were administered for blood sugars between 101 and 150 for 15 times for June 2006. Although the order was corrected for July 2006, two (2) units of insulin were administered for blood sugars between 101 and 150 for nine (9) times. There was no evidence in the record that the resident experienced any untoward effects from the inconsistency of insulin administration.	F 309	**3. Licensed nurses will be in-serviced on how to correctly check monthly MD orders, MAR and TAR. The in-service will also include how to properly transcribe new orders. The monthly POS (Physicians Order Sheets), MAR and TAR will be signed by the nurse who checks them and who is verifying their accuracy. In addition staff has been educated on monitoring elevation of feet as ordered, documentation of sliding scale, and to monitor orthotic devices as ordered. The dietician will review the medical records and dietary Kardex within 72 hours to ensure that the dietary recommendations have been implemented.** **4. At the beginning of each month the DON, ADON or RCC, and Nursing Management will be responsible for reviewing a sample of the POS, MAR and TAR for accuracy. The nurse managers also will be reviewing charts weekly to ensure transcriptions are being taken off correctly. This information is provided to the Quality Assurance team.**	08/13/06

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F 309	Continued From page 17 A face-to-face interview was conducted with the nursing supervisor on July 12, 2006 at 12:25 PM. He/she stated that nursing staff should have corrected the order. The record was reviewed July 12, 2006. 2. The dietician failed to follow up on a recommendation to change a diet order and licensed staff failed to discontinue an order for a supplement for Resident #9. A. The dietician failed to follow up on a recommendation to change Resident #9's diet order. Resident #9 was admitted to the facility on May 18, 2006. Admission orders included: " Carbohydrate controlled diet and Med Pass 2.0 2 X daily between meals for additional protein." A dietary progress note included the following: " May 25, 2006 ...Resident has uncontrolled DM (Diabetes mellitus), impaired vision and a few teeth. Place on Mech (mechanical) Soft diet for chewing purposes ..." The Interim Order Form included the following order: "June 16, 2006 at 3:00 PM, Please change diet, Carbohydrate Controlled diet to Mech Soft/ Carbohydrate Controlled diet due to chewing difficulty." The dietician failed to follow up on the recommendation to change the diet; the diet wasn't changed until 22 days later. The record was reviewed July 11, 2006.	F 309		

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F 309	Continued From page 18 B. Licensed staff failed to discontinue an order for the supplement Med Pass as ordered A dietary progress note included the following: " June 21, 2006, Residents weight changed since admission on 5/18/06 (169 lbs) and reweighed on 6/1/06 (191 lbs) resident was reweighed again to verify new weight. Adjustment of 500 calories for weight reduction. D/C (discontinue) Med Pass 2. 0 due to weight gain and albumin of 3.4 ... Meal intake very good eats approximately 80-90% of meals." The Interim Order Form included the following orders: " June 16, 2006 at 3:00 PM, Please change diet, Carbohydrate Controlled diet to Mech Soft/Carbohydrate Controlled diet due to chewing difficulty " and " Recommend D/C Med Pass 2.0 120 cc BID (two times a day) due to resident weight gain Albumin 3.4." A review of the MARs/TARs (Medication Administration Record/Treatment Administration Record) for June 2006 and July 1 through 11, 2006 indicated [entry of licensed nurse's initials for each day at 10: 00 AM and 6:00 PM] that Med Pass was administered. A face-to-face interview was conducted with the Unit Manager on July 11, 2006 at 10:50 AM. He/ She acknowledged that Med Pass was not discontinued as ordered by the physician. 3. Facility staff failed to elevate Resident #16's feet while sitting as ordered by the physician. A review of Resident #16's record included the following orders on the June 2006 physician's	F 309		

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F 309	Continued From page 19	F 309		

order form: "November 20, 2003 [initial order date], Keep feet elevated while sitting and in bed to decrease edema" and "October 7, 2004 [initial order date], when in w/c (wheelchair), bend foot rest up so that leg is only supported by calf rest."

The resident was observed on July 11, 2006 from 1:45 PM to 3:45 PM seated in a wheelchair in front of the nurses' station. There was a brace on the left leg and both feet were on the floor. The wheelchair did not have footrests. The unit secretary stated that the resident's w/c was broken.

The resident was observed on July 12, 2006 at 2: 10 PM in the w/c with both feet on the floor.

