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

PRINTED: 07/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095038		06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on June 23 through 25, 2009. The follow deficiencies were based on observations, staff interview and record review. The sample size was 13 residents based on a census of 47 residents on the first day of survey. There was one (1) supplemental resident.	F 000	**THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF THE METHODIST HOME'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.**	
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: 15 of 15 soiled Heating Ventilation and Air Conditioning (HVAC) vent louvers in resident rooms and four (4) of eight (8) loaner wheel chairs with cracked/torn arm rests in the Rehabilitation Department. These observations were made in the presence of Employees #1, 2, 3, 4 and 10. The findings include: 1. HVAC vent louver panels were soiled with accumulated dust in the following areas: First Floor rooms: 147, 150, 152, and 159, in 6 (six) of 6 (six) HVAC units observed between 9:26 AM and 10:15 AM on June 23, 2009. (Rooms 147 and 152 each had two (2) HVAC units).	F 253	1 – Corrective action taken immediately to clean all identified dusty HVAC vent louvers. 2 – All resident rooms in HCC-HVAC vent louvers checked for dust and cleaned immediately. 3 – Resident rooms will be randomly inspected daily. Measures taken to in-service staff to monitor effectiveness and compliance. 4 – Report compliance to Quality Assurance Committee on a quarterly basis. 1 – No residents were affected by the 4 loaner wheelchairs with cracked/torn armrests as they were not distributed. The 4 loaner wheelchairs labeled "DO NOT USE." 2 – Four new sets of armrests have been ordered and will be placed on the affected chairs upon arrival. 3 – Monthly inspection of the loaner wheelchair stock will be performed by the Rehabilitation Department. Any chairs with cracked/torn armrests will be labeled, removed, and parts replaced. 4 – Compliance will be monitored and reported to the Quality Assurance Committee quarterly.	6/25/09 6/27/09 6/27/09 Initiated 7/23/09 Ongoing 6/25/09 6/23/09 Initiated 6/25/09 Ongoing Initiated 7/23/09 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/ADMINISTRATOR	23 JULY 2009

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 253	Continued From page 1 Second Floor rooms: 244, 247, 252, 253, 259, and 261, in 10 of 10 HVAC units observed between 10:30 AM and 12:20 PM on June 23, 2009. (Rooms 247, 253, and 261 each had two (2) HVAC units). 2. Four (4) of eight (8) loaner wheel chairs in the rehabilitation department were observed with cracked and/or torn armrests at approximately 12:30 PM on June 23, 2009. In acknowledging the aforementioned findings, Employee #10 said, "I have ordered new coverings for the arms of the chairs." Employees #1, 2, 3, 4 and 10 acknowledged the findings at the time of the observations.	F 253		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: 12 of 14 sheet pans and three (3) of nine (9) hotel pans stored wet and ready for reuse, soiled and damaged floor and grout throughout the main kitchen; soiled: electrical components to one (1)	F 371	**1) Pots and Pans stored wet and ready for reuse.** 1. Corrective Action for Residents Affected by Deficient Practice: Identified sheet pans and hotel pans were pulled, Rewashed and allowed to air-dry. 2. Methods to identify other residents at risk for Deficient practice: All hotel pans were checked for proper drying 3. Measures/Systemic Changes to ensure deficient Practice does not recur. Re-educate Utility and Food Production staff on proper drying and storage of pans. Dietary Director/ Designee will check pots twice\day. 4. Performance Monitoring to Ensure Solutions are Sustained: Report audit findings at Quarterly QA meetings.	6/23/09 6/23/09 6/25/09 7/23/09

