STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095015		12/06/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLYN BOONE LEWIS HEALTH CARE CENTER	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An annual recertification survey was conducted December 3 through 6, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff. The sample included 27 residents based on a census of 177 residents on the first day of survey and five (5) supplemental residents.	F 000		
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 observations, record review and staff interviews for a sample of 27 residents, one (1) of four (4) residents identified with restraints, it was determined that the clinical record lacked evidence that a vest restraint was the least restrictive device for Resident #2. The findings include: During the review of the clinical record, physician's orders signed and dated November 16, 2007 with an original order date of May 15, 2007, indicated "Vest Posey jacket to protect pt. (patient) release every two (2) hours for mobility and circulation in bed/wheelchair." Resident #2 has a history of falls. On December 3, 2007 at approximately 9:30 AM, Resident #2 was observed sitting in the day room in a wheelchair in a Vest Posey jacket with the Velcro fasteners in the back, the straps attached	F 221	**Disclaimer** Preparation or execution of this Plan of Correction ("POC") does not constitute an admission or assent by the provider to the truth, accuracy or veracity of the facts alleged or conclusions set forth in the Statement of Deficiencies ("SOD"). The POC is prepared and executed solely because it is required under the law. By this response, Carolyn Boone Lewis Health Care Center acknowledges receipt of the SOD and alleges that it is in compliance. Accordingly, this POC is submitted as written allegation of compliance effective December 28, 2007.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calanthia Green	Administrator	12-28-07

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 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 observations, record review and staff interviews for a sample of 27 residents, one (1) of four (4) residents identified with restraints, it was determined that the clinical record lacked evidence that a vest restraint was the least restrictive device for Resident #2. The findings include: During the review of the clinical record, physician's orders signed and dated November 16, 2007 with an original order date of May 15, 2007, indicated "Vest Posey jacket to protect pt. (patient) release every two (2) hours for mobility and circulation in bed/wheelchair." Resident #2 has a history of falls. On December 3, 2007 at approximately 9:30 AM, Resident #2 was observed sitting in the day room in a wheelchair in a Vest Posey jacket with the Velcro fasteners in the back, the straps attached	F 221	**F 221 483.13(a)** **PHYSICAL RESTRAINTS** 1. Unit Manager referred resident #2 for rehab screen on 12-07-07. Rehab recommended a self release seat belt which is the least restrictive. Seat belt was placed on residents' wheelchair on 12-14-07. 2. All other residents identified with restraints has been assessed for the least restrictive device and referred to rehab for screens as needed. 3. Licensed staff were in-serviced on 12-07-07 on the use of restraints by Unit Manager and the referral process for rehab screens. 4. Random audits will be conducted to ensure the process is being followed and monitored in quarterly CQI.	12-28-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calanthia Green
TITLE: Administrator
(X6) DATE: 12-28-07

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 to the jacket were wrapped around the lower rims of the wheelchair. The resident was pulling on the vest in an attempt to remove it saying that he/she was hot. On December 3, 2007 at approximately 5:15 PM, the resident was observed in his/her wheelchair in the hallway across from the first floor nurse's station. He/she was pulling the vest up in an attempt to remove it; the vest was observed anchored at the resident's neck beneath his/her chin. Review of the clinical record revealed a consent form for vest restraint use signed and dated by the resident's responsible party on May 15, 2007. The resident's care plan for restraint use for safety was updated on October 24, 2007. A "Rehabilitation Screening" form in the record signed and dated October 29, 2007 by the physical therapist indicated, "Pt. using Posey Vest which [he/she] is able to remove on occasion allowing nursing to prevent a fall. ...[She/he] is on the least restrictive device at this time." The record lacked evidence that other devices and/or interventions had been tried. On December 5, 2007 at approximately 12:30 PM, a face-to-face interview was conducted with Employee #12. The employee stated, "This type of vest is the most restrictive; that type of restraint is not frequently used at the present time." During observation, the resident was unable to remove the restraint on both attempts. The record was reviewed on December 3, 2007.	F 221		
F 246	483.15(e)(1) ACCOMMODATION OF NEEDS	F 246		

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F 246 SS=D	Continued From page 2 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour, it was determined that clocks located in residents' rooms were not functional. These observations were made in the presence of Employees #1, 2, 3 and 11. The findings include: During the initial tour of the facility on December 3, 2007 between 8:30 AM and 10:00 AM, it was observed that clocks failed to keep time in the following rooms: 122, 128, 135, 234, 243, 334 in six (6) of 36 resident rooms observed. Employees #1, 2, 3 and 11 acknowledged the findings at the time of the observations.	F 246	**F 246 483.15(e) (1)** **ACCOMMODATION OF NEEDS** 1. Residents' #122, 126, 135, 234, 243 and 334 clocks that failed to keep correct time during survey period were removed immediately and replaced on 12-10-07. 2. All other residents' rooms and areas in the facility were clocks are located were checked for proper functioning and were removed and replaced as needed. 3. Purchasing Director was in-serviced on monitoring of clocks in residents' rooms and other areas where clocks are located in the facility by the Educator on 12-26-07. 4. Purchasing Director will conduct monthly rounds to ensure clocks are functioning properly. Findings will be reported in quarterly CQI.	12-28-07
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	F 253		

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F 253	Continued From page 3 maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled baseboards, ceiling tiles, corners, bed frames, ice machine, window tracts, front window of facility washing machines, damaged/marred walls, furniture, doors, dusty overbed lights, missing 2nd floor shower room tiles, broken front panels on overbed lights and odors detected in residents' rooms. The environmental tour was conducted on December 3, 2007 from 8:30 AM through 11:30 AM in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. A tour of the laundry was conducted on December 3, 2007 at 2:15 PM in the presence of Employee #5. The findings include: 1. Soiled, marred/damaged baseboards were observed in the following rooms: 119, 123, 128, 130, 136, 137, 139, 141, 144, 145, 147, 2nd and 3rd floor shower rooms in 13 of 36 rooms observed. 2. Stained ceiling tiles were observed in rooms 130 and 137 in two (2) of 12 rooms observed on the 1st floor. 3. Wax and dirt build-up in corners was observed in the following rooms: 128, 130, 135, 136, 142, 144, 145, and 147 in eight (8) of 12 rooms observed on the first floor. 4. Bed frames with accumulated dust were observed in the following rooms: 246, 237, 318, 321, and 337 in five (5) of 24 resident rooms observed on the 2nd and 3rd floors. 5. The 3rd floor pantry ice machine dispensing	F 253	**F 253 483.15(h)(2)** **HOUSEKEEPING/MAINTENANCE** **#1, #2, #3, #4, # 5, #6** 1. The soiled, marred/damaged baseboards in rooms 119, 123, 128.130, 136, 137, 139, 141, 144, 145, 147, 2nd and 3rd floor shower rooms were cleaned on 12-26-07, the stained tile in room 130 and 137 were removed and replaced immediate during survey period, the wax and dirt build up in rooms 128, 130, 135, 136, 142, 144, 145 and 147 were cleaned on 12-27-07. Bed frames sited with accumulated dust in rooms 246, 237, 318, 321 and 337 were cleaned immediately. The 3rd floor panty ice machine dispensing spout soiled with dust and debris was cleaned on the day it was sited. The soiled window tracks in rooms 126, 128, 130 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324 334 and 346 were cleaned immediately. review received 1/9/08 a	

