

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2011
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NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016
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L 000

Initial Comments

An annual state licensure survey was conducted on January 24 through February 2, 2011. The following deficiencies were based on observation, record review, staff and resident interviews. The sample included 27 residents based on a census of 169 residents on the first day of survey and 12 supplemental residents.

L 000

The Washington Home makes its best effort to operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.

L 001

3200.1 Nursing Facilities

Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia.
This Statute is not met as evidenced by:

A. Based on observations, staff interview and record review for one (1) of 27 sampled residents and 12 supplemental residents it was determined that the facility failed to ensure that a resident was free from unnecessary drugs. Resident #10.

The findings include:

During the medication pass observation on January 24, 2011 at approximately 9:35 AM, the nurse was observed administering Resident #10's medications, one of which included Cosopt Ocumeter Plus, instill one (1) drop in left eye every 12 hours for glaucoma. He/she informed the resident that she/he was going to administer his/her eye drops. Employee #15 instilled one drop in the right eye.

A review of Resident #10's record revealed physician's orders dated January 7, 2011

L 001

- L001 (A)
1. Resident #10-Nurse re-educated concerning Five-Rights of Medication administration.
 2. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering eye drops. During the medication administration observation completed with the nurse, no other residents receiving eye drops had any negative effects. The 5-Rights of Medication Administration were reviewed during the same unit meetings.

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[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator
(X6) DATE
4/8/11

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L 001	<p>Continued From page 1</p> <p>directed, " Cosopt Ocumeter Plus..instill (one) 1 drop in left eye every 12 hours for glaucoma.</p> <p>The findings were reviewed and confirmed by Employee #15 during a face-to-face interview on January 24, 2011 at 9:50 AM. The record was reviewed January 24, 2011.</p> <p>B. Based on observation and staff inerview it was determined that the facility failed to code the 672 [Resident Census and Conditions of Residents] and 802 [Roster Sample Matrix] forms to represent the current condition of residents in the facility.</p> <p>The findings include:</p> <p>On January 24, 2011 at 9:30 AM, Employee #2 presented the surveyor with the 672 and the 802 forms. A review of the 672 revealed that information contained was not consistent with the information provided by the facility on the 802 form(s).</p> <p>A face-to-face interview was conducted with Employee #2 at the time of the review. He/she acknowledged the differences. Additionally, a review of the " General Instructions and Definitions " form was conducted with Employee #2. The forms were returned to the facility to make the necessary modifications/changes.</p> <p>On January 26, 2011 at 9:00 AM, Employee #2 resubmitted the 672 and the 802 forms to the surveyor. Upon review of the 802 form(s) it was found that while changes had been made to correct the previously identified areas of concern, other discrepancies were identified. The forms were return to Employee #2 to make the additional modifications and/or changes to the</p>	L 001	<ol style="list-style-type: none"> 3. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers have received training through our pharmacy on how to conduct Medication Administration Observation rounds. 4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date <p><u>L001(B)</u></p> <ol style="list-style-type: none"> 1. Director of Nursing at monthly Nurse Manager meeting reviewed instruction sheets for completion of 672/802 2. Nurse Managers corrected coding errors for the 672/802 comparing the 802 with the 672 for match up accuracy of both forms. No residents were adversely affected. 3. Nurse Managers will complete 672/802 weekly matching data for accuracy. 	4/8/2011

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L 001	<p>Continued From page 2</p> <p>forms.</p> <p>On January 28, 2011 at approximately 3:00 PM the third revision of the 672 and 802 forms were accepted.</p> <p>C. Based on employee record review and staff interview for one (1) of four (4) Certified Nurse Aides (CNA), it was determined that the facility failed to ensure that performance reviews were conducted for CNAs at least once every 12 months.</p> <p>The findings include:</p> <p>A review of the Certified Nurse Aides employee records revealed the following: Employee #37 - Employee date of hire December 14, 2009, the Competencies were signed as completed on June 9, 2010.</p> <p>There was no evidence that the facility conducted a performance review for Employee #37 [CNA] at least once every 12 months.</p> <p>A face-to-face interview was conducted with Employee # 10 on January 31, 2011 at approximately 2:00 PM. He/she acknowledged that the performance review was not conducted at least once every 12 months for the aforementioned CNA.</p> <p>D. Based on record review and staff interview, it was determined that facility staff failed to ensure that newly hired staff background checks and references checks were final/completely investigated prior to the employees working in the facility as per the facility policy in one (1) of</p>	L 001	<p>The Director of Nursing or their designee will review instruction sheets or completion of the 672/802 with the Nurse Managers weekly, prior to completion of both documents to ensure accuracy.</p> <p>4. Director of Nursing will review total compilation of 672/802 data for the facility, matching forms for accuracy and querying nurse managers to correct identified variances. Outcomes will be reported to the Quality Improvement Committee quarterly.</p> <p>5. Compliance Date</p> <p><u>L001(C)</u></p> <p>1. The employee whose evaluation was deficient was completed during the week of February 2, 2011;</p> <p>2. The HRIS Analyst informs managers of all delinquent (over a month) evaluations on a monthly basis. The delinquent list is also forwarded to the Director of Human Resources and the CEO. The manager is responsible for completing all delinquent evaluations during the notified period (end of the month). Failure to comply will result in disciplinary action up to and including suspension; No residents were adversely affected as a result.</p> <p>3. In order for the deficient practice of delinquent performance evaluations, to not recur Human Resources will be responsible for the following:</p>	4/8/2011
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L 001	<p>Continued From page 3</p> <p>five (5) newly hired employees.</p> <p>The findings include:</p> <p>The facility's policy entitled: "Abuse and Neglect " Policy No: TX-00001.97, 1/11 stipulated: Resident Abuse and Neglect policy and procedures 7 step approach: 1. Screening- screen potential employees for history of abuse, neglect and mistreatment. Criminal background checks ...references from previous employers. "</p> <p>A review of Employee # 31 ' s file was conducted on January 26, 2011. The employee's file revealed the following:</p> <p>Date of hire December 13, 2010. A review of the employee application revealed that he/she attended school and/or resided in the states of Colorado and California.</p> <p>The criminal background check was initially sent on November 15, 2010. On December 31, 2010, January 16, and 26, 2011 the status of the background check was " in progress " and all jurisdictions were not checked for the criminal search. Additionally, Education History and Reference Verification status was " pending " .</p> <p>Employee #31 ' s record lacked evidence that a complete screening of background information was completed prior to the employee working 21 days in the facility.</p> <p>A face-to-face interview was conducted with Employee # 10 on January 26,, 2011 at approximately 3:45 PM. Employee #10 acknowledged that the criminal background check was not completed prior to Employee #31</p>	L 001	<p>a. Educating the managers and line staff about the importance of performance evaluations and how to schedule the appropriate time to complete and review the evaluation;</p> <p>b. The CEO and Director of Human Resources will emphasize the importance of adhering to the monthly schedules, as well as the during scheduled Town Hall Meetings during the month of May; Complete and present monthly progress reports to all department heads, which will highlight the percentage of performance evaluations completed, during Senior Management meetings.</p> <p>4. Annual Performance Evaluations will be monitored as follows:</p> <p>a. Completed evaluations will be data entered into Human Resources performance evaluation database within 72-hours of receipt.</p> <p>b. Based upon the evaluations entered, a monthly progress and delinquent report will be completed and distributed to department heads;</p> <p>c. Managers who continue to be delinquent will receive a formal disciplinary action up to and including termination;</p> <p>d. The timeliness in completing performance evaluations will be a standard that all managers will be evaluated on.</p> <p>5. Compliance Date</p>	4/8/2011