A face-to-face interview was conducted with the Director of Rehabilitation on July 12, 2006 at 4:28 PM concerning the resident's broken wheelchair. He/She stated, "The chair was broken this month. We submitted a 719A form and sent it to Medicaid. We are waiting to hear. We have extra parts here for wheelchairs. If there is an issue with a wheelchair, they [nursing staff] can call me and I can get the part."
The record was reviewed on July 11, 2006.

5. A review of Resident #21's record revealed that the facility staff failed to consistently administer orange juice according to physician's orders for blood sugar levels between 51-100 g/dl.

A review of the May and June 2006 Medication Administration Record revealed, a physician's order which directed, " ...Fingerstick twice daily with sliding scale coverage: - ...51-100: OJ [if the blood sugar level is between 51-100 give the

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F 309	Continued From page 20 resident orange juice] " . There were nine (9) days in May 2006 and six (6) days in June 2006 that the resident should have received orange juice for blood sugar levels within the coverage range. Additionally, the May and June 2006 nursing notes had no documented evidence of orange juice being administered when indicated by the physician's order. A face-to-face interview was conducted on July 13, 2006 at 10:25 AM with the Resident Care Coordinator. He/she acknowledged that the MARs did not reflect the resident receiving the orange juice in accordance with the physician's order. The record was reviewed July 13, 2006. 6. Facility staff failed to obtain an order for a palm protector and discontinue an order for braces that were not in use for Resident #26. A. Facility staff failed to obtain an order for a palm protector. A care plan for the problem "Requires supportive device related to contracture as evidenced by splint left hand" was initiated on September 7, 2005. The resident was observed in a wheelchair on July 12, 2006 at 2:55 PM. He/She had a palm protector on the left hand. A review of the current physician's order form for May 2006 lacked evidence of an order for a palm protector. The record was reviewed on July 12, 2006. B. Facility staff failed to discontinue an order for	F 309		

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F 309	Continued From page 21 bilateral knee splints. The current physician's order form dated May 2006 included the following order: "11/11/04 [initial order date], Functional Maintenance Program for nursing staff to apply knee brace (black) Tues and Thurs and Abductor brace (green) M-Fri - Always check skin." The resident was observed in a wheelchair on July 12, 2006 at 2:55 PM. He/She was not wearing a knee splint. The resident stated, "I don't wear splints on my legs. I don't have leg splints. I had them several years ago. I did get a new wheelchair and didn't need them." An occupational therapy screening form dated June 27, 2006 indicated: "Comments: Pt (Patient) continues to wear Lt (left) palm protector appropriately. Independent in wheelchair mobility. No change in self care or functional mobility status. Occupational therapy evaluation not indicated." A face-to-face interview was conducted with the restorative aide on July 12, 2006 at 3:00 PM. He/ She stated, "I started four months ago. I've only seen him with a palm protector." The record was reviewed on July 12, 2006. 7. Facility staff failed to include an order for Resident W1's bilateral orthotic devices on the current physician's order form. An interim order form revealed the following order :"3/23/06, [initial order date], (B) (Bilateral) wrist hand finger ortho for hand contractures." This order was not included on the current physician's	F 309		

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F 309	Continued From page 22 order form. The current physician's order form dated June 2006 included the following order: "8/25/05 [initial order date], Pt (patient) issued custom R-hand splint for contracture management, to be worn every day while out of bed ..." The resident was observed on July 13, 2006 at 7: 56 AM with a splint on the left hand. A face-to-face interview was conducted with the CNA on July 13, 2006 at 7:56 AM. He/she was asked where the right hand splint was. The CNA stated, "It is missing. We don't know what happened to it. They [nursing staff] are ordering one." The record was reviewed on July 13, 2006.	F 309		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview, it was determined that the facility staff failed to initiate a referral for rehabilitation services after the removal of a splint. Resident #6.	F 318	**F 318 483.25(e)(2) RANGE OF MOTION** **1. Resident # 6 wil be screened by the rehabilitation department. No limitations or changes were noted and no evaluation or additional therapy was needed.** **2. All residents with fractures were reviewed to ensure that rehabilitation received the screening orders.** **3. Nursing personnel has been in-serviced on the process of rehabilitation screening orders.** **4. Review of TAR for rehabilitation screening orders is a part of Quality Assurance program and presented to Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 318	Continued From page 23 The findings include: According to the facility's policy, "Resident Screening " , Revision date: June 1, 2005, Effective date: June 1, 2001. "Policy: ...A Rehabilitation screening will be completed by the PT/PTA, OT/OTA ... as permitted by the state practice act; on admission, readmission ...or when any resident shows a significant change in functional ability or safety. Procedure: 1. The screening procedure will be performed and documented within 2 (two) working days of admission, readmission, or notification of change in resident ' s functional ability or safety. Quarterly screening will be performed prior to the care plan conference." A significant change Minimum Data Set [MDS] was completed on March 20, 2006 as a result of a fractured left finger that occurred on February 15, 2006. The fracture was resolved April 26, 2006. There was no evidence that a rehabilitation screen was completed prior to the quarterly MDS dated June 12, 2006. A face-to-face interview with the unit manager was conducted on July 13, 2006 at 10:30 AM. He /she acknowledged that the nursing staff did not initiate a referral for the resident to have a rehabilitation screening. The record was reviewed July 12, 2006.	F 318		