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F 371	Continued From page 2 of one (1) deep fryer, handles on one (1) of one (1) tilt grill and two (2) of two (2) reach in refrigerators, two (2) of two (2) hot boxes, and two (2) of two (2) hand wash sinks; lack of or improperly installed air gaps on one (1) of one (1) ice machine, one (1) of one (1) preparation sink in the main kitchen, one (1) of one (1) sink in the dish room and two (2) of two (2) hand sinks; one (1) of one (1) can opener with metal shavings and debris, one (1) of one (1) protective panel disattached from the wall in the dish room, and soiled backsplash behind one (1) of one (1) 3-compartment sink. The tour of the main kitchen was conducted on June 23, 2009 from 9:00 AM until 11:00 AM and 12:30 PM until 12:50 PM in the presence of Employee #7. The findings include: 1. The following pans were stored wet and ready for reuse on the rack in the pot and pan areas: 12 of 14 sheet pans and three (3) of nine (9) hotel pans in 15 of 23 pans observed. 2. The floor and grout in the main kitchen was soiled with debris. Additionally, small depressions in the floor tile with accumulated debris were observed throughout the main kitchen. This is a repeat deficiency from the annual recertification survey completed June 13, 2008. 3. The electrical components underneath one (1) of one (1) deep fryer were observed with accumulated grease and debris.	F 371	**2)Floor in main kitchen was soiled with debris. Small depressions in the floor tile were observed throughout the kitchen.** 1. Corrective Action for residents Affected by Deficient Practice: Floor was swept and mopped. 6/23/09 2. Methods to Identify Other residents at risk for Deficient practice. Entire kitchen floor was inspected By Dietary and Maintenance manager and the floor was power sprayed the evening of the observation. 6/23/09 3. Measures or systemic changes to ensure deficient Practice does not recur. Re-educate Staff on proper floor cleaning. 6/25/09 Maintenance will power wash the floor once/ month. Damaged tiles will be replaced and floor re-grouted. 8/09/09 4. Performance Monitoring to Ensure Solutions are sustained. Dietary Director will report Findings at Quarterly QA meetings. 7/23/09 **2008 deficiency reflected damaged tile and grout that was replaced per Plan of Correction.** **3) Electrical Components underneath fryer observed With accumulated grease and debris.** 1. Corrective action for residents affected by deficient Practice. Electrical component under fryer was cleaned of accumulated debris with grease cutter. 6/23/09 2. Methods to Identify Other residents at risk for Deficient practice. Maintenance inspected all equipment with electrical components throughout the department. 6/23/09 3. Measures/Systemic Changes to ensure deficient Practice does not recur. Maintenance will add the Cleaning of the electrical component to their preventative maintenance schedule. 7/10/09 4. Performance Monitoring to Ensure Solutions are Sustained. Dietary Director will monitor the Cleanliness of the electrical components underneath the fryer. Findings will be reported at quarterly QA meetings. 7/23/09

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F 371	Continued From page 3 4.The inner aspect of the handle on one (1) of (1) tilt grill and (2) of two (2) reach in refrigerators were observed with accumulated debris. 5. Two (2) of two (2) hot boxes used to transport food from the kitchen to the resident units were observed soiled on the interior surfaces. 6. Two (2) of two (2) hand wash sinks were observed with accumulated dust and debris on the inner and outer surfaces. 7. Air gaps were missing or improperly installed in the following areas: One (1) of one (1) preparation sink Two (2) of two (2) hand washing sinks One (1) of one (1) sink in the dish room One (1) of one (1) ice machine The above areas were corrected during the survey. 8. One (1) of one (1) can opener was observed with Metal shavings and accumulated debris on the tip and interior surfaces of the can opener. 9. One (1) of one (1) protective wall surface attached to the wall of the dish room was observed pulling away from the wall on the mid left side of the panel. 10. One (1) of one (1) back splash located behind the three (3) compartment sink was observed soiled with accumulated grease, water spots and dust. Employee #7 acknowledged the above findings at the time of the observations.	F 371	**4) The inner handles of the tilt skillet and reach-in Refrigerators were observed soiled.** 1. Corrective action for residents affected by deficient Practice. The inner handles of tilt skillet and reach-in refrigerators were cleaned and sanitized. 2. Methods to Identify Other residents at risk for Deficient practice. All other handles on equipment Were cleaned and inspected throughout department. 3.Measures/Systemic Changes to ensure deficient Practice does not recur. Cleaning schedules have been written in more detail and staff have been instructed to initial when cleaning assignments have been completed. 4. Performance Monitoring to Ensure Solutions are Sustained. Cleaning checklist will be turned into Dietary Director weekly. Findings will be reported at Quarterly QA meetings. **5) Two (2) of two (2) hot boxes used to transport food from the kitchen to the resident units were observed soiled on the interior surfaces.** 1. Corrective action for residents affected by deficient Practice. The two hot boxes were cleaned and Removed from the department. 2. Methods to Identify Other residents at risk for Deficient practice. All other carts were inspected And cleaned throughout department. 3.Measures/Systemic Changes to ensure deficient Practice does not recur. Cleaning schedules have been written in more detail and staff have been instructed to initial when cleaning assignments have been completed. 4. Performance Monitoring to Ensure Solutions are Sustained. Cleaning checklist will be turned into Dietary Director weekly. Findings will be reported at Quarterly QA meetings.	6/23/09 6/23/09 7/15/09 7/23/09 6/23/09 6/23/09 7/15/09 7/23/09
		F 431		