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L 001	Continued From page 4 working in the facility.	L 001	<u>L001 (D)</u>	
L 031	<p>3207.6 Nursing Facilities</p> <p>The physician shall prescribe a planned regimen of medical care which includes the following:</p> <p>(a) Medications and treatments;</p> <p>(b) Rehabilitative services;</p> <p>(c) Diet;</p> <p>(d) Special procedures and contraindications for the health and safety of the resident;</p> <p>(e) Resident therapeutic activities; and</p> <p>(f) Plans for continuing care and discharge. This Statute is not met as evidenced by:</p> <p>Based on observation, record review and interview for two (2) of 27 sampled residents, it was determined that the physician failed to prescribe a planned regimen of medical care which includes the following: a review of the total program of care for one (1) resident ' s diagnosis of anemia and one(1) resident ' s pain management. Residents #7 and #17.</p> <p>The findings include:</p> <p>1. The Physician failed to stipulate parameters for pain medication prescribed for administration prior to wound treatment for Resident #7.</p> <p>At the start of a dressing change observation conducted on January 31, 2011 at 11:00 AM with Employee #20, he/she indicated that the resident has an order for pain medication of Oxycodone</p>	L 031	<p>1. Human Resources changed its back-ground screen vendor. ADP is now our background check provider as well as our overall HRIS system provider. By having one sole vendor, the recruitment and hiring process is streamlined. The HR Director also conducted a department meeting stressing the importance of adhering to the Selection and Hiring of Personnel policy. More specifically, it was stressed that in order for a new employee to begin employment, he/she must have met all of the pre-employment requirements, including a complete background screening.</p> <p>2. In the event that a newly hired employee's background screening (or any other pre-requisite) is not complete before their scheduled start date, he/she will be notified by Human Resources that their start date will be delayed. The hiring manager will also be notified.</p> <p>3. In order to assure that the deficient practice does not occur again, the following measures have been implemented:</p> <p>a. Terminated the contract with the former background check provider and implemented a new vendor on 2/14/2011;</p> <p>b. Educated the HR staff on the Selection and Hiring of Personnel policy;</p> <p>c. Background checks are submitted according to the states lived and worked during the past seven years, verify all necessary education/ schools that are applicable, etc.;</p>	

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L 031	<p>Continued From page 5</p> <p>IR 5 mg tablet prior to the dressing change and the Oxycodone was administered at 9:00 AM.</p> <p>A query was made " if the resident required additional medication, given the time of the dressing change, was there a physicians ' order to cover that " Employee #20 indicated that the resident also had an order for " Oxycodone IR 5 mg tablet: give 1 tab by mouth every 8 hours as needed for pain "</p> <p>A query was also made as to " how far in advance is pain medication given prior to the wound treatment? "</p> <p>After review of the physician ' s orders he/she acknowledged that parameters to administer pain medications prior to the wound treatment was not identified.</p> <p>The Physician failed to stipulate parameters associated with pre-medication administration before wound treatment for Resident #7. The record was reviewed on January 31, 2011.</p> <p>2. A review of the clinical record for Resident #17 revealed the physician failed to consistently review the total plan of care related to the status of the resident ' s anemia diagnosis.</p> <p>The history and physical examination dated March 16, 2010 revealed Resident #17 ' s diagnoses included Anemia, Hypertensive Cardiovascular Disease, Hypothyroidism, Diabetes Mellitus, Depression and status-post Cerebrovascular Accident.</p> <p>A review of interdisciplinary progress notes dated</p>	L 031	<p>a. In the event that a background check is pending and not complete by the scheduled start date, HR will notify the pending new hire and delay their start date until the background check is complete and in good standing;</p> <p>b. HR will keep the hiring manager informed of the pending new hire's status.</p> <p>4. Background checks are being completed within 3-5 days from submission. In the event that the vendor could not complete the background screen in its entirety, within the five day window, HR is notified via an alert. At that point, it is Human Resources responsibility to complete the check (i.e. references, verify education by obtaining a copy of the license/degree and verifying the education via the source). Identified trends and their corrections will be reported to QI and Quality Improvement Committee quarterly.</p> <p>5. Compliance Date</p> <p><u>L031 (1)</u></p> <p>1. Pre-medication administration parameter prior to wound treatment was obtained.</p> <p>2. Pre-medication prior to wound treatment orders were reviewed to ensure all residents in this category have medication parameters.</p> <p>3. Nursing and Medical Staffs were in-serviced to ensure orders in this category include a pre-medication administration parameter. Nurse Managers will review new pre-medication orders to ensure a parameter is included.</p>	4/8/2011

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L 031	<p>Continued From page 6</p> <p>January 21, 2011 at 10:00 AM revealed Resident #17 was hospitalized January 2 - 20, 2011. Upon admission to the acute care facility, he/she was found to be " severely anemic and responded well to 4 units of PRBC ' s " [packed red blood cells - blood transfusion]. According to the hospital discharge summary dated January 20, 2011, the patient was diagnosed with Upper GI bleed, non-STEMI [ST elevation myocardial infarction] secondary to demand ischemia and urinary tract infection.</p> <p>A review of interdisciplinary progress notes for the period of July 2010 thru January 1, 2011 lacked documented evidence that the medical staff documented an account of the status of the resident ' s anemia. A review of nutrition progress notes for the period of July 2010 thru December 2010 revealed the dietician documented " Dx (diagnosis) of anemia, MD monitoring. "</p> <p>A review of laboratory reports revealed the most recent complete blood count [CBC] was assessed February 17, 2011.</p> <p>A face-to-face interview was conducted with Employee #11 on January 31, 2011 at approximately 2:30 PM. He/she stated the resident had a chronic history of anemia and the recent hospitalization was secondary to an acute onset GI bleed. The record was reviewed January 28, 2011.</p>	L 031	<p>Medical Director will meet and discuss (education session) with the Medical Staff to document monitoring of chronic anemia.</p> <p>4. Nurse Managers will audit residents in this category and report outcomes, corrective actions, and trends identified to QI Committee quarterly.</p> <p>5. Date of Compliance <u>L031(2)</u></p> <p>1. Resident's anemia was treated in the hospital and resident returned to the facility.</p> <p>2. All residents with diagnosis of chronic anemia were reviewed for appropriate monitoring documentation.</p> <p>3. Registered Dietitian and Nutritionist will document actual communication between nutrition and physicians in a nutrition progress note, for clinical nutrition follow-up of chronic medical conditions, such as anemia. Medical Director will remind Medical Staff to document monitoring of chronic anemia. Medical Director will meet and discuss (education session) with the Medical Staff to document monitoring of chronic anemia.</p> <p>4. Registered Dietitian and/or Nutritionist will audit communication documentation for residents with chronic anemia and report outcome, corrective action, and trends to QI Committee quarterly. QI will audit Medical Staff documentation in the medical record of monitoring chronic anemia.</p>	4/8/2011
L 051	<p>3210.4 Nursing Facilities</p> <p>A charge nurse shall be responsible for the following:</p>	L 051	<p>5. Compliance Date</p>	4/8/2011

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L 051	<p>Continued From page 7</p> <p>(a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;</p> <p>(b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;</p> <p>(c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;</p> <p>(d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e) Supervising and evaluating each nursing employee on the unit; and</p> <p>(f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:</p> <p>A. Based on record review and staff interview for two (2) of 27 sampled residents and two (2) of 12 supplemental residents, it was determined that the charge nurse failed to: notify the resident's responsible party of changes to the residents mode of transportation of allowing the staff to wheel the resident backwards; notify one (1) resident 's responsible party of an elopment attempt; notify the responsible party that one (1) resident developed a pressure sore and notify the physician/nurse practitioner of one (1) resident 's significant weight loss. Resident #19, #26, #M1, and #P1.</p> <p>The findings include:</p>	L 051	<p><u>L051 (A)</u></p> <ol style="list-style-type: none"> Resident # 19 Nurse Manager of unit where resident resides conducted a one to one education with nurse caring for resident, that nurse is to notify the responsible party immediately following any changes in resident #19 plan of care. Following notification made to responsible party of resident #19 an entry will be made in the nursing progress note. Nurse Managers will audit 10% of the resident medical records on their respective units of any residents that have experienced any change in condition, medication order change or any other situations where family notification is warranted. Audits will be submitted to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note. 	