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F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that laundry detergent was not secured and left on shelves in residents' rooms. These findings were observed in the presence of Maintenance, Housekeeping and Nursing Staff. The findings include: Laundry detergent such as Extra and a gallon of Tide were in open view on shelves in residents' rooms 200 and 431 in two (2) of two (2) observations between 9:00 AM and 4:15 PM on July 12, 2006.	F 323	**F 323 483.25(h)(1) ACCIDENTS** **1. Laundry Detergent in rooms 200 and 431 were removed during the survey visit.** **2. All rooms of residents who launder their clothes on site were checked for laundry detergent.** **3. Nurse Managers and/ or designees and housekeeping personnel will check all rooms for laundry detergent and it will be secured. Residents affected by this procedure will be informed of this practice.** **4. The Safety committee and the nursing team will monitor the environment for laundry detergents. This will be reported at the Quality Assurance meeting.**	8/11/06 **8/11/06**
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for one (1) of 29 sampled residents, it was determined that the nutritionist/dietician failed to complete an initial assessment for a resident with	F 325	**F 325 483.25(i)(1) NUTRITION** **1. Resident #3 nutritional status has been reviewed, weight records monitored, and adequate nutritional interventions implemented.** **2. The dieticians will have immediate access to the census records to ensure that new admissions and re-admissions are noted daily.** **3. The current policy and procedure on nutritional assessments and progress note will be reviewed and revised of indicated. The dieticians will be in-serviced on any revisions.** **4. The plan of correction will be monitor by the dietitian during the monthly quality improvement audit to ensure compliance.**	8/11/06 **8/11/06**

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F 325	Continued From page 25 weight loss. Resident #3. The findings include: A review of Resident #3's record revealed that the resident was noted with a 10 pound weight loss after returning from a five (5) day hospital stay on March 1, 2006. According to the facility's policy, "Food & Nutrition Services Policy- Nutritional Assessments and Progress Notes" , Policy No. 8 dated April 2001, revised date January 2006. "I Policy: The Dietitians/Nutritionist complete comprehensive nutritional assessments of residents and chart notes on progress of care within 5-7 days of admission, annually and for any significant changes. III -Procedures: 1. ...A nutritional assessment is initiated within 5-7 days of admission date." The "Weight Record " included the following weights: February 2006 - 116 pounds (lbs) March 2006 - 106 lbs The March 29, 2006 dietary note documented, " Resident's March weight declined. Resident was hospitalized February 24, 2006 returned March 1, 2006. Return weight 106 lbs (pound), no re-weight noted. Diet meal intake 75 100 %." A face-to-face interview was conducted on July 13, 2006 at 2:55 PM with the dietitian. He/she acknowledged that the resident had lost 10 pounds in one month and that there was no dietary assessment completed until March 29, 2006. The record was reviewed July 13, 2006.	F 325		

