

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

PRINTED: 10/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/02/2008
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NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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{F 000} INITIAL COMMENTS

A follow-up survey to the annual certification survey completed July 25, 2008 and an investigation of Incident # 08-I-3571/ DC00001606 were conducted on October 1 and 2, 2008. The following deficiencies were based on observation, resident and staff interview and record review. The sample size was 15 residents based on 60% of the census of 163 residents from the first day of the annual certification survey completed July 25, 2008 and 14 supplemental residents.

{F 000}

F 157
SS=G 483.10(b)(11) NOTIFICATION OF CHANGES

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

F 157

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Christa Brasfield, Administrator 10/29/08

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 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview one (1) of 14 supplemental residents, it was determined that facility staff failed to notify the physician when Resident F2 complained of left hip pain and who subsequently sustained a left hip fracture.</p> <p>The findings include: A review of Resident F2 's record revealed no night shift (11:00 PM through 7:30 AM) nursing note regarding the status of the resident for the night of September 19 into September 20, 2008.</p> <p>According to a late entry night shift nurse 's note for September 20, 2008 at 7:00 AM, dated September 20, 2008 at 5:00 PM; " CNA told writer that resident c/o [complained of] pain when turning resident for care. On assessment resident c/o pain when moving L [left] leg. Resident was grimacing. Pain was rated 8 on scale of 0-10 (where 0 is no pain and 10 the worst she can experience.) ...No visible injury note on bilateral legs-two tabs of Tylenol 650 mg po (oral) were given @ 7:05 AM - L hip was warm to touch. Reevaluation pain at 7:45 AM, resident had some relief. Pain rated at that time 7:45 AM at 3 on the same scale 0 to 10. Will continue to monitor."</p> <p>There was no evidence in the record that the</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> 1. Day Shift Charge Nurse called Resident #F2 Physician on 10/20/08 and informed him on resident's change in condition. Staff member was educated on resident assessment and change in condition, Physician notification and proper and timely documentation and pain management. 2. A review of documentation for residents on the 24 hour report for the past 30 days with change in condition were reviewed to assure that MD and RP was notified. 3. Licensed staff was in-serviced on resident assessment, change in condition, physician notification, proper and timely documentation and pain management on 10/28/08 by the Educator . A concurrent review evaluation form will be implemented on 10/28/08. 4. Random chart audits will be conducted by Unit Managers monthly for notification of change in condition to MD and RP and a report provided to the CQI committee monthly of problems identified and corrective actions implemented.. 	10/28/08 On-going Monthly 3rd Thurs. On-going

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F 157	<p>Continued From page 2</p> <p>night shift nurse informed the day shift nurse (7:00 AM through 3:30 PM) and the physician of Resident F2 ' s continued complaint of left hip pain.</p> <p>According to a nurse ' s note dated September 20, 2008 at 9:20 AM, " It was brought to my attention per CNA assigned on nights that resident has pain when turning. The writer assessed resident ' s hip and noted swelling and hot to touch ...PMD (private medical doctor) called and responded. Orders given for x-rays of both hips. Tylenol 325 mg tabs 2, given for elevated temperature and comfort. "</p> <p>According to the " X-ray Examination Report " dated September 20, 2008, " Left Subcapital Fracture. "</p> <p>A face-to-face interview was conducted with Employee #10 on October 2, 2008 at approximately 2:00 PM. He/she acknowledged that the night shift nurse failed to inform the day shift nurse and the physician of the resident ' s continued complaint of left hip pain. The record was reviewed October 2, 2008.</p>	F 157		
{F 221} SS=D	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and resident interviews and record review for one (1) of 15 sampled residents, it was determined that facility</p>	{F 221}		