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L 051	<p>Continued From page 8</p> <p>1. The charge nurse failed to notify the responsible party of the modifications with the residents ' mode of transportation for Resident # 19. A review of the medical record revealed an " Interim Order Form " dated January 25, 2011 at 9:30AM directing the following:</p> <ol style="list-style-type: none"> 1. Okay to move patient in merry walker backwards when he/she is not actively walking him/herself -see progress note, 2. Check CMP (complete metabolic panel), 3. Start lasix 40 mg po (by mouth) daily for fluid overload, 4. Start ambien 5 mg po daily at hs (bed time) for insomnia, ... " <p>A review of the " Nurses Notes " dated January 25, 2011 at 2:40 PM revealed an entry indicating " patient relative gave permission for ambien 5mg po at hs for insomnia, also updated him/her on other orders diet, lasix, blood work "</p> <p>The entry failed to indicate that the relative/responsible party was informed about the modifications to allow staff to wheel his/her relative backwards.</p> <p>A face-to-face interview was conducted on January 26, at 11:30 AM with Employee #32 a query was made if the relative was informed about the order to allow the staff to wheel the resident backwards.</p> <p>Employee #32 indicated that he/she " did include the order to allow staff to wheel the resident backwards in the update. "</p>	L 051	<ol style="list-style-type: none"> 3. Nurse managers are to review their unit 24 hour reports daily for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the resident to review if documentation of notification of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party. Nurse Managers and supervisors of all facility units will hold unit education sessions with charge nurses by April 8, 2011 to remind nurses whenever changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. 4. Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note. 5. Compliance Date 1. On 11/28/2010, when resident #26 left the building, the resident was alert and deemed able to make her own decisions. The resident was her own responsible party and left the building accompanied by a friend. Resident 26 stated she would return to facility at a specific time. 	4/8/2011

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L 051	<p>Continued From page 9</p> <p>The clinical record lacked documented evidence that the relative was informed about the order to allow the staff to wheel his/her relative backwards. The record was reviewed on January 25, 2011.</p> <p>2. The charge nurse failed to notify the resident's responsible party of the resident's attempt to elope for Resident #26.</p> <p>A review of Resident #26's clinical record revealed that a nurse's note dated November 28, 2010 at 3:00 PM documented, "Resident condition stable. Hospice care in progress. Adjusting to new environment well. Resident tried to elope during morning time. Nurse Practitioner notified. Order to apply wander guard to resident ankle, for safety and check wander guard every week day for function. House supervisor notified. Monitor continues."</p> <p>The record lacked documentation that facility staff notified the resident's responsible party of the resident's attempt to elope.</p> <p>A face-to-face interview was conducted with Employee#3 on February 1, 2011 at 9:30 AM. He/she acknowledged that the responsible party was not notified of the change of condition of the resident. The record was reviewed February 1, 2011.</p> <p>3. The charge nurse failed to notify the resident's responsible party that the resident developed a pressure sore for Resident #M1.</p>	L 051	<p>Staff documented the occurrence as an elopement when the resident did not return to the facility by the time the resident specified. The resident nor the friend did not make any attempt to contact the facility when the specified time the resident was to return had passed. The staff proceeded to document the occurrence as an elopement. As stated, the resident was her own responsible party, therefore it was not necessary to notify a responsible party of the resident's not returning to the facility.</p> <p>2. Nurse Managers will audit 10% of the resident medical records on their respective units of any residents that have experienced any change in condition, medication order change or any other situations where family notification is warranted. The audits will be forwarded to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note.</p>	

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L 051	<p>Continued From page 10</p> <p>A review of Resident #M1's clinical record revealed that a nurse's note dated October 27, 2010 at 3:00 PM documented, " Resident is alert and verbally responsive was observed today with reopen left buttocks wound measure 1 cm x 0.5 cm, with scant drainage noted. Nurse Practitioner made aware, new order for Santyl daily and reassess after 14 days."</p> <p>A review of Resident #M1's Treatment Administrative Record (TAR) for December, 2010 revealed the following wound care order initiated October 26, 2010: " cleanse left buttocks open area with soap and water, apply Santyl cover with 2x2 and secure with Tegaderm daily." The wound was resolved in December 2010.</p> <p>A review of Resident #M1's clinical record revealed that a nurse's note dated January 19, 2011 at 3:00 PM documented, " Resident remain stable, reported by nursing assistant, resident had a opening to left buttocks, measure 0.5 cm x 0.1 cm, reopen with scant amount of clear drainage. Evercare Nurse Practitioner made aware, new order in place until heal."</p> <p>The record lacked documentation that facility staff notified the resident's responsible party between October 27, 2010 and January 19, 2011 that resident developed a pressure sore.</p> <p>A face-to-face interview was conducted with Employee#3 on January 31, 2011 at 9:30 AM.</p>	L 051	<p>3. Nurse managers are to review their unit 24 hour reports daily for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the resident to review if documentation of notification of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note.</p> <p>4. Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note.</p> <p>5. Compliance Date</p>	4/8/2011

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L 051	<p>Continued From page 11</p> <p>He/she acknowledged that the record lacked evidence of responsible party notification regarding the resident's pressure ulcer. The record was reviewed January 31, 2011.</p> <p>4. The charge nurse failed to inform the physician/nurse practitioner of Resident P1 ' s significant weight loss.</p> <p>A review of the dietary note in the resident ' s clinical record revealed a note dated October 18, 2010 which stated, " Nutritional note wt [weight] declined 138 lb or 8.6% is significant but he/she is above IBW [Ideal Body Weight. " Another note dated December 16, 2011 stated, " Current wt [weight] 135.2# [pounds] or 9.8% lost in 180 days significant. "</p> <p>A review of the documentation of the monthly weights in the resident ' s clinical record revealed that the resident ' s weight declined from 160 pounds in April 2010 to 138 pounds in October which was reflective of a significant weight loss of 13% in six [6] months or 180 days.</p> <p>A review of the significant change Minimum Data Set [MDS] which was completed on December 4, 2010 revealed that the MDS was coded for the significant weight loss.</p> <p>A review of the nursing and dietary documentation failed to reveal any evidence that the physician/NP was informed of the resident ' s significant weight loss.</p> <p>A face-to-face interview was conducted with Employee # 6 at approximately 10:00 AM on February 2, 2011. He/she acknowledged that the</p>	L 051	<ol style="list-style-type: none"> 1. Resident # M1 Nurse Manager of unit where resident resides conducted a one to one education with nurse caring for resident, that nurse is to notify the responsible party immediately following any changes in resident #M1 plan of care. Following notification made to responsible party of resident #M1 an entry will be made in the nursing progress note. 2. Nurse Managers will audit 10% of the resident medical records on their respective units of all residents that have experienced any change in condition, medication order change or any other situations where family notification is warranted. The Audits will be forwarded to the Quality Improvement Nurse. Nurse Managers and supervisors of all facility units will hold unit education session with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to a responsible party of a resident regarding change(s) to the residents' plan of care, the notification is to be documented in the nursing progress note. 3. Nurse managers are to review their unit 24 Hour reports for changes to the resident plan of care. If the 24 hour report shows changes in the resident plan of care, the nurse manager will go to the medical record of the resident to review if 	