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F 253	Continued From page 4 spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334, and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower	F 253	2. All other residents rooms and Areas That could be affected were inspected by Director of Environmental Services to ensure that baseboards are clean, tiles are free of stains, there is No wax builds up in corners, bed Frames are free from dust and debris, Ice machine on 3rd floor is free from dust and debris and window tracks in residents rooms and throughout the facility are not soiled. 3. In-services were given on 12-20-07 on cleaning of baseboards, reporting soiled ceiling tile to maintenance dept. cleaning wax and dirt build up in corners cleaning of bed frames, the cleaning of the ice machine and the cleaning of window tracks by the Director Of Environmental Services. 4. Director of Environmental Services will make monthly rounds to ensure baseboards are clean tiles are free of stains, there is no wax build up in corners bed frames are free from dust and debris, ice machine on 3rd floor is free from dust and debris and window tracks in residents rooms and throughout the facility are not soiled and report findings in Quarterly CQI.	12-28-07

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F 253	Continued From page 4 spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334, and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower	F 253	#7 1. Cited black substance on inner part of front window on washer was cleaned on 12-4-07 2. All other washers were inspected by laundry staff and washers were cleaned as needed. 3. Staff was in-serviced on 12-21-07 by Director of Environmental Services on Cleaning and maintenance of washers. 4. Monitoring will be done by laundry staff weekly and finding will be reported in quarterly CQI. #8 1. The walls cited in rooms 123, 136, 137, 141, 312, 313, 338, 318 338, and 2nd floor shower rooms and 3rd floor pantry as marred/scarred walls during the survey period will be repaired by 12-30-07. 2. All other residents rooms were inspected for marred/scarred walls by the maintenance staff and will be repaired as needed. 3. In-service was given by Director of Maintenance to maintenance staff on making rounds and repairing marred/scarred walls in resident's rooms and other areas of the facility.	12-28-07

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F 253	Continued From page 4 spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334, and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower	F 253	4. Monthly rounds will be done by Maintenance staff to ensure walls are not marred/scarred and finding will be reported in Quarterly CQI. #9 1. The broken chairs sited during the survey in the 3rd floor smoking room 3rd floor dining room and the 2nd floor dining room were removed immediately. 2. All other areas that could be affected Were inspected by Director of Environmental Services and chairs were removed or repaired as needed. 3. Housekeeping staff were in-serviced on 12-20-07 on inspecting chairs throughout The facility on their assigned units daily to ensure compliance. 4. Findings will be reported in quarterly CQI.	12-28-07 12-28-07

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F 253	Continued From page 4 spout was observed soiled with an accumulation of dust and debris in one (1) of one (1) ice machine observed on the 3rd floor. 6. Soiled window tracts were observed in the following rooms: 126, 128, 130, 136, 137, 142, 144, 145, 147, 207, 210, 230, 246, 308, 324, 334, and 346 in 17 of 36 resident rooms observed. 7. One (1) of two (2) working washers was observed with a black substance on the inner part of the front window. 8. Damaged, marred/scarred walls were observed in the following rooms: 123, 136, 137, 141, 312, 313, 338, 318, 338, 2nd and 3rd floor shower rooms, and 3rd floor pantry in 12 of 36 rooms observed. 9. Broken chairs were observed in the following areas: 3rd floor smoking room one (1) of three (3) arm chairs, 3rd floor dining room one (1) of three (3) arm chairs, and 2nd floor dining room three (3) of six (6) chairs. 10. Damaged doors were observed in the following areas: 2nd floor smoking room one (1) of one (1) door, 1st floor day room one (1) of two (2) doors, and 2nd floor day room one (1) of one (1) door. 11. Overbed lights were observed with an accumulation of dust in the following rooms: 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337, and 378 in 14 of 36 resident rooms observed. 12. Floor tiles were observed missing in the 2nd floor shower room in one (1) of one (1) shower	F 253	**#10, #12 #13** 1. Damaged doors on 2nd floor smoking room and 1st floor day room citied during survey period was repaired on 12-24-07. The broken tile in the 2nd floor shower room will be repaired by 1-28-08. The broken front panel of the over bed light in rooms 126 and 142 were repaired the same day cited. 2. All other doors, shower rooms, and over bed light panels in facility were inspected for damage and repaired as needed by maintenance staff. 3. Maintenance staff was in-serviced on 12-24-07 by Director of Maintenance on monitoring of doors, tile and over bed lights for damage throughout the facility and the importance of preventative maintenance. 4. Monthly rounds will be done by maintenance staff and findings will be reported in quarterly CQI. **#11** 1. Over bed lights sited with accumulated Dust in room 130, 136, 137, 139, 142, 144, 145, 147, 237, 246, 312, 321, 337 and 378 were cleaned on 1221-07. 2. All other residents' rooms were inspected and were cleaned as needed. Weekly rounds will be conducted by the Director Environmental Services to ensure compliance.	12-28-07

review received 1/7/08

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F 253	Continued From page 5 room observed on the 2nd floor. 13. The front panel of the over bed light was observed broken in rooms 126 and 142 in two (2) of 12 resident rooms observed on the 1st floor. 14. Strong urine and fecal odors were detected in the following areas: rooms 113 and 114 on December 3, 2007 at 9:10 AM and December 4, 2007 at 8:00 AM and 1:40 PM, room 140 on December 3, 2007 at 9:20 AM and room 219 at 8:55 AM on December 4, 2007. The above findings were acknowledged by Employees #1, 2, 3, 4, 5, 6, 7, and 11 at the time of the observations.	F 253	3. Housekeeping staff were in-serviced on 12-20-07 on proper cleaning of over bed lights. 4. Findings will be monitored and reported in quarterly CQI. #14 1. Rooms 113, 114, 140 and 219 that were cited for strong urine and fecal orders were cleaned, beds were washed and privacy curtains were replaced on 12-4-07. 2. All other resident rooms were inspected for urine and fecal orders and were clean and sanitized as needed. 3. Environmental Services staff was in-serviced on 12-21-07 by Director of Environmental Services on cleaning and sanitizing of residents' rooms. 4. Rounds will be done by housekeeping staff and finding reported in quarterly CQI.	12-28-07 Review received 1/7/08 12-28-07
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	F 278		

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F 278	Continued From page 6 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 one (1) of 27 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident for rehabilitation/restorative care. Resident #20 . The finding include: 1. Facility staff inaccurately coded Resident #20 for rehabilitation/restorative care. The resident was observed on December 4, 2007 at approximately 11:00 AM. Both hands were contracted. Further observations were made on December 4, 2007 at approximately 1:00 PM, 3: 00 PM and 4:00 PM; on December 5, 2007 at approximately 8:30 AM, 10:30 AM, 12:30 PM, and 2:30 PM, and on December 6, 2007 at approximately 8:45 AM. The resident's was not observed with a hand splint or brace A review of the resident's quarterly MDS completed August 6, 2007 coded Section G4 "Functional Limitation in Range of Motion" for partial loss and limitation on one side to hand including wrist or fingers; Section P3 "Nursing Rehabilitation/Restorative Care" was coded for splint or brace assistance. The quarterly MDS	F 278	**F 278 483.20(g) - (j)** **RESIDENT ASSESSMENT** 1. MDS Coordinator corrected resident #20 MDS on 12-12-07 for rehab/restorative Care. Rehab screen was requested on 12-11-07 and complete on 12-12-07 and The recommendations was for palm proctors and range of motion. 2. All other residents identified with Restorative/rehab care records have Been reviewed for PMD orders and Correct implementation and Documentation. 3. MDS Coordinator was in-serviced on 12-06-07 on the correct coding for restraints and restoratative care by the DON. 4. Random audits will be done by unit managers of residents with splints to ensure proper coding on MDS and PMD orders and finding reported in quarterly CQI.	12-28-07