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F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by : Based on observation,staff interview and record review for one (1) of 29 sampled residents, it was determined that facility staff failed to monitor behaviors for Residents #20, who was receiving antipsychotic medication. The findings include: A review of Resident #20's record revealed a physician's order initially dated April 11, 2006, " Risperdal 1 mg daily" and April 12, 2006, "Haldol Dec IM every 2 weeks." There was no evidence in the record that facility staff identified or monitored the behaviors for which the above medications were prescribed. A face-to-face interview was conducted with the charge nurse on July 12, 2006 at 1:10 PM. He/ she stated, " [Resident #20] has schizophrenia. That's why [Resident #20] is getting the medication." However, the charge nurse could not identify specific behaviors for which the resident was receiving the above cited	F 329	**F 329 483.25(l)(1) UNNECESSARY DRUGS** **1. Resident #20 was re-assessed by the clinical team. It was determined that the medication was still necessary. The behavior is now included on the behavioral monitoring Record and will be monitored as documented.** **2. A list of residents receiving anti-psychotics was generated and the records were reviewed to ensure the behavior was monitored.** **3. An in-service was conducted with the clinical team on the documentation of the MAR particularly as it pertains to behavioral monitoring.** **4. Monitoring of the behavior is a part of the MAR and TAR/ MD orders audit tool and is presented to the Quality Assurance committee.**	8/18/06 **8/18/06**

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F 329	Continued From page 27 medications. The record was reviewed July 12, 2006.	F 329		
F 385 SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by : Based on record review for one (1) of 29 sampled residents, it was determined that the attending physician failed to include reference to Resident # 7's left foot stump on the H&P (History and Physical) or the progress notes. The findings include: A review of Resident #7's record revealed admission orders dated March 24, 2006 which included the following diagnoses: Diabetes Mellitus, Lethargy, Altered Mental Status, Sepsis, Pneumonia, Diabetic Ketoacidosis, Pleural Effusion, Renal Insufficiency and Left Foot Stump . The admission MDS (Minimum Data Set) dated April 6, 2006 at Section I (Disease Diagnoses)	F 385	**F 385 483.40(a)** **Physician Services** **1. The History and Physical (H&P) and Progress Note for resident #7 was updated to reflect a left foot stump.** **2. All residents with amputations were reviewed for notation in the H&P and Progress Note.** **3. An in-service was given at the Medical Staff Meeting on accurately completing H&P and Progress Notes.** **4. Accuracy of the H&P and Progress notes will be added to medical record audit and presented at the Quality Assurance meeting.**	8/28/06 **8/28/06**

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F 385	Continued From page 28 included "missing limb." A podiatrist's progress note dated March 30, 2006 revealed the following: "...Prior Transmetatarsal amputation left ..." The H&P dated March 24, 2006 revealed the following: Under Surgical Procedures was written "none known" and under "Review of Systems- " no complaints" was written. The H&P did not include reference to the left foot stump. The attending physician's progress notes (March 29, April 26, and May 17, 2006) were reviewed. There was no reference to the left foot stump. The record was reviewed on July 11, 2006.	F 385		
F 428 SS=D	483.60(c)(1) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for three (3) of 29 sampled residents and two (2) supplemental residents, the pharmacist failed to complete a monthly drug regimen review. Residents #5, 16, 19, J1 and J2. 1. The pharmacist failed to complete a drug regimen review for Resident #5 for June, 2006. A review of Resident #5's "Chronological Record of Drug Regimen Review" revealed that the last	F 428	**F 428 483.60(c)(1) Drug Regimen Review** **1. Residents #5,16,19,J1, and J2 cannot be retrospectively corrected however, the residents were seen by the pharmacist and the drug review was completed.** **2. The consultant pharmacist compared the facility census with the drug review report and found no other residents affected by this deficient practice.** **3. The consultant pharmacist will obtain a copy of the facility census when completing monthly drug reviews to ensure no missing reviews** **4. The consultant pharmacist audit will include the pharmacy section of the medical record and will be reported at the Quality Assurance meeting.**	8/20/06 **8/20/06**

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F 428	Continued From page 29 date the pharmacist reviewed the resident's record was May 15, 2006. There was no evidence that the pharmacist had completed a June 2006 review. A face-to-face interview with the unit manager was conducted on July 11, 2006 at 12:25 PM. He /she acknowledged that a drug regimen review should have been completed for June 2006. The record was reviewed July 11, 2006. 2. A review of Resident #16's record revealed that the pharmacist failed to perform a drug regimen review for January 2006. The pharmacist drug regimen review form indicated that a review was performed on December 19, 2005 and the following review was dated February 27, 2006. There was no evidence of a drug regimen review performed for January 2006. The record was reviewed on July 11, 2006. 3. A review of Resident #19's record revealed that the pharmacist failed to perform a drug regimen review for June 2006. There was a drug regimen review in the record for May 2006. A face-to-face interview was conducted with the unit manager on July 12, 2006 at 11:45 AM who acknowledged the lack of a June 2006 pharmacist drug regimen review. The record was reviewed on July 12, 2006. 4. A review of Resident J1's record revealed that the pharmacist failed to perform the drug regimen review for June 2006.	F 428		