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L 051	<p>Continued From page 12</p> <p>physician/NP was not notified of the resident ' s significant weight loss. Another face-to-face interview was conducted with Employee #26 at approximately 10:30 AM on February 2, 2011. He/she stated, " He/she was initially above his/her IBW and his/her Albumin level is good [3.5]. I have been working with him/her to make sure he/she gets the foods he/she likes. The record was reviewed on January 28, 2011.</p> <p>B. Based on record review and staff interview for eight (8) of 27 sampled residents, and two (2) of 12 supplemental residents, it was determined that the charge nurse staff failed to accurately code the MDS [Minimum Data Set] for one (1) resident for restraint and splints, four (4) for falls, one (1) resident for hearing impairment, one (1) resident for diagnoses of hypertension, pacemaker, alzheimer's and pressure ulcer, one (1) resident for alzheimer's, urinary tract infection, and pressure ulcer, one (1) resident for allergies, physical behavior, Parkinson and hypertension, one (1) resident for anemia, hyperlipedemia and risk for pressure ulcer, one resident for alzheimer's and two (2) residents for allergies. Residents #2, #4, #5, #15, #19, #20, #22, #26, #F1 and #P1.</p> <p>The finding include:</p> <p>1. The charge nurse failed to code Section J on the quarterly MDS (Minimum Data Set) for data pertaining to falls for Resident #2.</p> <p>A review of the residents " Care Plans " dated November 8, 2010 and November 11, 2010 revealed that the resident sustained a fall on</p>	L 051	<p>documentation of notification of the responsible party is reflected in the medical record. Variances will be corrected by immediate notification of the responsible party and documentation of the notification in the medical record. Nurse managers and supervisors of all units will hold unit education sessions with charge nurses by April 8, 2011 to remind nurses whenever any changes occur in the resident plan of care, the charge nurse will notify the responsible party for the resident. During the education session, the discussion will include, that following notification to the responsible party, regarding changes, documentation of the notification is made in the nursing progress note.</p> <p>4. Making use of the unit 24 hour report to identify changes in residents plan of care as a guide, the QI nurse will conduct weekly chart audits to ensure that notification to responsible parties of changes to residents plan of care, have been documented in residents nursing progress note</p> <p>5. Compliance Date</p> <p><u>L051 (B.)</u></p> <p>1. The records cannot be altered retrospectively to the dates of non-compliance. The records of residents #2, #4, #5, #15, #19, #20, #22, #26, #F1, #P1 were reviewed and the need for consistency in documentation reinforced with staff. Resident #4 record was updated and coded include the merry-walker as a restraint.</p>	4/8/2011

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L 051	<p>Continued From page 13</p> <p>both of the dates mentioned.</p> <p>Review of the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of December 15, 2010 revealed that the facility staff failed to code " Section J 1700 Fall History on Admission; Section J 1800 Any Falls Since Admission or Prior Assessment ... and Section J 1900 Number of falls Since Admission or Prior Assessment ... "</p> <p>Section J1700 Fall History on Admission indicates (complete only if Section A0310A = 01 or A0310E = 1)</p> <p>Review of section A0310E Type of Assessment was coded (1), therefore all of the above mentioned in Section J should have been completed.</p> <p>A face-to-face interview was conducted on January 31, 2011 with Employee #19 at 1:45 PM. After review of the MDS, he/she acknowledged the areas that were not coded. The record was reviewed on January 31, 2011.</p> <p>2. The charge nurse failed to accurately code Resident #4 for restraints and a splint.</p> <p>A review of Resident #4 's quarterly MDS 2.0 [Minimum Data Set] dated September 15, 2010 revealed that facility staff failed to accurately code Section P (3) Nursing rehabilitation/restorative care for splint or brace assistance, P (4) Devices and restraints.</p> <p>According to the 3.0 MDS dated December 6, 2010 revealed Section P (P0100) Physical Restraints was coded " 0 " indicating restraints not used and Section O (O0500) Restorative</p>	L 051	<p>2. The MDS staff will continue to audit all residents' records and educate caregivers to ensure accurate coding of residents assessments. The MDS staff has conducted educational sessions with the Nurse Managers reviewing how to accurately code the MDS for restraints & splints, falls, diagnosis, allergies, and pressure ulcers. No residents had any negative effects due to inaccurate coding. The MDS Coordinator audited 10% of the MDS assessment in the medical records on each unit. Where discrepancies were found, on-the-spot education was completed and where possible coding corrected.</p> <p>3a. The MDS staff will continue to audit all residents' records and educate caregivers to ensure accurate coding of residents assessments.</p> <p>b. The MDS RN Coordinator will review and discuss coding of the MDS with Interdisciplinary team (IDT) members prior to signing.</p> <p>c. Diagnosis sheets will updated during monthly POS exchange and quarterly at the time of the IDT assessment.</p>	

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L 051	<p>Continued From page 14</p> <p>Nursing Programs coded " 0 " for splint or brace assistance.</p> <p>Resident observed on January 25, 2011 at approximately 9:20 AM in bed with bilateral hand splints. Resident observed at 11:30 AM at the nurse ' s station sitting in a merry walker with belt around waist and a safety bar attached to the chair.</p> <p>A face-to-face interview was conducted on January 25, 2011 at approximately 1:30 PM with Employees #6 and Employee #19. He/she acknowledged that the resident was not coded for restraints and splints. The record was reviewed January 25, 2011.</p> <p>3. The charge nurse failed to accurately code quarterly MDS for Resident #5 for HTN, Pacemaker, Alzheimer ' s, Pneumonia, and risk for developing ulcer for Resident #5.</p> <p>A review of Resident #5's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 2, 2010 revealed that facility staff failed to accurately code for HTN, Pacemaker, Alzheimer ' s, Pneumonia and risk for developing ulcer.</p> <p>According to the MDS dated completed on December 2, 2010 the resident was not coded in Section I Active Diagnoses for I0700 (Hypertension), I2000 (Pneumonia), I4200 (Alzheimer ' s Disease), I8000 (Pacemaker) and section M Skin Condition for M0150 (Risk of Pressure Ulcer).</p>	L 051	<p>d. The MDS Coordinator audited 10% of the MDS assessment in the medical records on each unit. Where discrepancies were found, on-the-spot education was completed and where possible coding corrected.</p> <p>4. Compliance with MDS assessment accuracy and coordination will be reported during weekly Focus QI. Variances and corrections will be reported to the Quality Improvement Committee quarterly.</p> <p>5. Compliance Date</p>	4/8/2011

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L 051	<p>Continued From page 15</p> <p>A face-to-face interview was conducted on January 25, 2011 at approximately 9:30AM with Employee #5. He/she acknowledged the findings. The record was reviewed. January 25, 2011.</p> <p>4. The charge nurse failed to accurately code quarterly MDS for Resident #15 for Alzheimer ' s, UTI and risk for developing ulcer for Resident #15.</p> <p>A review of Resident #15's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 7, 2010 revealed that facility staff failed to accurately code for Alzheimer ' s, UTI and risk for developing ulcer.</p> <p>According to the MDS dated completed on December 7, 2010 the resident was not coded in Section I Active Diagnoses for I2300 (UTI), I4200 (Alzheimer ' s Disease) and section M Skin Condition for M0150 (Risk of Pressure Ulcer).</p> <p>A face-to-face interview was conducted on January 31, 2011 at approximately 9:30AM with Employee #7. He/she acknowledged the findings. The record was reviewed January 31, 2011.</p> <p>5. The charge nurse failed to code Resident #19 for restraints.</p> <p>A review of the "Physician's Order Form" dated and signed January 2, 2011 indicated "patient to use merry walker for safe ambulation."</p>	L 051		