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		F 371	**6. Two hand wash sinks were observed with dust and debris on the inner and outer surfaces** 1. Corrective Action for residents Affected by Deficient Practice Both hand sinks were cleaned and sanitized.	6/23/09
			2. Methods to Identify Other residents at risk for Deficient practice. All other sinks throughout the Kitchen were cleaned and sanitized.	6/23/09
			3.Measures/Systemic Changes to ensure deficient Practice does not recur. Cleaning schedules have been written in more detail and staff have been instructed to initial when cleaning assignments have been completed.	7/15/09
			4. Performance Monitoring to Ensure Solutions are Sustained. Cleaning checklist will be turned into Dietary Director weekly. Findings will be reported at Quarterly QA meetings.	7/23/09
			7) Air gaps were missing or improperly installed. 1. Corrective Action for residents Affected by Deficient Practice – Air gaps were increased and backflow preventers were installed in all deficient areas.	6/24/09
			2. Methods to Identify Other residents at risk for Deficient practice. All other plumbing areas were checked for air gaps/ backflow preventers.	6/24/09
			3. Measures/Systemic Changes to ensure deficient Practice does not recur Maintenance will check Plumbing in the kitchen during their preventative maintenance audits.	7/23/09
			4. Performance Monitoring to Ensure Solutions are Sustained. Dietary Director will report any Plumbing issues at Quarterly QA meetings.	7/23/09
			8) One (1) of one (1) can opener was observed with metal shavings and accumulated debris on the tip and interior surfaces of the can opener. 1. Corrective Action for residents Affected by Deficient Practice The can opener was cleaned and sanitized.	6/23/09
			2. Methods to Identify other residents at risk for Deficient practice. The can opener in the Kitchen will be cleaned and sanitized after each use.	6/23/09
			3.Measures/Systemic Changes to ensure deficient Practice does not recur. Cleaning schedules have been written in more detail and staff have been instructed to initial when cleaning assignments have been completed.	7/15/09
			4. Performance Monitoring to Ensure Solutions are Sustained. Cleaning checklist will be turned into Dietary Director weekly. Findings will be reported at Quarterly QA meetings.	7/23/09

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9) One protective wall surface attached to wall of Dish room was observed pulling away from wall on the mid left side of the panel.

1. Corrective Action for residents Affected by Deficient Practice
The wall surface panel removed and rear surface cleaned. 7/24/09

2. Methods to Identify Other residents at risk for Deficient practice
Other panels inspected to determine if removal, Cleaning and reattachment are necessary. All Panels will be secured and caulked. 7/31/09

3. Measures/Systemic Changes to ensure deficient Practice does not recur
Maintenance and dish room personnel will check Panels in the dish room during their preventative Maintenance audits and tour of duty. 7/31/09

4. Performance Monitoring to Ensure Solutions are Sustained
Dietary Director will report findings at Quarterly QA Meetings. 7/31/09 Ongoing

10) One (1) of one (1) back splash located behind the three (3) compartment sink was observed soiled with accumulated grease, water spots and dust.

1. Corrective Action for residents Affected by Deficient Practice
The backsplash behind the pot sink was cleaned and sanitized. 6/23/09

2. Methods to Identify Other residents at risk for Deficient practice. All other sinks throughout the Kitchen were inspected, cleaned and sanitized. 6/23/09

3. Measures/Systemic Changes to ensure deficient Practice does not recur.
Cleaning schedules have been written in more detail and staff have been instructed to initial when cleaning assignments have been completed. 7/15/09

4. Performance Monitoring to Ensure Solutions are Sustained. Cleaning checklist will be turned into Dietary Director weekly. Findings will be reported at Quarterly QA meetings. 7/23/09

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F 431 SS=D	Continued From page 4 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of two (2) of two (2) medication rooms and staff interview, it was	F 431		