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F 428	Continued From page 30 A review of Resident J1s "Chronological Record of Drug Regimen Review" revealed that the pharmacist reviewed the resident's record in May 2006. There was no evidence that the pharmacist completed a June 2006 review. 5. A review of Resident J2's record revealed that the pharmacist failed to perform the drug regimen review for June 2006. A review of Resident J2's "Chronological Record of Drug Regimen Review" revealed that the pharmacist reviewed the resident's record in May 2006. There was no evidence that the pharmacist completed a June 2006 review.	F 428		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that shower seats and a geri chair were not cleaned thoroughly after use by residents. These findings were observed in the	F 441	**F 441 483.65(a) INFECTION CONTROL** **1. The two shower chairs were cleaned and disinfected on July 12, 2006, by the housekeeping supervisor. The geri chair was cleaned by the certified nursing assistant, then disinfected by the housekeeping staff.** **2. All shower chairs were inspected for cleanliness and disinfected as needed. No resident was affected by this finding.** **3. Shower chairs will be checked daily for cleanliness by the housekeeping personnel, Supervisor and Director of the department.** **4. The corrective plan will be monitored by all personnel of the housekeeping department and daily routine checks will be made by the Supervisor and Director. This will be reported to the Quality Assurance committee.**	7/31/06 7/31/06

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F 441	Continued From page 31 presence of Housekeeping, Maintenance and Nursing Staff. The findings include: 1. Two (2) of three (3) shower chairs were observed on unit 4 South at 4:00 PM on July 12, 2006 soiled with a dark brown substance. 2. A geri chair in room 201 was observed at approximately 8:00 AM on July 12, 2006 with a dark brown substance in one (1) of one (1) observation.	F 441		
F 456 SS=E	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by : Based on observations during the survey, it was determined that boilers and mixing valves were not adjusted to ensure that hot water temperatures did not exceed 110 degrees Fahrenheit (F). These findings were observed in the presence of Maintenance, Housekeeping and Nursing Staff. The findings include: Second Floor Dining Room-116 degrees F, 2 South Shower Room 119 degrees F and 217-114 degrees F in three (3) of eight (8) observations between 7:55 AM and 9:30 AM on July 12, 2006.	F 456	**F 456 483.70(c) (2) SPACE AND EQUIPMENT** **1. The boilers and mixing valves that were identified have been adjusted and corrected to read between 100 – 105 degrees Fahrenheit (F).** **2. Domestic water temperatures throughout the facility have been inspected and adjusted to read between 100 – 105 degrees Fahrenheit (F). No residents were affected by this finding.** **3. The boilers and mixing valves used to maintain domestic water temperatures will be inspected twice daily as part of the Engineering daily and evening maintenance rounds. Discrepancies in water temperatures will be corrected immediately.** **4. The Director of Engineering will monitor and conduct monthly audits of the domestic water temperatures and report all findings at the Quality Assurance meeting.**	7/31/06 **7/31/06**

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F 456	Continued From page 32 Third Floor Room 300-119 degrees F in one (1) of eight (8) observations between 2:45 PM and 3: 30 PM on July 12, 2006.	F 456		
F 469 SS=C	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that flies, gnats and mosquitoes were observed on seven (7) of seven (7) nursing units. The findings include: Flies, gnats and mosquitoes were observed throughout the building during the survey period in the following areas: Unit 1 North: 8:30 AM on July 11, 2006, 7:45 AM and 3:30 PM on July 12, 2006 and 7:15 AM and 1 :45 PM on July 13, 2006. Unit 1 South: 9:15 AM and 2:30 PM on July 11, 2006, 11:00 AM on July 12, 2006 and 7:05 AM and 12:00 PM on July 13, 2006. Unit 2 North: 2:00 PM on July 11, 2006, 11:55 AM on July 12, 2006 and 10:30 AM on July 13, 2006.	F 469	**F 469 483.70(h) PHYSICAL ENVIRONMENT** **1. Engineering staff will ensure that all window screens are properly fitted. The curtain fan on the One South exit door to the courtyard was checked and is in proper working condition.** **2. Nursing and housekeeping personnel will identify residents who hoard food, fruits and liquids. Personnel will remove all food items from their rooms as needed.** **3. Western Pest Control was notified of the problem and an extra service was performed of the facility.** **4. Western Pest Control will monitor the problem and notify the Housekeeping Director of any concerns. The Housekeeping Director will also monitor the environment and report findings to the Quality Assurance Committee.**	8/13/06 **8/13/06**