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L 051	<p>Continued From page 16</p> <p>An observation was made on January 28, 2011 at approximately 10:35 AM. Resident #19 was observed sitting in the merry walker, attempting to reach for an object and pulling at the seat cushion. A trunk restraint was observed to be in place to secure the resident to the merry walker in order to prevent he/she from falling out during ambulation.</p> <p>A review of the resident's annual MDS [Minimum Data Set] with an ARD (Assessment Reference Date) of November 29, 2010 in Section P: titled Restraints, lacked evidence that the resident was coded for "using a trunk restraint" while in a chair,</p> <p>A face-to-face interview was conducted on January 28, 2011 at 10:30 AM with Employee #4. After review of the MDS and the definition of restraint he/she acknowledged the above findings. The record was reviewed on January 28, 2011.</p> <p>6a. The charge nurse failed to code Section J on the quarterly MDS (Minimum Data Set) for data pertaining to falls for Resident #20.</p> <p>A review of the resident's " Care Plan Face Sheet " dated December 21, 2010 revealed that the resident sustained a fall on October 15, 2010.</p> <p>Review of the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of December 13, 2010 revealed that the facility staff failed to code " Section J 1700 Fall History</p>	L 051		

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L 051	<p>Continued From page 17</p> <p>on Admission; Section J 1800 Any Falls Since Admission or Prior Assessment ... and Section J 1900 Number of falls Since Admission or Prior Assessment ... "</p> <p>Section J1700 Fall History on Admission indicates (complete only if Section A0310A = 01 or A0310E = 1)</p> <p>Review of section A0310E Type of Assessment was coded (1), therefore all of the above mentioned in Section J should have been completed.</p> <p>A face-to-face interview was conducted on January 31, 2011 with Employee #19 at 1:45 PM. After review of the MDS, he/she acknowledged the areas that were not coded. The record was reviewed on January 31, 2011.</p> <p>6b. The charge nurse failed to code Resident #20 for restraints. A review of the " Physician ' s Order Form " dated and signed January 2, 2011 indicated " merry walker for safe ambulation " . An observation was made on January 28, 2011 at approximately 11:35 AM Resident #20 was observed sitting in the merry walker with seat belt attached.</p> <p>Review of the residents annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of November 29, 2010 in Section P: titled Restraints, lacked evidence that the resident was coded for " using a trunk restraint " while in a chair, the trunk restraint was observed to be in place to secure the resident to the merry walker in order to prevent he/she from falling out during ambulation. "</p> <p>A face -to-face interview was conducted on</p>	L 051		

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L 051	<p>Continued From page 18</p> <p>January 28, 2011 at 10:30 AM with Employee #4. After review of the MDS and the definition of restraint he/she acknowledged the findings. The record was reviewed January 31, 2011.</p> <p>7. The charge nurse failed to code the MDS for Allergies, Physical behavior, Parkinson and HTN #22</p> <p>Facility staff failed to accurately code quarterly MDS for Allergies, Physical behavior, Parkinson and HTN. Resident #22</p> <p>A review of Resident #22's quarterly MDS [Minimum Data Set] with Assessment Reference Date December 23, 2010 revealed that facility staff failed to accurately code for Allergies, Physical behavior, Parkinson and HTN.</p> <p>According to the MDS dated completed on December 30, 2010 the resident was not coded in Section I Active Diagnoses for I0700 (Hypertension), I5300 (Parkinson Disease), I8000 (Allergies) and section E Behaviors 0200 (Physical Behavior).</p> <p>8. The charge nurse failed to code admission MDS for Anemia, hyperlipidemia and accurately code for risk of pressure ulcer for Resident #26.</p> <p>A review of Resident #26's admission MDS [Minimum Data Set] with Assessment Reference Dated of November 30, 2010 revealed that facility staff failed to code for Anemia, hyperlipidemia and accurately code for risk of pressure ulcer.</p>	L 051		

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L 051	<p>Continued From page 19</p> <p>According to the MDS dated completed on December 4, 2010 the resident was not coded in Section I Active Diagnoses for I0200 (Anemia), I3300 (Hyperlipidemia), and section M Skin Condition for M0150 (Risk of Pressure Ulcer) resident was coded 0 (No) instead of 1 (yes).</p> <p>A face-to-face interview was conducted on January 28, 2011 at approximately 9:30AM with Employee #3. He/she acknowledged the findings. The record was reviewed. January 28, 2011.</p> <p>9. The charge nurse failed to code the Admissions MDS 3.0 dated November 22, 2010 for "Hearing Impairment" under Section I [Additional Active Diagnosis] for Resident #F1.</p> <p>A review of the Physical Examination conducted by the physician and signed on November 17, 2010 revealed that Resident #F1 had a diagnosis of " Deaf " .</p> <p>The Physician ' s Order Form dated January 2011 and signed by the physician on January 10, 2011 revealed a diagnosis of " Hearing Impaired-Deaf " .</p> <p>A review of the Admission MDS 3.0 with a completion date of November 22, 2010 revealed that " Hearing Impairment " was not coded in Section I 1800 [Additional Active Diagnosis].</p>	L 051		

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L 051	<p>Continued From page 20</p> <p>A face-to-face interview was conducted with Employee #6 on February 1, 2011 at 11:30 AM. After review of the documents he/she acknowledged that "Hearing Impairment" was not coded on the admission MDS 3.0.</p> <p>The charge nurse failed to code the Admissions MDS for "Hearing Impairment". The record was reviewed February 1, 2011.</p> <p>10. The charge nurse failed to accurately code Resident #P1 's quarterly Minimum Data Set (MDS) for falls.</p> <p>A review of Section J1800 of the quarterly MDS with a completion date of October 4, 2010 revealed that the resident was coded with a zero [0], which indicated that he/she had no falls during the required assessment period. The assessment asked the following question; "Has the resident had any falls since admission or the prior assessment?" The facility staff responded "no".</p> <p>A review of the nursing documentation in the resident 's clinical record revealed the following note, dated August 3, 2010. "Resident was observed on floor today at 10:00AM by therapy aide."</p> <p>A face-to-face interview was conducted with Employee #18 at approximately 9:45 AM on February 2, 2011. The employee stated I don 't know why it was missed. I 'll have to research it and get back to you." The employee returned to this surveyor approximately 15 minutes later</p>	L 051		