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F 278	Continued From page 7 completed November 5, 2007 Section G4 was coded for full loss and limitation on both sides; and Section P3 "Nursing Rehabilitation/Restorative Care" was coded for splint or brace assistance. A review of the clinical record lacked an order for the use of a splint or brace for the resident. A face-to-face interview was conducted with Employees #3 and15 on December 6, 2007 at approximately 9:00 AM. The surveyor and Employees #3 and 15 observed the resident in his/her bed with bilateral tightly clenched contracted hands. Employees #3 and 15 were unable to find information on the resident in the Nursing Rehabilitation/ Restorative Care book. The resident's record also lacked evidence of any Nursing Rehabilitation/ Restorative Care services. Employee #3 and 15 acknowledged that the resident was inaccurately coded for Nursing Rehabilitation/ Restorative Care services. The record was reviewed December 6, 2007.	F 278		
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	F 279		

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F 279	Continued From page 8 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 observations and record review and staff interview for three (3) of 24 sampled residents, it was determined that facility staff failed to develop a care plan with appropriate goals and approaches for one (1) resident receiving psychotropic medication, one (1) resident with contractures and one (1) resident receiving anticoagulant therapy. Residents # 16, 20 and F2. The findings include: 1. Facility staff failed to develop a care plan with goals and approaches for Resident #16 receiving a psychotropic medication. The November 2007 "Physician's Order Form" signed November 15, 2007 revealed, "Clonazepam 0.5 mg one tab by mouth twice daily for agitation behavior." A review of the November and December 2007 Medication Administration Record revealed that Clonazepam 0.5 mg was initialed [indicating that the medication was administered to the resident] twice daily. A review of the record lacked evidence that a	F 279	**F 279 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS #16, #20, #F2** 1. Unit Managers developed a care plan for resident #16 with approaches and goals on 12-04 -07 for psychotropic medication. A care plan was developed for resident #20 with approaches and goals on 12-04-07 for contractures. A care plan was developed for resident F2 with approaches and goals on 12-5-07 for anticoagulant therapy. 2. All other residents identified on psychotropic medication, contractures, and anticoagulant therapy records were reviewed and care plans were developed as needed. 3. Unit Managers, DON and MDS Coordinator was in-serviced on 12-21-07 on care plan development for residents on psychotropic medication, residents on anticoagulant therapy and residents with contractures by the Educator. 4. Random audits will be conducted by Unit Managers to monitor residents' records for care plan development on admissions, during care plan and PRN. Findings will be monitored in Quarterly CQI.	12-28-07

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F 279	Continued From page 9 care plan was developed with goals and approaches for Resident #16's use of a psychotropic medication. A face-to-face interview was conducted with Employee #3 on December 4, 2007 at 3:50 PM. He/she acknowledged that a care plan was not developed for the use of a psychotropic medication. The record was reviewed December 4, 2007. 2. Facility staff failed to initiate a care plan for Resident #20 with contractures in both hands. The resident was observed on December 4, 2007 at approximately 11:00 AM. Both hands were contracted. Further observations were made on December 4, 2007 at approximately 1:00 PM, 3: 00 PM and 4:00 PM, on December 5, 2007 at approximately 8:30 AM, 10:30 AM, 12:30 PM, and 2:30 PM, and on December 6, 2007 at approximately 8:45 AM. The resident's hands were contracted. A review of the resident's quarterly MDS completed August 6, 2007 coded Section G4 "Functional Limitation in Range of Motion" for partial loss and limitation on one side to hand including wrist or fingers; Section P3 "Nursing Rehabilitation/Restorative Care" was coded for splint or brace assistance. The quarterly MDS completed November 5, 2007 Section G4 was coded for full loss and limitation on both sides; and Section P3 "Nursing Rehabilitation/Restorative Care" was coded for splint or brace assistance. The resident's care plan was reviewed by the Interdisciplinary Care Team on August 7, and	F 279		

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F 279	Continued From page 10 November 6, 2007. There was no evidence that a care plan was initiated with appropriate goals and approaches for the resident with contractures in both hands. A face-to-face interview was conducted with Employee #3 on December 6, 2007 at approximately 2:45 PM. He/she acknowledged that a care plan was not initiated for the contractures in both hands. The record was reviewed December 6, 2007. 3. Facility staff failed to develop a care plan with goals and approaches for Resident F2 receiving anticoagulant therapy. A review of Resident F2's admission orders dated November 21 and signed by the physician November 24, 2007 directed, "Coumadin 3 mg one tab p.o. [by mouth] qd [every day] for DVT [deep vein thrombosis]." A review of the care plan, last reviewed December 6, 2007, revealed that there were no goals and approaches for anticoagulant therapy. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 1:50 PM. He/she acknowledged that a care plan was not developed for anticoagulation therapy. The record was reviewed December 6, 2007.	F 279		
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.	F 280		

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F 280	Continued From page 11 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 record review and staff interview for one (1) of 27 sampled residents, it was determined that facility staff failed to update Resident #19's care plan for falls. The findings include: A review of Resident #19's record revealed that the resident fell on June 19, 22, 30, August 22, September 4 and October 8, 2007. The resident was screened by the physical therapist on July 25, 2007. No therapy was initiated as a result of the screen. There was no evidence in the record that additional goals and approaches were initiated after the aforementioned falls. There were no injuries noted.	F 280	**F 280 483.10(k)(2)** **COMPREHENSIVE CARE PLANS** 1. Unit Manager updated resident #19 Care plan on 12-6-07 for Additional goals and approaches for fall prevention and rehab screen was requested on 12-06-07. 2. All other residents identified for falls care plans were reviewed and were updated with additional goals and approaches if needed. 3. Unit Managers were in-serviced on 12-24-07 for updating care plans for residents with falls for additional goals and approaches by the Educator. 4. Unit Managers will do random chart audits for care plan updates and will monitor in quarterly CQI.	12-28-07

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F 280	Continued From page 12 A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 5:30 PM. He/she acknowledged that additional goals and approaches were not initiated after the aforementioned falls. The record was reviewed December 6, 2007.	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 staff interview and record review for one (1) of 27 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to obtain physician orders to monitor PT/INR (Prothrombin Time and International Normalized Ratio) levels for two (2) residents receiving Coumadin(Warfarin) as per manufacturer's recommendations. Residents #4 and F1. The findings include: According to the manufacturer's recommendations, "Acceptable intervals for PT (Prothrombin Time)/INR (International Normalized Ratio) determinations are normally within the range of 1 to 4 weeks after a stable dosage has been determined" from the web site www.bristol-myers-squib. 1. Facility staff failed to obtain physician's orders to obtain PT/INR laboratory (lab) tests for Resident #4. The Physician Order Sheet [POS] and Plan Care	F 281	**F 281 483.20(k)(3)(I) COMPREHENSIVE CARE PLANS** #1, #2 1. Unit Manager obtained orders for PR/INR for resident #4 and F1 on 12-5-07 and labs were drawn on 12-6-07 and labs were within normal limits. 2. All other resident identified on anticoagulants records were reviewed and corrected as needed. 3. Licensed staff was in-serviced on 12-24-07 on anticoagulant therapy policy and procedures by unit managers. 4. Random chart audits will be done by Unit Managers for residents on anticoagulant therapy to ensure lab orders have been followed per PMD orders and monitored in Quarterly CQI.	12-28-07

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F 281	Continued From page 13 dated August 13, 2007 and October 30, 2007 revealed, "Coumadin 5 mg po [by mouth] qd [everyday] for a blood thinner." A review of the POS for September, October and November 2007 revealed that there were no physician's orders for PT/INR. A review of the resident's record revealed that PT/INR values were obtained on August 15, 2007 and were within expected limits. There was no evidence that additional PT/INR values were drawn after August 15, 2007. A review of the September, October, November and December 2007 Medication Administration Records revealed that Warfarin (Coumadin) 5 mg was initialed [indicating that it was administered] daily. A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she acknowledged that there was no physician order to monitor the PT/INR level since August 15, 2007. The record was reviewed December 4, 2007. 2. Facility staff failed to obtain a physician's order for PT/INR lab tests for Resident F1. The Physician Order Sheet and Plan of Care signed and dated October 22, 2007 revealed, "Coumadin 2.5 mg po [by mouth] qd [everyday] for a blood thinner." There was no order for PT/INR laboratory studies included in the October, November and December 2007 Physician's Order Forms. A review of the October, November and	F 281		