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F 469	Continued From page 33 Unit 2 South: 9:00 AM and 1:15 PM on July 11, 2006, 10:30 AM and 3:45 PM on July 12, 2006 and 9:15 AM on July 13, 2006. Unit 3 South: 8:55 AM and 2:00 PM on July 11, 2006, 8:30 AM and 2:45 PM on July 12, 2006 and 9:00 AM and 2:00 PM on July 13, 2006. Unit 4 North: 8:30 AM and 1:20 PM on July 11, 2006, 8:00 AM and 2:00 PM on July 13, 2006 and 9:20 AM and 11:30 AM on July 13, 2006. Unit 4 South: 8:45 AM and 2:00 PM on July 11, 2006, 9:45 AM and 3:30 PM on July 12, 2006 and 10:10 AM and 1:45 PM on July 13, 2006. Gnats were observed in the board room on the lower level throughout the survey period. Residents access this level for banking. It was observed on July 11, 12 and 13, 2006 between 7:00 AM and 8:15 AM that the inner and outer courtyard doors were locked in an open position. The doors did not open or close automatically. A face-to-face interview was conducted with the Director of Security on July 13, 2006 at 7:15 AM. He/she stated that the night security guard was responsible for unlocking the courtyard doors. He stated, " The doors should not be locked open, but automatically open and close. "	F 469		

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F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for one (1) of 29 sampled residents, facility staff failed to obtain stool specimens for testing as ordered by the physician for Resident #2. The findings include: A significant change MDS (Minimum Data Set dated June 6, 2006 included the diagnoses of Anemia under Section I. The physician's orders read as follows: June 2, 2006, "Stool guaiac q day (everyday) x3 days." June 13, 2006, "Stool guaiac Q daily x3 days." June 17, 2006, "Stool guaiac q daily x3." A review of the TAR (Treatment Administration Record) for June 2006 revealed either initials or " 0" entered for June 3 through 5, June 14 through 16 and June 18 through 20, 2006. A review of the nurses' progress notes revealed that a stool specimen was collected on June 19 and 20, 2006, both of which were noted to be negative for blood. There was no evidence in the record of other stool specimens collected. A face-to-face interview was conducted on July 13, 2006 at approximately 10:00 AM with the	F 502	**F 502 483.75(j) (1) LABORATORY SERVICES** **1. Nursing re-assessed resident #2, and in consultation with MD did additional follow up lab work .** **2. All residents with occult blood orders was audited to ensure completion of lab tests.** **3. Staff has been re-educated on ensuring all lab Test are completed as ordered.** **4. A review of the physicians orders including lab is a part of the comprehension Nursing Audit. This information is presented to the Quality Assurance Committee**	8/13/06 8/13/06

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F 502	Continued From page 35 Licensed Practical Nurse whose initials are entered on the TARs and the unit manager who acknowledged that only two (2) specimens were obtained on June 19 and 20, 2006. The record was reviewed on July 12, 2006.	F 502		
F 508 SS=D	483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for one (1) of 29 sampled residents, facility staff failed to obtain a chest X-ray (CXR) for Resident #23. The findings include: A review of Resident #23's record revealed a physician's order dated May 2, 2006, "CXR - for aspiration pneumonia in 1 week." There was no evidence in the record that the chest X-ray had been completed at the time of this review. A face-to-face interview with the unit manager was conducted on July 12, 2006 at 10:45 AM. He /she stated, "[Resident #23] was transferred to another unit right after the order was written. I guess the chest X-ray got missed." The record was reviewed July 12, 2006.	F 508	**F 508 483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES** **1. Resident #23 had a chest x-ray done. The chest x-ray was negative.** **2. All resident charts was reviewed for completion of chest x-ray orders. There were no other residents found to be affected by this practice.** **3. Nursing personnel have been re-educated on Proper completion of orders and 24 hour chart check** **4. Review of the physicians orders, MAR and TAR is a part of the Quality Assurance program. The results are presented at the Quality Assurance meeting.**	8/13/06 **08/13/06**