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F 431	Continued From page 5 determined that facility staff failed to properly label and remove 40 of 40 vials of expired influenza vaccine from currently dated medications, replace two (2) of two (2) emergency Glucagon kits in the emergency box, and remove the medication of one (1) deceased resident from currently utilized medications. The findings include: 1. The facility staff failed to properly label and remove expired medications from the medication refrigerator. On June 23, 2009 at approximately 2:00 PM during the inspection of the second floor medication room, 40 of 40 vials of "Influenza Virus Vaccine 2008/2009 formula" in the medication refrigerator were found expired. The expiration date on each vial of the vaccine was May 2009. The label applied by the pharmacy on the outside of the box of the vials of vaccine indicated that the vaccine expired October 2009. The observation was made in the presence of Employee # 6. In acknowledging the finding, he/she said, "We did not look at the vials, the date on the outside of the box from the pharmacy is October 2009." 2. Facility staff failed to ensure that the "Glucagon Emergency Kit" was available in the emergency box. On June 23, 2009, at approximately 2:00 PM, during the tour of the medication storage areas, the second floor Emergency Box was observed.	F 431	1. The vials of expired influenza vaccine were removed from the refrigerator and disposed of per pharmacy instruction. 2. Expiration dates on all medications in the facility were checked to determine the potential for recurrence of this deficient practice. Medications identified as "expired" were immediately removed and Pharmacy was notified to provide replacements. 3. The Consultant Pharmacist will complete monthly medication audits to verify that no meds in the facility have expired. This audit will include all storage locations (refrigerators, interim drug box, emergency box, narcotic box, med cart), and all medication types (bulk and unit dose). Expiration dates appearing on external containers will also be compared to expiration dates on vials inside the containers to ensure there are no discrepancies. In the event any expired meds are found, they will be removed by the pharmacist and replaced promptly. Monthly reports will be prepared after each visit with cumulative findings prepared quarterly. These reports will be submitted to the facility and to the pharmacy. The medication audits will be conducted separately from the current monthly Drug Regimen Reviews. 4. The Consultant Pharmacist will report compliance to the Quality Assurance and Improvement Committee each quarter until100% compliance x 4 consecutive quarters is reached. 1. Pharmacy was notified and requested to replace the Emerg Box after the Glucagon Kit was observed missing. 2. All contents of the E-Box were compared against the medication list attached to the outside of the box to make sure other emergency drugs were not missing. All were present.	6/23/09 6/23/09 7/1515/09 7/23/09 6/24/09 6/24/09

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F 431	Continued From page 6 The box was under double lock. A review of the medication list attached to the outside of the box revealed that the contents of the box included two (2) "Glucagon Emergency Kits". Further review of the contents of the emergency box failed to reconcile with the list posted on the box. It was observed that the container for the two (2) "Glucagon Emergency Kits" in the box was empty. The aforementioned observation was made in the presence of Employee #6. Employee #6 acknowledged the finding and stated, "I do not know what happened, but the kits were never used. There is no sign-out sheet indicating it was ever used." 3. Facility staff failed to remove the medication of a deceased resident from currently utilized medications. During the tour of the facility's first floor medication room, it was observed that facility staff failed to remove a topical analgesic cream that was labeled for a resident who died on April 15, 2009. The cream was stored with currently used medications/supplies in the cabinet in the first floor medication room. The observation was made in the presence of Employee #4. In acknowledging the aforementioned finding, Employee # 4 said, "The resident expired two or three months ago."	F 431	3. The Consultant Pharmacist will audit monthly the interim drug box, emergency box, and narcotic box to ensure that these boxes contain the drugs listed on the medication lists attached to the boxes, and to make sure none of the meds in the boxes have expired. The pharmacy policy regarding the "back up" boxes will be updated to reflect this added responsibility for the Consultant Pharmacist. Monthly reports will be prepared after each visit. Compliance rate is set at 100%. 4. The Consultant Pharmacist will report to the Quality Assurance/Improvement Committee each quarter until 100% compliance x 4 consecutive quarters is reached. 1. The topical analgesic for the deceased resident was removed immediately and discarded. 2. Med rooms on both nursing units were checked for meds of discharged residents. None were found. 3. Nurses will be in-serviced on correct/timely disposal of meds when residents are discharged, and current policy will be updated. Med rooms will be checked during monthly Med Room inspections by the Pharmacist and compliance documented. 4. Pharmacist will report compliance to QA/QI Committee quarterly until 100% compliance is achieved x4 consecutive quarters.	7/15/09 7/23/09 6/23/09 6/25/09 7/30/09 7/23/09 7/23/09
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 492		