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F 281	Continued From page 14 December 2007 Medication Administration Records revealed that Warfarin (Coumadin) 2.5 mg was initialed [indicating that it was administered] daily. A review of the record revealed that there were no PT/INR laboratory values since the resident's return from the hospital on October 22, 2007. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 10:45 AM. He/she acknowledged that there was no physician order to monitor Warfarin therapy. The record was reviewed December 6, 2007.	F 281		
F 309 SS=D	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 observations, staff interviews and record review for four (4) of 27 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to: monitor behaviors for two (2) residents, failed to obtain a physician's order prior to administering a treatment for one (1) resident, obtain laboratory tests for two (2) residents, assess one (1) resident with bilateral hand contractures, and administer oxygen to one (1) resident as ordered by the physician. Residents #3, 4, 16, 20, 21, F2 and F3.	F 309		

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F 309	Continued From page 15 The findings include: 1. Facility staff failed to monitor Resident #3's behavior as per physician's orders. A review of Resident #3's record revealed a physician's order initially dated November 13, 2006 and renewed on the physician's order forms (monthly orders) August 30, September 22 and October 25, 2007 that directed, "Monitor behavior q shift for kicking and abusive language." There was no evidence in the record that the resident's behavior had been monitored for kicking and abusive language for September and October, 2007. According to the November 2007 Treatment Administration Record (TAR) the resident's behavior was monitored every shift from November 1 through 20, 2007. Hand written on the November 2007 TAR next to the behavior monitoring order was " D/C " (discontinue). There was no physician's order to discontinue the behavior monitoring. A face-to-face interview was conducted with Employee #1 on December 4, 2007 at 3:30 PM. He/she acknowledged that there was no behavior monitoring for August, September and October 2007 and that there was no physician's order to discontinue the behavior monitoring in November 2007. The record was reviewed December 4, 2007. 2. Facility staff failed to obtain a physician's order prior to performing a treatment to Resident #4's left foot. At the completion of a dressing change	F 309	**F 309 483.25** **QUALITY OF CARE** **#1 & #3** Resident #3, #16 1. Unit Manager obtained a behavior Monitoring order for resident #3 on 12-20-07 and obtained A behavior monitoring record/ sheet for Resident #16 on 12-05-07. 2. All other residents identified on psycho tropic's therapy records were reviewed for behavior monitor Orders and records were updated as Needed. 3. Licensed staff was in-serviced on On psychotic orders and accuracy Of behavior monitoring process. By Unit Managers on 12-27-07. 4. Random MAR audits will be done By unit managers and findings will Monitored in quarterly CQI. #2 Resident #4 1. Charge nurse obtained a treatment order for resident #4 on 12-4-07. 2. All other residents identified with wound care, records were reviewed for treatment orders and corrected as needed.	12-28-07

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F 309	Continued From page 16 observation conducted on December 4, 2007 at 11:15 AM, it was observed that Resident #4's left foot was wrapped in gauze that was dated December 3, 2007 and initialed [indicating that the dressing change was performed]. According to the October 2007 Treatment Administration Record, Panafil ointment was applied to the left foot from October 1 through 31, 2007. There was no documented evidence that the left foot dressing was done from November 1 through December 2, 2007. Employee #11 was asked why he/she did not do the dressing to the left foot. He/she replied, " I don't have an order to administer a treatment to the left foot." Employee #11 was asked to remove the dressing. Once the dressing was removed, a green substance was observed on the gauze. Employee #11 stated, " It's Panafil." The lateral left foot had a darkened area measuring 1 x 2 cm - unstageable. There was no odor or drainage observed. A review of the physician's orders for October, November and December 2007 lacked evidence that there was an order for a treatment to Resident #4's left foot. The record was reviewed on December 4, 2007. 3. Facility staff failed to monitor Resident #16's behavior; the resident was receiving a psychotropic medication. The November 2007 "Physician's Order Form" signed November 15, 2007 revealed, "Clonazepam 0.5 mg one tab by mouth twice daily for agitation behavior."	F 309	3. Licensed staff was in-serviced on 12-26-07 by DON on obtaining treatment orders for all wounds. 4. Unit Managers will do random chart audits for treatment orders and findings will be reported in quarterly CQI.	12-28-07

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

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F 309	Continued From page 17 A review of the November and December 2007 Medication Administration Record revealed that Clonazepam 0.5 mg was initialed [indicating that it was given] daily. A review of the record lacked evidence that Resident #16's behavior was being monitored for November and December 2007. A review of the nursing notes lacked evidence that the resident had any documented episodes of agitation. A face-to-face interview was conducted with Employee #3 December 4, 2007 at 3:50 PM. He/she acknowledged that the resident's behavior was not monitored. The record was reviewed December 4, 2007. 4. Facility staff failed to assess Resident #20 with bilateral hand contractures. The resident was observed with bilateral contracted hands on December 4, 2007 at approximately 11:00 AM, 1:00 PM, 3:00 PM, and 4:00 PM; December 5, 2007 at approximately 8:30 AM, 10:30 AM, 12:30 PM, and 2:30 PM; and on December 6, 2007 at approximately 8:45 AM. A review of the resident's quarterly MDS completed August 6, 2007 coded Section G4 "Functional Limitation in Range of Motion" for partial loss and limitation on one side to hand. The quarterly MDS completed November 5, 2007 coded Section G4 for full loss and limitation on both hands. The resident's care plan was reviewed by the Interdisciplinary Care Team on August 7, and	F 309	#4 Resident #20 1. MDS Coordinator corrected resident #20 MDS on 12-12-07 for rehab/restorative Care. Rehab screen was requested on 12-11-07 and complete on 12-12-07 and the recommendations was for palm protectors and range of motion. Unit Manager developed a care plan for resident #20 with approaches and goals on for contractures 2. All other residents identified with Restortative/rehab care, records have been reviewed for Primary Medical doctors orders and correct implementation and documentation and care plans developed and updated with approaches and goals. 3. MDS Coordinator and Unit Managers was in-serviced on 12-06-07 on the correct coding for rehab/restorative care and care plan development for contractures by the DON. 4. Random audits of residents with splints and records will be reviewed for contracture care plan development and findings will be reported in quarterly CQI.	review received 1/7/08 12-28-07

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F 309	Continued From page 18 November 6, 2007. There was no evidence that a care plan was initiated with appropriate goals and approaches for the resident with contractures in both hands. There was no evidence in the record that facility staff initiated an assessment of the change in the resident's bilateral hand range of motion. A face-to-face interview was conducted with Employees #3 and 14 who acknowledged that there was no assessment conducted after a change in the resident's status. The record was reviewed December 6, 2007. 5. Facility staff failed to obtain a PT/PTT for Resident #21 as per physician's orders. A review of Resident #21's record revealed a physician's telephone order dated October 27, 2007 and signed by the physician on October 30, 2007, that directed, "Lovenox 80 mg subcutaneous daily x 4 days and Coumadin (anticoagulant) 10 mg orally at bedtime for 2 days then Coumadin 5 mg orally at bedtime. PT (Prothrombin Time) and PTT (Partial Thromboplastin Time) on Monday, Tuesday, Wednesday, Thursday and Friday, then PT weekly x 4 weeks then PT monthly." Facility staff identified the following dates for drawing the PT/PTT: October 29, 30 and 31, 2007 and November 1, 2, 5 and November 12, 2007. The PT/PTT was drawn as follows: October 29, 30, and 31 and November 1, 2 and 12, 2007. There was no evidence that the PT/PTT was drawn on November 5, 2007.	F 309	#5 & 6 Resident 21 and F2 1. Unit Manager obtained next Scheduled blood draw for PT/INR On resident #21 on 11-12-07 and PT/PTT on resident #F2 on 12-5-07. 2. All other residents identified with lab test orders for PT/INR and PT/PTT records have been reviewed and test completed as ordered. 3 Licensed staff was in-serviced on 12-24-07 by DON on the importance of obtaining lab draws and informing the Unit Managers if test is not done. 4. Residents receiving anticoagulant therapy records will be audited for compliance and findings reported in quarterly CQI.	12-28-07