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L 051	<p>Continued From page 21</p> <p>with a corrected copy of Section J [fall] of the MDS. He/she stated, " I don ' t know how I missed it. I checked my notes and found that he/she [the resident] did have a fall. " The record was reviewed on January 28, 2011.</p> <p>The charge nurse failed to accurately code Resident #P1 ' s quarterly Minimum Data Set (MDS) for falls.</p> <p>C. Based on record review and staff interview for four (4) of 27 sampled residents and one (1) of 12 supplemental residents reviewed, it was determined that the charge nurse failed to develop care plans for: two (2) residents with allergies; one (1) resident on anticoagulation therapy; one (1) resident with hearing aids and medications at the bedside who utilized side rails for bed mobility and one (1) resident with a venous access device who the interdisciplinary team agreed to care plan for falls, incontinence, dental care and medications at the bedside. Residents # 4, #7, #17, #18, and #F1.</p> <p>The findings include:</p> <p>1. The charge nurse failed to develop a care plan for allergies for Resident #4.</p> <p>The physician ' s order sheet signed and dated January 11, 2011 revealed, " Allergies: Benadryl, Periactin. "</p> <p>A review of Resident #4 ' s clinical record revealed that there was no care plan to address the resident ' s allergy to Benadryl.</p> <p>There was no evidence that facility staff initiated</p>	L 051		
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L 051	<p>Continued From page 22</p> <p>a care plan with goals and approaches to address the resident's allergy to Benadryl.</p> <p>A face-to-face interview was conducted with Employee #6 on January 25, 2011 at approximately 12:30 PM. He/she acknowledged that there was no care plan initiated for the resident's allergy to Benadryl. The record was reviewed on January 25, 2011.</p> <p>2. The charge nurse failed to develop a care plan for allergies for Resident #7. Review of the December 2010 Physician ' s Orders revealed that the resident had allergies to Penicillins and Cephalosporins. Review of the care plans last updated December 9, 2010 lacked evidence of a care plan for allergies to Penicillins and Cephalosporins for Resident #7. A face-to-face interview was conducted on February 1, 2011 at 11:25 AM with Employee #3. After review of the care plans he/she acknowledged the findings. The record was reviewed on February 1, 2011.</p> <p>3. A review of the clinical record for Resident #17 revealed that the charge nurse failed to develop a care plan for the potential adverse effects related to the use of anticoagulation therapy.</p> <p>The history and physical examination dated March 16, 2010 revealed Resident #17's diagnoses included Anemia, Hypertensive Cardiovascular Disease, Hypothyroidism, Diabetes Mellitus, Depression and Status-Post Cerebrovascular Accident.</p> <p>Physician's orders dated December 1, 2010 revealed the resident's medication regimen</p>	L 051	<p><u>L051 (C)</u></p> <ol style="list-style-type: none"> Resident #4, #7—an allergies care plan has been added to the medical record. Resident #17—anticoagulant care plan has been added to the medical record Resident # 18—hearing aide & self administration of medications care plans has been added to the medical record. Care plan also added to reflect use of side rails for mobility by resident. Resident #F1—care plan added to medical record for self administration of medications. Care plan initiated and added to medical record for care of a Mediport. Care plans initiated and added to the medical record for urinary incontinence, falls and dental care. By April 8, 2011 Unit Nurse Managers will conduct a side by side audit of CAA (Care Assessment Areas) & CAT (Care Assessment Triggers) to match with resident care plans. Negative trends will be corrected at the time of the audit. Nurse managers will be given a training session on how to use the CAAs & CATs to enhance the resident care planning process. No other residents were affected. 	

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L 051	<p>Continued From page 23</p> <p>included Aspirin 81mg daily for prophylaxis.</p> <p>The comprehensive care plan, most recently updated December 16, 2010 lacked evidence of problem identification, approaches and interventions for the use of anticoagulant therapy (Aspirin).</p> <p>A face-to-face interview was conducted with Employee #3 on January 24, 2011. He/she acknowledged that the care plan lacked identification, approaches and interventions for Aspirin. The clinical record was reviewed January 24, 2011.</p> <p>4. The charge nurse failed to initiate a care plan with appropriate goals and approaches for the use of a hearing aide, side rails for mobility and self administration of medication for Resident #18.</p> <p>4a. A review of the clinical record for Resident #18 revealed that facility staff failed to develop a care plan for the use of a hearing aide.</p> <p>According to the MDS [Minimum Data Set] 3.0 dated November 30, 2010 revealed in Section B (Hearing, Speech, and Vision) /B0300 (Hearing) was coded " 1 " indicating ability to hear(with hearing aid or hearing appliances if normally used) with minimal difficulty.</p> <p>A review of the " Nursing Monthly Summary " for November 2010 and December 2010 revealed " Hearing: check was in front of the space for hearing aid. "</p> <p>The comprehensive care plan, most recently</p>	L 051	<p>3. Once per month nursing unit managers will audit 10% of resident records to ensure IDT care plans and MDS documentation match. A chart audit tool will be created for usage by the nurse managers: nurse managers prior to using tool will receive training to use the tool.</p> <p>4. Unit Nurse Managers will forward monthly chart audits to the QI for identification of trends and corrections. Outcomes will be reported to the Quality Improvement Committee quarterly.</p> <p>5. Compliance Date</p>	4/8/2011

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L 051	<p>Continued From page 24</p> <p>updated November 2, 2010 lacked evidence of problem identification, approaches and interventions for the use of a hearing aid. The chart was reviewed January 31, 2011.</p> <p>4b. Physician ' s orders dated and signed January 11, 2011 directed, " Ciloxan Ophthalmic 0.3% ointment, apply to right eye twice daily for chronic conjunctivitis (indefinitely). "</p> <p>An observation of Resident #18 on January 24, 2011 revealed medication was stored in resident ' s bedside table proximal to the resident ' s bed. Facility staff acknowledged that the resident self-administered his/her eye drops in accordance with physician ' s orders.</p> <p>A review of the plan of care for Resident #18 lacked problem identification, objectives and approaches for self administration of eye drops.</p> <p>A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for self administration of eye drops. The record was reviewed on January 24, 2011.</p> <p>4c. According to a physician ' s " interim order " dated January 23, 2011 at 8:00 PM revealed, " May use ½ [half] side rails when in bed for functional mobility.</p> <p>During the orientation tour of the facility on January 24, 2011 at approximately 9:20 AM,</p>	L 051		
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L 051	<p>Continued From page 25</p> <p>Resident #18 was observed lying in bed with both upper side rails up.</p> <p>A review of the care plan lacked problem identification, objectives and approaches for side rails for bed mobility.</p> <p>A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 10:00AM. He/she acknowledge that the record lacked a care plan for the use of side rails for bed mobility. The record was reviewed January 24, 2011.</p> <p>5a. The charge nurse failed to develop a care plan with goals and approaches for Resident #F1 to keep medication at the bedside.</p> <p>On January 26, 2011 at 3:00 PM a tour of Resident #F1 's room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the medication was on the resident night stand. Employee #16 stated, "[He/she] self administers the spray to his/her throat."</p> <p>Additionally, Resident #F1 wrote the following on his/her communication board, " I spray it in my mouth. "</p> <p>The Physician Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Cetacaine Spray 2 sprays every 3</p>	L 051		
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L 051	<p>Continued From page 26</p> <p>hours as needed for pain-may keep at bedside to use as needed. "</p> <p>A review of plan of care /care plan section of Resident #F1 ' s current clinical record revealed that a care plan did not exist for self administers medication (Cetacaine).</p> <p>There was no evidence that a plan of care was initiated with goals and approaches for Resident #F1 to self administer the Cetacaine.</p> <p>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that there was no plan of care initiated with goals and approaches for Resident #F1 to self administer the Cetacaine. The record was reviewed on February 1, 2011.</p> <p>5b. The charge nurse failed to develop a care plan with goals and approaches for the use of the Mediport for Resident #F1.</p> <p>The Interim Order Form dated January 12, 2011 at 12:15 PM and signed by the physician on January 13, 2011 directed, " Use Emla cream or generic brand 30 minutes before every month Mediport flush. "</p> <p>A review of plan of care /care plan section of Resident # F1 ' s current clinical record revealed that a care plan did not exist for goals and approaches for the care of the Mediport.</p> <p>There was no evidence that a plan of care was</p>	L 051		
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L 051	<p>Continued From page 27</p> <p>initiated with goals and approaches for the care of the Mediport for Resident #F1.</p> <p>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6. He/she acknowledged that there was no plan of care initiated with goals and approaches for the care of the Mediport for Resident F1. The record was reviewed on February 1, 2011.</p> <p>5c. The charge nurse failed to develop a care plan with goals and approaches for dental care, falls and incontinence for Resident #F1.</p> <p>A review of the Care Assessment Area (CAA) Summary completed November 22, 2010 revealed that urinary incontinence, falls, and dental care was check in the , " Care Area Triggered " column and urinary incontinence, falls, and dental care was checked in the Addressed in care plan column.</p> <p>A review of plan of care /care plan section of Resident # F1 ' s current clinical record revealed that a care plan did not exist for goals and approaches for urinary incontinence, falls, and dental care.</p> <p>There was no evidence that a plan of care was initiated with goals and approaches for urinary incontinence, falls, and dental care for Resident #F1.</p> <p>A face-to-face interview was conducted on February 1, 2011 at 11:30 AM with Employee #6.</p>	L 051		
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L 051	<p>Continued From page 28</p> <p>He/she acknowledged that there was no plan of care initiated with goals and approaches for urinary incontinence, falls, and dental care for Resident F1. The record was reviewed on February 1, 2011.</p> <p>D. Based on record review and staff interview of four (4) of 27 sampled residents it was determined that the charge Nurse failed to: document quarterly assessments for one (1) resident; accurately transcribe wound treatment orders for one (1) resident; document behavioral monitoring for two (2) residents; transcribe a verbal order and document a concern for one (1) resident; and maintain dental examinations on the active medical record for one (1) resident. Residents #4, #6, #10 and #22.</p> <p>The findings include:</p> <p>1a. The charge nurse failed to consistently document Resident #4 ' s behavior on the behavioral monitoring tool for Resident #4.</p> <p>Resident #4 had a current physician's order dated January 7, 2011 for Lexapro 10mg every day for depression and Trazodone 50mg at bedtime for insomnia.</p> <p>A review of the clinical record revealed behavioral monitoring sheets completed for August and September 2010. There were no behavioral monitoring sheets for October, November, December 2010 and January 2011.</p> <p>An interview was conducted with Employee #6</p>	L 051	<p><u>L051 (D) – 1a.</u></p> <ol style="list-style-type: none"> Behavioral monitoring tool cannot be corrected retrospectively. Nurse re-educated to match documentation of behavior monitoring tool with actual resident behavior occurrences.No other resident was affected. QI will assist Nurse Managers to audit antipsychotics and anti-anxiety medications monthly to monitor behavior monitoring tool coding accuracy. QI will report outcome trends and corrections to the Quality Improvement Committee quarterly. Compliance Date <p><u>L051 (D) – 1b.</u></p> <ol style="list-style-type: none"> Resident #4 - An annual dental consult was conducted on Resident #4 and placed into the medical record. The dates were April 10, 2010 and October 9, 2010. All residents will have an annual dental consult documented in their medical record. Quality Improvement Nurse using pharmacy consult reports (antipsychotics, anti-anxiety medications) to conduct monthly audit of behavior monitoring tool coding accuracy. No residents were negatively impacted. 	<p>4/8/2011</p> <p>4/8/2011</p>