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F 492	Continued From page 7 that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled resident records, it was determined that facility staff failed to document an incident in Resident #10's record. The findings include: According to 22DCMR3232.4, "Each incident shall be documented in the resident' s record and reported to the licensing agency within forty-eight (48) hours of occurrence ..." A review of an incident report revealed the following: "On April 24, 2009 at 12:15 PM, [Resident #10] reported that [he/she] had been slapped on both sides of [his/her] face during the night ..." The facility conducted an investigation regarding the above incident. There was no evidence that the resident was slapped. There were no bruises or redness on the resident's face. A face-to-face interview was conducted with Resident #10 on June 25, 2009 at 11:30 AM. Resident #10 was asked if he/she was every harmed by a staff member. Resident #10 replied, " No" with no further response to questions asked. A review of the resident's record revealed that the nurses' notes, social services notes and physician's notes lacked documentation of the	F 492	1. Documentation in the resident's record for this incident should have been completed in April, 2009. Considering the time that has elapsed, no corrective action could be accomplished at the time the deficient practice was identified.	6/23/09
			2. Incident reports prepared over the past 12 months have been reviewed and compared to resident charts to determine if documentation is missing from the record. All incidents have been documented.	6/26/09
			3. Nursing will continue to document incidents related to resident injuries (pressure ulcers, falls, skin tears, fractures, etc.) in the medical record. Social Worker will document incidents related to alleged abuse, neglect, or misappropriation of residents' property. Incident Reports will be compared against documentation included in residents' records at the end of each month. Acceptable compliance threshold is set at 100%.	7/16/09
			4. Compliance rates will be reported to the Quality Assurance/Improvement Committee quarterly. Reporting will continue until 100% compliance is met x4 consecutive quarters.	7/23/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095038		06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOME	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 8 incident. The psychiatrist saw the resident on April 24, 2009. According to the psychiatrist' s progress note, "Still with increased frequency of yelling though clearer today. Denies major depressive feeling ..." According to the social worker' s note dated April 24, 2009 at 11:00 AM, "Resident was seen by psychiatrist today. Still increased frequency of yelling though voice giving out some. Appetite is decreased. Increased psychotic features this past week and increased confusion ..." According to the nurse' s note dated April 24, 2009 at 12:00 PM, " Resident seen and examined by psychiatrist ...today ...Resident now has diagnosis of dementia with psychotic features and depressive D/O NOS. Nursing will continue to monitor resident' s behavior ..." A face-to-face interview was conducted on June 25, 2009 at 10:30 AM with Employee #9. After reviewing the resident' s record, Employee #9 acknowledged that the above cited incident was not documented in the resident's record. The record was reviewed June 25, 2009.	F 492		
F 514	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	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 9 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 record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to correctly transcribe a physician's order for Resident #2. The findings include: A review of Resident #2's record revealed a physician's order dated May 29, 2009 that directed, "Decrease Lexapro to 10 mg by mouth daily for Dementia, increase mood and psychotic disorder management." A review of the May 2009 and June 2009 MARs revealed a physician's order "Lexapro 10 mg tablet by mouth every day along with 5 mg to equal 15 mg for dementia." There was no evidence that the above cited order was transcribed onto the May and June 2009 MARs. During the medication pass conducted on June 23, 2009 at 9:00 AM, it was observed that the resident was administered Lexapro 10 mg. A face-to-face interview with Employee #6 was conducted on June 23, 2009 at 10:30 AM. He/she acknowledged that the physician's order dated May 29, 2009 to decrease Lexapro to 10 mg tablet by mouth daily was not transcribed onto the May and June 2009 MAR. The record was reviewed on June 24, 2009.	F 514	1. The transcription error identified for the Lexapro order on the June MAR was corrected and a Medication Error Report generated immediately. 2. In-service education will be conducted semi-annually on medication transcriptions with specific focus on end-of-the-month transcriptions. 3. An RN Staff Nurse has been assigned to complete end of the month transcriptions. A full time Nursing Supervisor has been assigned to review the MARs on the last day of each month to ensure all orders received during the month have been correctly transcribed on to MARs for the new month. 4. Audits will be conducted monthly on at least 20% of all charts to determine if medications have been correctly transcribed/carried over. The acceptable compliance threshold is 100%. Compliance rates will be reported to the Quality Assurance/Improvement Committee on a quarterly basis until 100% compliance has been met x4 consecutive quarters.	6/24/09 6/30/09 6/30/09 7/23/09