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F 309	Continued From page 19 PT/PTT values were within the expected ranges for October 29, 30, 31 and November 1 and 2, 2007. The PT/PTT for November 12, 2007 was approximately 10 times the expected value. The resident was sent to the hospital for further evaluation of the elevated PT and concurrently cellulitis to both lower extremities. A face-to-face interview was conducted with Employee #1 on December 5, 2007 at 4:00 PM. He/she acknowledged that the November 5, 2007 PT/PTT was not done. The record was reviewed December 5, 2007. 6. Facility staff failed to obtain a PT/PTT (Partial Thromboplastin Time) lab tests for Resident F2 as ordered by the physician. A review of a physician's order dated November 21 and signed November 24, 2007 directed, "PT/PTT on November 23, 2007 and q [every] month " . A review of a lab order form dated November 26, 2007 revealed, " ...test requested- PT, PTT ... " Both tests requested were marked done [indicating that labs were drawn]. A review of lab results dated December 6, 2007 lacked evidence of PT/PTT results. A face-to-face interview was conducted with Employee #8 on December 6, 2007 at 1:50 PM. He/she stated, "The labs were drawn [pointing to the lab order form], but we did not get the results. I called the lab and they don't have results." Employee #8 further acknowledged that there was no follow up to obtain PT/PTT labs before	F 309		

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F 309	Continued From page 20 today [December 6, 2007]. The record was reviewed December 6, 2007. 7. Facility staff failed to administer Resident F3's oxygen per the physician's order. On December 6, 2007 at approximately 9:30 AM it was observed that Resident F3 was lying in bed with a nasal cannula in his/her nose. The O2 [oxygen] concentrator was not plugged into the wall. Employee #3 in the room at the time of the observation immediately plugged the oxygen concentrator into the wall. Resident F3 suffered no untoward effects. A review of the November 2007 physician's order signed November 15, 2007 revealed, "O2 at 4L/min via nasal cannula." A face-to-face interview was conducted on December 3, 2007 at approximately 9:30 AM with Employee #3. He/she acknowledged that the O2 concentrator was unplugged and not delivering the oxygen per the physician's order.	F 309	#7 Resident #F3 1. Unit Manager plugged the 02 concentrator into the wall outlet on 12-6-07. 2. All other residents' identified on 02 therapy units were checked for proper operation and corrected as needed. 3. All staff was in-serviced on the importance of proper function of 02 concentrators and 02 therapy on 12-24-07 and 12-26-07 by the DON. 4. Random and frequent checks for 02 concentrators function will be done by nursing staff and findings will be reported in quarterly CQI.	12-28-07
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to	F 323		

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F 323	Continued From page 21 maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's electric bed plug, missing wheel on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in residents' rooms, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. The findings include: 1. Panafil ointment and Calmoseptin were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 2. The prong of a resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation. 3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation. 4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room. The window was unable to completely close. The Resident F4 did not complain of being cold, however complained of the wind. 5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337. 6. There was no eye wash station observed in the	F 323	**F 323 483.25(h) F 323 483.25(h)** **ACCIDENTS AND SUPERVISION** **#1** 1. Medication was removed from bedside At time of observation for resident #20. 2. All other residents bedside were checked for medication inappropriately placed and medications were removed as needed. 3. In-service was given to licensed staff on 12-24-07 for proper procedure of administration by DON and Unit Managers. 4. Random audits will be performed by Educator and findings will be Reported in quarterly CQI. #2, #3, #4 1. The bed with the prong missing in room 312A was immediately removed and replaced. The missing wheel on bed 223A was placed on bed the day of the survey. The window was repaired on the same day of observation. 2. All other residents' rooms were checked to ensure beds were compliant and windows were opening and closing properly.	12-28-07

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F 323	Continued From page 21 maintain a hazard free environment as evidenced by: ointments located at a resident's bedside, broken prong on a resident's electric bed plug, missing wheel on a resident's bed, window that failed to completely close in a resident's room, pest strips hanging in residents' rooms, lack of an eye wash station in the laundry and a blocked door between the rooms where the washers and dryers were located in the laundry. These findings were observed in the presence of Employees #1, 2, 3, 4, 5, 6, 7, and 11. The findings include: 1. Panafil ointment and Calmoseptin were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 2. The prong of a resident's electric bed plug in 312A was observed missing. The resident was in the bed at the time of the observation. 3. The wheel of a resident's bed was observed missing in room 223A. The resident was in the bed at the time of the observation. 4. The curtain in room 323 was observed briskly moving as the wind blew into the resident's room. The window was unable to completely close. The Resident F4 did not complain of being cold, however complained of the wind. 5. Pest strips were observed hanging from the ceiling above residents' beds in rooms 313 and 337. 6. There was no eye wash station observed in the	F 323	3. Maintenance staff was in-serviced on 12-25-07 on procedure for monitoring maintenance of beds by the Director of maintenance. 4. Monitoring of Preventive maintenance of beds will be done monthly and findings will be reported in quarterly CQI. #5 1. The pest strips that were cited in rooms 313 and 337 were removed immediately. 2. All other residents' rooms were checked for pest strips and were removed as needed. 3. Staff were in-serviced on 12-21-07 on placing unauthorized articles/products in the facility and following the regulations by the Unit Manager. 4. Unit Managers will make random rounds To ensure units are free of pest strips and findings will be reported in quarterly CQI.	12-28-07 12-28-07

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

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F 323	Continued From page 22 laundry. Employee #5 stated that the sink had an eye wash faucet, but was repaired a few weeks ago and the eye wash faucet was not replaced. 7. One (1) side of the door between the washing area and the drying area in the laundry was unable to be opened. The other side of the door in the washing area was blocked by a large floor mat, bins and other debris. Employees #1, 2, 3, 4, 5, 6, 7, and 11 acknowledged the above findings at the time of the observations.	F 323		
F 386 SS=D	483.40(b) PHYSICIAN VISITS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for two (2) of 27 sampled residents, it was determined that the physician's progress notes failed to include a review of one (1) resident's skin condition and address hand contractures for one (1) resident. Residents #4 and 20. The findings include: 1. The physician failed to include a review of Resident #4's skin in the progress notes.	F 386	**F 386 483.40** **PHYSICIAN VISITS** **Resident #4 and # 20** **#1, & #2** 1. Unable to correct residents' #4 and #20 physicians progress notes and physicians were notified of their resident's with wounds and hand contractures. the importance of documenting wounds and hand contractures in their progress notes. 2. All other residents identified with wounds charts were reviewed and a list was given to the Medical Director to ensure future compliance. 3. Medical Director in-serviced medical staff to include wound documentation in their progress notes on 12-27-07. 4. DON will monitor physician wound documentation and finding will be reported in quarterly CQI. review received 1/1/08	12-27-07