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L 051	<p>Continued From page 29</p> <p>on January 25, 2011 at approximately 10:30 AM; he/he stated that the staff had failed to initiate the monitoring sheet for October, November, December 2010, and January 2011. The clinical record was reviewed on January 25, 2011.</p> <p>1b. The charge nurse failed to maintain dental evaluations in Resident #4 ' s active medical record.</p> <p>According to the physician orders dated January 7, 2011 revealed, " Annual Dental Consult " ...order initiated March 12, 2010.</p> <p>A review of Resident #4 ' s record revealed no dental evaluation. There was no evidence that an annual dental screen was completed for 2010.</p> <p>A face-to-face interview was conducted with Employee #6 on January 25, 2011 at approximately 11:30 AM. He/she acknowledged that there was no dental evaluation on Resident #4 ' s active clinical record. Dental evaluations were received via fax from the [Dental MD] revealing a dental evaluation was conducted on April 10, 2010 and October 9, 2010. The record was reviewed on January 25, 2011.</p> <p>2. A review of the clinical record for Resident #6 revealed facility staff failed to accurately transcribe wound treatment orders onto the January 2011 Medication Administration Record [MAR]. The transcribed orders lacked evidence of a "frequency " to perform the treatment.</p> <p>A review of physician ' s orders dated January 3, 2011 revealed the wound treatment was prescribed daily [frequency].</p>	L 051	<p>3. A letter will be sent to the Dentist outlining the deficiency and the regulation. Unit secretaries will audit open resident records for documentation of the annual dental consult.</p> <p>4. Negative outcomes from the audit will be reported to the Dentist, the Nurse Manager and trended for Quality Improvement.</p> <p>5. Compliance Date</p> <p><u>L051 (2)</u></p> <p>1. Resident #6 - Incomplete order was corrected. Missing order transcribed.</p> <p>2. Nurse Managers to conduct unit meetings reviewing standards for transcription of physician orders. The Nurse Managers audited 10% of charts on their units to ascertain if standards of order transcription were followed: no negative outcomes for other residents were seen</p> <p>3. Staff nurses re-educated regarding documentation standards for order transcription. All nurses will receive a medication update training session to include standards of transcribing orders.</p> <p>4. Nurse Managers to forward documentation of unit meetings to Director of Nursing. Director of Nursing will forward reports to Quality Improvement Nurse. Attendance will be reported quarterly to Quality Improvement Committee.</p> <p>5. Compliance Date</p>	<p>4/8/2011</p> <p>4/8/2011</p> <p>4/8/2011</p> <p>4/8/2011</p>

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L 051	<p>Continued From page 30</p> <p>The findings were reviewed and confirmed during an interview with Employee #3, January 26, 2011 at approximately 11:00 AM.</p> <p>3a. The charge nurse staff failed to transcribe a verbal order to flush right eye after administration of eye drop to wrong site for Resident #10.</p> <p>Physician ' s orders dated January 7, 2011 directed Cosopt Ocumeter Plus, instill one (1) drop in left eye every 12 hours for glaucoma.</p> <p>During a medication pass observation on January 24, 2011 at approximately 9:30 AM, Employee #15 instilled one drop in right eye. After instilling the drop, Resident #10 state, " It ' s burning; I had cataract surgery " Employee #15 proceeded to inform [NP]. Verbal order given by [NP] to " flush right eye. "</p> <p>A review of the clinical record lacked evidence that an order was written to flush right eye. This was acknowledged in the presence of Employee #6 on January 24, 2011 at approximately 11:00 AM. The clinical record was reviewed on January 24, 2011.</p> <p>3b. The charge nurse failed to document resident ' s " voiced concern " regarding burning in right eye after administration of eye drop for Resident #10.</p> <p>Physician ' s orders dated January 7, 2011 directed Dorzolamide HCl 2%-0.5 %(Cosopt Ocumeter Plus), instill one (1) drop in left eye</p>	L 051	<ol style="list-style-type: none"> 1. Resident #10-Nurse documentation of resident eye not burning following administration of eye drops was an error in documentation. Note corrected. Verbal order of nurse practitioner to flush resident's eye recorded as late entry. 2. Nurse re-educated concerning 5-Rights of Medication administration. Nurse instructed to use Lippincott Manual to review the procedure for administering eye drops to resident. Nurse Manager conducted a follow up Medication Administration Observation with individual nurse. During the medication administration observation, no negative effects were seen with other residents receiving eye drops. 3. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering medications (eye drops). The 5-Rights of Medication Administration were reviewed during the same unit meetings. 4. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. 	