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by : Based on observation, interview and record review for five (5) of 29 sampled residents, it was determined that Certified Nurse Aides (CNA) inconsistently and or inaccurately documented baths/showers on the ADL (Activities of Daily Living) sheets. Residents #2, 3, 5, 9 and 20. The findings include: 1. CNAs failed to accurately code the ADL sheets for Resident #2. A review of Resident #2's ADL sheets for May and June 2006 revealed that the sheets were marked to indicate that the resident had received one (1) shower in May and one (1) shower in June, 2006. The resident was scheduled to receive showers for Mondays, Wednesdays and Fridays. A face-to-face interview with nursing staff was conducted on July 11, 2006 at 2:00 PM. The	F 514	**F 514 483.75(l)(1) CLINICAL RECORDS** **1. Residents #2, 3, 5, 9 and 20 ADL sheets were reviewed for accuracy and therefore cannot be retrospectively corrected. All residents were assessed by nursing and as noted by the survey team were clean and well-groomed.** **2. All residents ADLs were reviewed for accuracy in documentation** **3. Nursing personnel were re-educated on proper completion of ADL sheets and documentation of showers/baths** **4. Review of the ADL sheets and its accuracy is a part of the nursing comprehensive medical records audit. The results are presented at the Quality Assurance meeting.**	8/13/06 **8/13/06**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	07/13/2006

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F 514	Continued From page 37 CNAs stated that Resident #2 receives showers three (3) times per week. When queried why the ADL sheet was not marked correctly, the CNAs stated, "Don't know." The resident was observed to be clean and well-groomed. The record was reviewed July 11, 2006 . 2. CNAs failed to consistently code bathing care for Resident #3. A review of Resident #3's ADL sheet for June 2006, revealed that five (5) areas were left blank, indicating that the resident received no personal hygiene care. The resident was observed to be clean and well-groomed. A face-to-face interview with a CNA was conducted on July 11, 2006 at 3:40 PM. He/she identified three (3) of the five (5) areas not initialed. He/she stated, "I forgot to sign off." The record was reviewed July 11, 2006. 3. CNAs failed to accurately code the ADL sheets for Resident #5. A review of Resident #5's ADL sheet revealed that the resident received one (1) shower for June 2006. The resident was scheduled to receive a shower on Mondays, Wednesdays and Fridays. A face-to-face interview was conducted on July 11, 2006 at 12:25 PM with a CNA who had cared for Resident #5 during June 2006. The CNA stated, "I gave [Resident #5] a shower and	F 514		

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F 514	Continued From page 38	F 514		

washed [his/her] hair every Monday, Wednesday and Friday that I was assigned to [him/her]. I just made a mistake when I marked the paper (ADL sheet)."

The resident was observed clean and well-groomed. The record was reviewed July 12, 2006.

4. CNAs failed to accurately code the ADL sheets for Resident #9.

A review of Resident 9's ADL sheet for July 2006 was coded to indicate that the resident received no showers from July 1 through 12, 2006. The resident was scheduled to receive showers on Tuesdays and Thursdays.

A face-to-face interview was conducted with the CNA caring for Resident #9 on July 12, 2006 at 2: 30 PM. He/she stated, "I gave [Resident #9] a shower yesterday." The CNA acknowledged that the charting was inaccurate. The resident was observed clean and well-groomed. The record was reviewed July 12, 2006.

5. CNAs failed to accurately code the ADL sheets for Resident #20.

A review of Resident #20's June 2006 ADL sheet revealed that five (5) areas were left blank indicating no personal hygiene care was done and that he/she received one (1) shower for June 2006.

A face-to-face interview with Resident #20 was conducted on July 12, 2006 at 10:00 AM. The resident was asked if he/she received frequent

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F 514	Continued From page 39 showers. The resident nodded, indicating yes. The resident was observed clean and well-groomed. The record was reviewed July 12, 2006.	F 514		