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F 386	Continued From page 23 The "Pressure Ulcer Report" form for Resident #4 revealed, "Location: Left foot side posterior; August 27, 2007, Stage I, Measurement-5 x 5 cm, unopened discoloration; September 5, 2007, Stage I, Measurement-4.2 x 5 cm, unopened discoloration fading, purplish; October 3, 2007, Stage-I, Measurement- 4 x 3 cm; pink granulation tissue, no odor/drainage. " The "Wound Report" form for Resident #4 revealed, "Original date identified: August 21, 2007, where acquired: facility, Right Ankle, Measurement- 2.5 x 1.5 cm, description [unable to read] and dry; August 29, 2007 - no description documented; September 5, 2007, Right Ankle 1.8 x 1 cm, no drainage/odor pinkish with granulation; October 3, 2007, Right Ankle, Measurement- 2 x 2 cm, dark pigmentation with dry [unable to read] no odor or drainage. " A review of the physician's progress notes dated September 14 and October 30, 2007 lacked evidence that the physician addressed the resident's skin. A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she acknowledged that the physician's progress notes lacked evidence that the areas to the left foot and the right ankle were addressed. The record was reviewed on December 4, 2007. 2. The physician failed to address Resident #20's hand contractures i the progress notes. The resident was observed on December 4, 2007 at approximately 11:00 AM, 1:00 PM, 3:00 PM	F 386		

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F 386	Continued From page 24 and 4:00 PM. Both hands were contracted. A review of the resident's record revealed physician's progress notes dated July 30, August 30, September 30, and October 22, 2007. There was no evidence that the physician addressed the resident's hand contractures. A face-to-face interview was conducted with Employee #3 on December 6, 2007 at 3:45 PM. He/she acknowledged that the physician's progress notes failed to acknowledge the resident's contracted hands. The record was reviewed December 6, 2007.	F 386		
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	**F 425 483.60(a),(b)** **PHARMACY SERVICES** **#1, #2** 1. Director on Nursing called pharmacy to inform them of expire medication in the emergency box and medication cart on 12-5-07. 12-06-07 pharmacy came in to exchange the boxes. The expired medication was removed from medication on 12-5-07 by charge nurses. 2. All other emergency boxes and Medication carts were checked for expired medications and were removed as needed. 3. All licensed staff was in-serviced on 12-24-07 by the Educator and DON on monitoring expired dates on the emergency boxes and medication carts. 4. Emergency medication boxes and medication carts will be monitored by pharmacy monthly and unit managers/team leaders weekly and findings will be reported to Quarterly CQI.	12-28-07

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F 425	Continued From page 25 by: Based on observations and staff interview, for three (3) of three (3) nursing units, it was determined that facility staff failed to remove expired medication from an emergency box and medi cation carts. The findings include: The facility failed to remove expired medications from the emergency box and medication carts. 1. On Monday, December 5, 2007, between 11:00 AM and 4:00 PM, during the inspection of the facility's emergency boxes, the Emergency Box # 946 in the first floor medication room contained the following expired drugs: Two (2) vials of Furosemide 40mg/ml (4ml), expired December 1, 2007 and November 1, 2007. One vial of Lidocaine 2% 30 ml, expired December 1, 2007. Two (2) vials of Diazepam 10mg/2ml, expired December 1, 2007 The expiration date on the emergency box was October 2007. During a face-to-face interview with Employee #8, he/she stated that the pharmacist checked the nursing units two (2) weeks ago. The pharmacist did not mention any expired medications. 2. On Monday, December 5, 2007, between 11:00 AM and 4:00 PM, during the inspection of	F 425		

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F 425	Continued From page 26 the facility's medication carts, the following drugs were expired: 2nd Floor Unit, Cart 2 -Team 1 One (1)- Ceftriaxone 1gm reconstituted vial, expired May 2007 Employee #16 acknowledged that the medication was expired at the time of the observation. 3rd Floor Unit, Cart 3-Team 1 Eight (8)- Promethazine Injection 25mg/ml - 1ml vial, expired April 2007 One (1) -Acetylcysteine 20 % 30 ml vial, expired Employee #17 acknowledged that the medications were expired at the time of the observation.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 27 sampled residents, it was determined that the pharmacist failed to identify the lack of monitoring for Resident #4 who was receiving Warfarin. (Coumadin).	F 428	**F 428 483.60(c)** **DRUG REGIMEN REVIEW** 1. DON obtained orders for PT/INR for resident #4 on 12-5-07 and was drawn on 12-6-07. Pharmacy was called on 12-6-07 by the DON and informed of the missing pharmacy monitoring. 2. All other residents' identified on anticoagulant therapy records were reviewed and corrected as needed by DON, Unit Manager/ Charge Nurses. 3. All licensed staff was in-serviced on 12-24-07 by the DON on the policy and procedure for residents on anticoagulants and pharmacy was sent a copy of the facility policy on 12-6-07. 4. Random chart audits for anti-coagulant lab orders by unit manager and pharmacy will provide the consultant pharmacist with a list of resident of residents anticoagulants for monitoring every 30 days and finding will be reported in quarterly CQI.	12-28-07

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F 428	Continued From page 27 The findings include: A review of Resident #4's record revealed a physician's order dated August 13, 2007 and renewed November 2007 directing, "Warfarin Sodium 5 mg tablet, one (1) tab by mouth every day for blood thinner." A review of Resident #4's record revealed that laboratory studies were not completed to monitor the use of Warfarin. According to the manufacturer's recommendations, "Acceptable intervals for PT/INR determinations are normally within the range of 1 to 4 weeks after a stable dosage has been determined" from the web site www.bristol-myers-squib. A review of the "Medication Regimen Review" revealed that the pharmacist reviewed the resident's medications September, October, November and December, 2007. There were no irregularities identified on the aforementioned reviews. The record lacked evidence that the pharmacist identified that there was no monitoring for the use on Warfarin. A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she acknowledged that the pharmacist failed to identify the lack of monitoring for the use of Warfarin. The record was reviewed December 4, 2007.	F 428		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 28 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 observations and staff interview, for three (3) of three (3) nursing units, it was determined that the facility staff failed to date and initial multi-dose medication vials when first opened.	F 431	**F 431 483.60,(d),(e)** **PHARMACY SERVICES** 1. Multi-dose medication and vials that lacked date and initials when first opened were discarded and Reordered on 12-5-07. 2. All other medication carts and medication refrigerators were checked for compliance and corrected as needed. 3. Licensed staff was in-serviced on 12-24-07 on dating and initialing Multi-dose medication vials when first open by Nurse Manager 4. Charge nurse and night shift will monitor daily open vials for dates and report findings to quarterly CQI.	12-28-07