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L 051	<p>Continued From page 31</p> <p>every 12 hours for glaucoma.</p> <p>During a medication pass observation on January 24, 2011 at approximately 9:30 AM, Employee #15 instilled one drop in right eye. After instilling the drop, Resident #10 stated, " It ' s burning; I had cataract surgery "</p> <p>A review of the " Medication Occurrence Report " dated January 24, 2011 revealed, Dorzolamide 1 drop instilled in wrong eye (right). Resident has no complain of pain. "</p> <p>According to Nurses Notes dated 1/24/11 at 11:30 AM revealed, " AM medication pass this AM, writer instilled Cosopt in resident right eye, Resident states it does not burn. NP made aware. "</p> <p>The clinical record lacked evidence that resident voiced concern that right eye was burning. This was done in the presence of Employee #15 immediately after the eye drop was instilled in right eye. The clinical record was reviewed on January 24, 2011.</p> <p>4.A review of the clinical record for Resident #22 revealed the charge nurse failed to consistently document the resident ' s behavioral status on the facility's Behavior Monitoring Flow Record.</p> <p>According to physician ' s orders dated January 1, 2010, the resident ' s medication regimen included the following psychotropic medications</p>	L 051	<p>Nurse Managers received an education. session presented by the pharmacy, on how to conduct Medication Administration Observations. Negative trends and corrections will be reviewed during the facility QI monthly Meeting.</p> <p>5. Compliance Date</p>	4/8/2011

Health Regulation & Licensing Administration

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L 051	<p>Continued From page 32</p> <p>that were initiated November 8, 2010: Ativan 1mg PO daily at bedtime as needed for agitation; Seroquel 25mg by mouth every evening for psychosis/ for agitation and Lexapro 20mg by mouth every day for depression.</p> <p>A review of the Behavior Monitoring Flow Records for the months of November and December 2010, and January 2011 revealed that licensed staff inconsistently documented episodes of targeted behaviors.</p> <p>A face-to-face interview was conducted with Employee #5 on January 26, 2011 at 1 PM. He/she stated that the behavior monitoring records were initiated to monitor episodes of scratching, biting, refusing blood sugar check and insulin coverage and jittering and nervousness in addition to assessing the effectiveness of psychotropic medication. Inconsistencies in the documentation of episodes of behaviors on the monitoring record were acknowledged. The record was reviewed January 26, 2011.</p>	L 051		
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L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of</p>	L 052		
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L 052	<p>Continued From page 33</p> <p>ulcers:</p> <p>(c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by:</p> <p>A. Based on observation, record review and</p>	L 052		

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L 052	<p>Continued From page 34</p> <p>interview for three (3) of 27 sampled records, and 12 supplemental residents, it was determined that the facility failed to ensure that sufficient nursing time was given to residents to ensure the safe practice of self-administration of medications. Residents #1, #18 and #F1.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to provide sufficient nursing time to Resident #1 to ensure the safe practice of self-administration of medications. <p>Upon review of the clinical record for Resident #1, it was determined that multiple " natural " medications were stored at the bedside and self-administered by the resident. There was no evidence that the interdisciplinary team determined that self-administration was a safe practice for Resident #1.</p> <p>A review of the admission Minimum Data Set (MDS) dated October 13, 2010 revealed that Resident #1 was coded as cognitively intact, non-ambulatory with impairment of lower extremities, no impairment of the upper extremities and required extensive assistance for activities of daily living.</p> <p>A review of the clinical record lacked evidence that the interdisciplinary team (IDT) made a determination that it was safe for the resident to self-administer drugs. The care plan lacked evidence of the determination regarding the storage and documentation of the administration of drugs.</p> <p>A face-to-face interview was conducted with Employee #3 on January 25, 2011 at approximately 4:00 PM who acknowledged the</p>	L 052	<p><u>L052 (A)</u></p> <ol style="list-style-type: none"> 1. Residents #1, 18 and FI received an assessment to ensure they were safe to administer medications. Facility purchased and gave resident a lock box with a pad lock and key (nurse also given a second key for box) in order that the resident can safely secure the medications they self-administer. 2. The Nurse Managers conducted a sweep of all other residents on their unit to ascertain if there were other residents self administering their medications in order to offer any other residents a lock box: no other residents were found to self administer their medications. The Self-Administration of Medication policy has been amended to include a safety assessment of each resident desiring to administer their medications. The assessment will be done for an initial review, quarterly at the time of review of the interdisciplinary care plan and when a significant change occurs to the resident. 3. Upon admission to the facility the resident will be queried to determine if they want to self-administer their medications. If an affirmative answer is given, the Self-Administration of Medications policy will be implemented. 	

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L 052	<p>Continued From page 35</p> <p>findings. The record was reviewed on January 25, 2011.</p> <p>2. The facility failed to allow sufficient nursing time to ensure Resident #18's ability to self administer eye ointment.</p> <p>According to Resident #18 ' s January 2011 Physician ' s Order Sheet signed by the physician on January 11, 2011 directed, " Ciloxan Ophthalmic 0.3% Ointment... apply to right eye twice daily for chronic conjunctivitis (indefinitely). A review of the Medication Administration Record for January 2011 revealed initials indicating " Ciloxan Ophthalmic 0.3% ointment ... apply to right eye twice daily for chronic conjunctivitis " was administered daily at 10:00 AM and 6:00 PM. A review of the clinical record lacked evidence that the interdisciplinary team (IDT) made a determination that it was safe for the resident to self-administer drugs. The care plan lacked evidence of the determination regarding the storage and documentation of the administration of drugs.</p> <p>A face-to-face interview was conducted on January 24, 2011 at approximately 12:00 Noon with Resident #18. He/she stated, " Yes, I put my own ointment in my right right eye. They showed me how to do it, and they watched me do it. I wash my hands before and after putting it in my eye. The ointment is for my conjunctivitis. "</p> <p>A face-to-face interview was conducted on January 24, 2011 at approximately 11:30 AM with Employees #6 and 15. Both stated, " [Resident#18] self administers his/her eye ointment twice a day. The record was reviewed January 24, 2011.</p>	L 052	<p>The Nurse Manager and Nursing Supervisors will conduct an education session with all clinical nurses regarding the Self-Administration of Medication policy and the amendment made to the policy.</p> <p>3. A quarterly audit of the implementation of the Self-Administration policy will be conducted by Nurse Managers. Identified trends and their corrections will be reported to QI and Quality Improvement Committee quarterly.</p> <p>5. Compliance Date</p>	4/8/2011

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L 052	<p>Continued From page 36</p> <p>3. The facility failed to provide sufficient nursing time to ensure that the the IDT (interdisciplinary team) team evaluated Resident #F1 for self administration of medications.</p> <p>On January 26, 2011 at 3:00 PM a tour of Resident #F1 ' s room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the medication was on the resident night stand. Employee #16 stated, "[He/she] self administers the spray to his/her throat."</p> <p>B. Based on observation, record review and interview for three (3) of 27 records reviewed, it was determined that facility staff failed to provide sufficient nursing time to meet professional standards of care during the administration of eye drops for two (2) residents and failed to fully assess one (1) resident prior to medication administration. Resident ' s #10, #17 and #18.</p> <p>The findings include:</p> <p>1. An observation of medication administration revealed facility staff failed to administer Resident #10's eye drop in accordance with professional standards.</p> <p>Physician ' s orders dated January 7, 2100 directed the administration of Cosopt Ocumeter Plus instill one (1) drop in left eye every 12 hours for glaucoma.</p> <p>According to the " 2006 Lippincott ' s Nursing Procedure Manual, page 283 under " Medication Administration, to instill eye drops...pull the lower</p>	L 052	<p><u>L052 (B)</u></p> <ol style="list-style-type: none"> 1. Resident #10, #18 - Nurse administering eye drops was given one on one education—technique for administering eye drops. 2. Follow up random medication administration observation conducted with same nurse as nurse administered eye drops. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with at least one nurse on their units. 3. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse managers have received training through our pharmacy on how to conduct Medication Administration Observation rounds. 	