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F 431	Continued From page 29 The findings include: On December 5, 2007, between 11:00 AM and 4:00 PM, the medication carts and refrigerators were inspected on each unit. 1st Floor Unit Xalatan ophthalmic drops - two (2) vials Employee #1 acknowledged that the vials of Xalantan listed above were not dated and/or initialed at the time of the observations. 2nd Floor Unit Xalatan ophthalmic drops - three (3) vials Bacteriostatic water 30 ml - one (1) vial Employee #16 acknowledged that the vials listed above were not dated and/or initialed at the time of the observations. 3rd Floor Unit PPD 5 TU/0.1ml - one (1) vial Xalatan ophthalmic drops - one (1) vial Sterile Water 30 ml - one(1) vial Employee #17 acknowledged that the vials listed above were not dated and/or initialed at the time of	F 431		
F 441 SS=E	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	F 441		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 30 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 and staff interview, it was determined that facility staff failed to maintain an effective infection control program as evidenced by: soiled oxygen concentrator filters, medications located at a resident's bed side and a soiled chair. A review of the facility's infection control program failed to utilize collected data to initiate preventive measures. The findings include: 1. Soiled oxygen concentrator filters were observed in rooms 128 and 136. Residents in both rooms were using the device. 2. Panafil ointment and Calmoseptin ointment were observed at the bedside in Resident #20's room. The Panafil was prescribed for Resident #7 and the Calmoseptine was prescribed for Resident #16. 3. The seat, back and arms of an arm chair in the 3rd floor B hallway were soiled and stained. This prompted a review of the facility's infection control program. A review of the Infection Control Program was	F 441	**F 441 483.65(a)** **INFECTION CONTROL** **#1, #2, #3** 1. Charge nurse removed concentrator Filter on 12-03-07 from rooms 128 and 126. Medicarion was removed from bedside at the time of observation for resident #20 a new supply of ointment was ordered for resident #20. The chair cited on the 3rd floor back hall that was stained and soiled was discarded on 12-5-07. 2. All other concentrators through Out the facility was inspected And filters were cleaned as needed And bedside were checked for Medication and removed as needed And a new supply ordered. All Furniture was checked for soiled/ Stains and was cleaned as needed. The infection control policy and Unit based infection control work Sheets were reviewed by the Administrator, Director of Quality Assurance, DON and Unit Managers On 12-20-07 to ensure policy Control compliance.	Review received 1/7/08

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F 441	Continued From page 31 conducted on December 5, 2007 at 1:40 PM with Employee #10. Employee #10 explained that he/she had been the Infection Control Program coordinator for about three (3) years. Employee #10 stated, "I started tracking infections in September 2007. There was really nothing else in place that I knew of prior to when I started this program. Because of HIPPA (Health Insurance Portability and Accountability Act), I didn't write down all the information like organisms, antibiotics used, and dates. I did identify the infections that were acquired in house and those that came from the hospital." Employee #10 presented a monitoring tool summarizing infections monthly and quarterly. A quarterly monitoring tool listing infections for July, August and September 2007 was reviewed. The number of infections described in the "Statuses of concerns for this quarter" were not consistent with the number of infections described in the unit totals. The quarterly summary listed the following number of infections: Clostridium Difficile (C-Diff) - 1 Methicillin resistant staphylococcus Aureus (MRSA) -4 Urinary Tract infections (UTI) - 8 Skin infections - 8 Respiratory infections - 5 There was a listing of each infection type for each unit. A summary of the total number of infections listed included: C. diff - not identified for any unit MRSA - 5 UTI - 5	F 441	3. Nursing staff was in-serviced by Unit Managers on cleaning the Concentrators filters on 12-3-07, On medication at the bedside ad on not using other resident's medication 12-7-07 and housekeeping staff was in-serviced on 12-21-07 on procedures for cleaning chairs by Director of Environmental Services. On 12-27-07 Director of Nursing In-serviced Educator on proper Use of the infection control work Sheets. 4. Random rounds will be done to Ensure concentrators filters are Clean, no interexchange of other Residents' medication for usage, No medication at the bed side and There are no furniture soiled/stainded And DON will monitor usage of The infection control worksheet And findings will be reported to. Quarterly CQI.	Received 1/7/08 12-28-07

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F 441	Continued From page 32 Skin infections - 9 Respiratory infections - 5 There was no explanation for the difference in the number of infections listed on the quarterly summary and the number of infections listed by unit. Employee #10 stated that there is an infection control in-service conducted monthly. There was no evidence that the data collected monthly regarding infections was utilized to initiate measures to prevent the spread of infection. Listed on the quarterly report under " Statuses of Corrections " were the statements: " preventing the spread of infection and inadequate infection control program. " Based on documents presented, facility staff failed to accurately track the number of facility infections, dates of onset of infection, organisms when available, antibiotic use, reconcile differences between the July, August and September 2007 quarterly report with individual unit reports of types and numbers of infections, and utilize collected data to initiate preventive measures. However, there was no evidence that the rate of infections had increased based on the review of the 27 sampled residents and the review of unit based data of residents on antibiotic therapy for the October 2007.	F 441	F456 483.70(c)(2) SPACE AND EQUIPMENT #1 1. The washer that was cited in the laundry room with no thermometer to monitor water temperature during the survey period is being cleaned and sanitized by a laundry compound with water temperature below 180 degrees. 2. All other washers were inspected to proper amounts of compound are being released from dispenser appropriately to ensure proper cleaning and sanitizing of clothes.	
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.	F 456		

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F 456	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined that facility staff failed to maintain laundry equipment in safe operating condition. Additionally, facility staff failed to maintain a log documenting the temperature of the water coming into the waters. These observations were made in the presence of Employee #5 on December 3, 2007 at 2:15 PM. The findings include: 1. Two (2) of three (3) washers were in service at the time of the observation. There was no thermometer on the middle washer to monitor water temperature in one (1) of two (2) functioning washers observed. It was observed that the distal washer with a thermometer had a reading of 180 degrees Fahrenheit of water coming into the washer. Subsequent to the inspectionof the washers, facilty staff removed the water temperature gauge from the third washer (that was out of service) and placed it on the middle washer. The temperature of the water coming into the washer was 180 degrees Fahrenheit. There was no evidence that facility staff maintained logs documenting the temperature of the water coming into the washers. 2. Two (2) of two (2) washers were observed leaking during the wash cycle. Employee #5 acknowledged the above findings at the time of the observations.	F 456	3. In-service was given to laundry Supervisor by Director of Environmental Service on inspecting clothes for cleanliness after removing from washer on 12-21-07. 4. Monitoring will be done daily by laundry supervisor and findings will be reporter in quarterly CQI. #2 1. The two washers observed leaking Leaking washer will be replaced On doors by 12-28-07. 2. Maintenance staff will conduct monthly checks on washers to ensure compliance. 3. Maintenance staff was in-serviced On 12-26-07 by maintenance supervisor on preventative maintenance of washer and dryers 4. Monitoring for compliance of washer and dryers findings will be reported in quarterly CQI.	12-28-07 12-28-07
F 469	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST	F 469		

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F 469 SS=C	Continued From page 34 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 facility staff failed to maintain a pest free environment. The findings include: Flying or crawling insects were observed as follows: 1. On December 3, 2007, flying insects were observed in rooms 108 and 115 at 12:15 PM and 1st floor dining room at 4:30 PM. 2. On December 4, 2007, flying insects were observed in the 1st floor nursing station at 7:30 AM and 10:05 AM, 2nd floor nursing station at 10:05 AM, room 114 at 11:30 AM, room 237 at 11:30 AM and 3rd floor nursing station at 4:00 PM. A roach was observed crawling across the counter of the 2nd floor nurses' station at 8:35 AM. 3. On December 5, 2007, flying insects were observed in room 114 at 8:30 AM, 3rd floor dining room at 9:00 AM, ground floor dining room at 12:15 PM and 2nd floor dining room at 4:00 PM.	F 469	**F 469 483.70 (h)(4)** **PHYSICAL ENVIRONMENT-PEST CONTROL** #1, #2, #3, #4 1. Room 108, 114, 115, 1st, 2nd and 3rdfloor nursing stations 1st, 2nd, 3rd and ground floor dining rooms were cleaned and trash removed on 12-7-07 that were cited during survey with flying insects. Pest control contractor came in on 12-7-07 and 12-18-07 to exterminate the facility. 2. All other residents' rooms were checked for insects and exterminated and cleaned as needed. Trash cans are being cleansed weekly and prn to prevent further occurrences. 3. Housekeeping staff was in-serviced on 12-21-07 for trash removal, cleaning of trash cans and proper cleaning techniques by environmental services director. 4. Weekly rounds will be conducted by Director of Environmental Services To monitor for effectiveness and Findings will be reported in Quarterly CQI.	12-28-07

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F 469	Continued From page 35 4. On December 6, 2007, flying insects were observed in the 3rd floor dining room at 10:20 AM and 2nd floor hallway by room 207 at 2:30 PM. A face-to-face interview was conducted with Employee #5 on December 6, 2007 at 9:30 AM. He/she stated, "[A pest control company] comes to spray every week. We still have some problems with flying and crawling insects and mice."	F 469		
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 that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on a review of the "Nursing Daily Staffing" sheets and staff interview for three (3) of five (5) days reviewed, it was determined that facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day. This is a repeat deficiency. The findings include: According to 22 DCMR 3211.3, "Beginning no later that January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day." The "Nursing Daily Staffing" sheets were reviewed with Employee #8 for December 1, 2, 3,	F 492	**F 492 483.75(b) ADMINSTRATION** 1. A tickler sheet has been developed and given to DON, Staffing Coordinator and Supervisors to staff facility Based on census and staff Have been instructed to Utilized agency and overtime When call-ins have occurred. 2. Staffing sheets will be reviewed daily by DON, staffing coordinator and supervisors to ensure compliance and facility will overstaff to allow for call ins. 3. In-service was given to staffing coordinator and supervisors on 12-07-07 of staffing facility appropriately by DON. 4. Daily monitoring will be done by DON, Staffing Coordinator and Supervisors and findings reported in quarterly CQI.	12-28-07

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F 492	Continued From page 36 4 and 5, 2007 and revealed inadequate nurse staffing on the following days: Date — Nursing Hours December 1, 2007 — 3.46 December 2, 2007 — 3.36 December 3, 2007 — 3.40 On December 6, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Employee #8 who acknowledged that the staffing was below 3.5 nursing hours per resident per day due to staff not reporting to work. Employee #8 stated, "The agencies are supposed to replace staff. Sometimes the agency person does not report and the agency does not have any one to replace the person who called in."	F 492		
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 staff interview and record review for four (4) of 27 sampled residents, it was determined that facility staff failed to consistently	F 514		

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F 514	Continued From page 37 document one (1) resident's skin condition, and discontinue medications, laboratory studies and treatments on monthly physician's orders for two (2) residents. Residents #4, 7 and 14. The findings include: 1. Facility staff failed to consistently document Resident #4's skin condition. The facility's policy entitled, "Skin Integrity Program" revised August 3, 2007 revealed, " ..Procedure for breaks in skin integrity: ...6. The charge nurse will complete weekly documentation of all wounds (skin breakdown ...) stasis ulcer flow sheets or pressure ulcer flow sheet)..." The "Nursing Admission Assessment Form" dated August 13, 2007, documented, "...Skin Assessment: "Skin is dry, no open area observed "; Braden Scale: Score total-14 [Total of 12 or less represents high risk]". The "Pressure Ulcer Report" form for Resident #4 revealed, "Location: Left foot side posterior; August 27, 2007, Stage I, Measurement-5 x 5 cm, unopened discoloration; September 5, 2007, Stage I, Measurement-4.2 x 5 cm, unopened discoloration fading, purplish; October 3, 2007, Stage-I, Measurement- 4 x 3 cm; pink granulation tissue, no odor/drainage. " The "Wound Report" form for Resident #4 revealed, "Original date identified: August 21, 2007, where acquired: facility, Right Ankle, Measurement- 2.5 x 1.5 cm, description [unable to read] and dry; August 29, 2007 - no description documented; September 5, 2007, Right Ankle 1.8 x 1 cm, no	F 514	**F 514 483.75(i)(1)** **CLINICAL RECORDS** **#1** **Resident #4** 1. Charge Nurse obtained an order For treatment and the skin sheet Was updated on 12-4-07 at the time Of survey. 2. All other residents had a head to Toe skin assessment on 12-7-07, 12-10-07 and 12-11-07 to ensure no wounds or skin condition was missed and documented as needed. 3. All staff was in-serviced on the proper use of the skin and bath sheets and wound assessments on 12-7-07 by DON. 4. Random audits of skin and bath book will be done weekly by Unit Managers and Charge Nurses And findings will be reported in Quarterly CQI.	12-28-07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095015		12/06/2007

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F 514	Continued From page 38 drainage/odor pinkish with granulation; October 3, 2007, Right Ankle, Measurement- 2 x 2 cm, dark pigmentation with dry [unable to read] no odor or drainage. " A review of the physician's progress notes dated September 14 and October 30, 2007 lacked evidence that the physician addressed Resident #4's skin. The nursing progress notes revealed the following: August 13, 2007 at 8:00 PM: " Resident readmitted to the unit from [hospital name] ...Feet no open area noted ...Skin with no open area ..." August 21, 2007 at 10:00 PM: " ...Open blister to right ankle 2.5 x1.5 cm noted pink and dry. Doctor [name] made aware ordered tx [treatment] ..." October 3, 2007 at 3:00 PM: "Weekly wound assessment was done today to left foot and right ankle open blister. See weekly skin assessment book. No further open areas noted ..." December 4, 2007 at 3:00 PM: "Resident has a dark hardened area pulling from skin, no odor drainage present. Area is unopened on outer side of left foot area. Measures 2.5 x 2.5 cm ..." A face-to-face interview was conducted with Employee #2 on December 4, 2007 at 3:00 PM. He/she stated, "The ulcers are healing." Employee #2 acknowledged that the record lacked consistent assessments. The record was reviewed on December 4, 2007. 2. Facility staff failed to discontinue a treatment and medications on monthly physician's orders for Resident #7. Resident #7 had an open wound on the right thigh that healed on	F 514	#2 and #3 Residents #7 & #14 1. The POS and MAR was corrected For resident #7 for discontinuation of medication/Treatment and resident #14 for lab Orders on 12-5-07. 2. All other residents' charts were Reviewed for compliance and Corrections were done as needed. 3. All licensed was in-serviced on Reviewing the monthly POS/ MAR And documentation on 12-27-07 by Unit Managers. 4. Random POS/MAR audits will Be conducted By Unit Manager and night Charge Nurses to ensure compliance and findings will be reported in quarterly CQI.	12-28-07

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F 514	Continued From page 39 November 1, 2007. A review of Resident #7's record revealed a physician's order dated November 1, 2007, directed, "Discontinue Give Tylenol 650 mg po (orally) bid (twice daily) 30 minutes prior to wound treatment. Discontinue Zinc Sulfate 220 mg po q d (daily) for wound healing. Discontinue Vitamin C 500 mg po bid for wound healing. Discontinue clean right inner thigh open area with NSS (normal sterile saline) dry then apply Panafil ointment with dressing bid x 14 days." According to the November 2007 physician's order form (monthly orders) the aforementioned orders were included on the form. The physician signed the form on November 11, 2007. The discontinued medications were not given after November 1, 2007. A face-to-face interview was conducted with Employee #3 on December 5, 2007 at 11:30 AM. He/she acknowledged that the aforementioned orders should have been discontinued on the monthly physician's order form. The record was reviewed December 5, 2007. 3. Facility staff failed to discontinue laboratory studies on monthly physician's order forms for Resident #14. A review of Resident #14's record revealed a physician's order dated August 8, 2007, directed, "Discontinue HgbA1C (Glycosylated Hemoglobin) q 3 months. Patient is not diabetic." The physician's order forms (monthly orders) were signed by the physician on September 16, October 1 and November 12, 2007 and included,	F 514		

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F 514	Continued From page 40 "HgbA1C every 3 months Feb/May/Aug/Nov." There was no evidence in the record that the HgbA1C was drawn for November 2007. A face-to-face interview was conducted with Employee #3 on December 4, 2007 at 3:00 PM. He/she acknowledged that the order should have been discontinued on the physician's order forms for September, October and November 2007. The record was reviewed December 4, 2007.	F 514		