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{F 221}	<p>Continued From page 3</p> <p>staff failed to perform an initial Interdisciplinary Team (IDT) assessment prior to use of seatbelt for Resident #10.</p> <p>The findings include:</p> <p>Resident #10 was observed on October 1, 2008 at approximately 12:00 PM wearing a seat belt.</p> <p>An interview was conducted with the resident and Employees #6 and #7 on October 1, 2008 at approximately 1:25 PM. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head, both employees also responded: "The seatbelt is for safety purposes, [he/she] has always had the seatbelt when [he/she] is up in the wheelchair. [He/she] will fall without the seatbelt."</p> <p>A review of the physician's 60 day orders, dated and signed August 26, 2008, revealed that there was no physician's order for a seatbelt.</p> <p>A review of the resident's record lacked evidence that the resident received initial physical and/or occupation therapist assessments and a recommendation for a seat belt.</p> <p>A review of the resident's record lacked evidence that the resident received an initial IDT assessment prior to the use of a seat belt.</p> <p>A face-to-face interview was conducted on October 2, 2008, at approximately 9:25 AM with Employee #3. He/she acknowledged that an initial IDT assessment was not performed prior to the use of a seatbelt. He/she also acknowledged that the resident's record lacked a physician's order and physical and/or occupational therapist</p>	{F 221}	<p>F221</p> <ol style="list-style-type: none"> Unit Manager removed resident #10 from the wheelchair on the day of survey and placed her in a wheelchair without a seatbelt. An order was obtained for an OT/PT screen for safety needs when out of bed in wheelchair on 10/01/08. Staff involved were educated on 10/01/08 on facility restraint protocol use. Residents identified with restrictive devices were reviewed for appropriate assessment, care plans and orders. Corrections were made as needed. Staff were re-educated on facility restraint program by Educator A random audit of the medical records of residents observed with restrictive devices will be reviewed monthly and report provided to the CQI Committee of problems identified and corrective actions implemented. 	<p>10/29/08</p> <p>Monthly 3rd Thurs. On-going</p>	

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{F 221}	Continued From page 4 assessments prior to the initiation of the use of a seatbelt. The record was reviewed on October 2, 2008.	{F 221}	F 253		
{F 253} SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by marred/scarred entry doors, chairs and sofas. The environmental tour was conducted on October 1, 2008 from 9:20 AM through 10:08 AM in the presence of Employees #1 and 2. The findings were acknowledged at the time of the observations. The findings include: 1. The entry doors to the first floor day room were observed marred and scarred in two (2) of two (2) entry doors observed. 2. Arm chairs and sofas were observed marred/scarred as follows: A. Arm chairs and sofas in the first floor day room in nine (9) of nine (9) arm chairs observed and three (3) of three (3) sofas observed. B. Arm chairs in the second floor day room in four (4) of four (4) arm chairs observed. C. Arm chairs and sofas in the third floor day	{F 253}	#1 & #2 1. (1) The bottom half of the entry doors to the dayroom on the first floor have been covered with a stainless steel kick plate. (2) Sofas and chairs were assessed. Those that were salvageable were cleaned and the wooden parts painted. Others were discarded. 2. Environmental rounds were conducted to ensure walls, furniture and floors were in good repair. Furniture that was salvageable was repaired, walls painted. Replacement furniture ordered. 3. Environmental rounds will be conducted weekly by the representatives from Environment Services, Nursing, Maintenance and the CQI Coordinator. 4. Findings/Results of the Environmental Rounds will be reported in quarterly CQI.	10/28/08 10/26/08 11/30/08 On-going On-going Monthly 3rd Thurs. On-going	

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<p>{F 253}</p> <p>{F 279} SS=D</p>	<p>Continued From page 5</p> <p>room in six (6) of six (6) arm chairs observed and two (2) of two (2) sofas observed.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff and resident interviews for two (2) of 15 sampled residents, it was determined that facility staff failed to initiate a care plan for one (1) resident with impaired skin integrity, and one (1) for the use of a seatbelt. Residents #8 and 10.</p> <p>The findings include:</p> <p>1. Facility staff failed to initiate a care plan for</p>	<p>{F 253}</p> <p>{F 279}</p>		

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{F 279}	<p>Continued From page 6</p> <p>Resident #6's impaired skin.</p> <p>A review of Resident #6's record revealed the following nurses' notes:</p> <p>September 15, 2008 at 3:45 PM: "...Observed an area on the resident's (Lt) buttock like blisters ..."</p> <p>September 23, 2008 at 4:00 PM: "CNA reported seeing red spots throughout resident's body, legs and stomach. The nurse went into the resident's room to assess but the resident refused..."</p> <p>A review of the resident's record lacked evidence that facility staff initiated a care plan with appropriate goals and approaches to address the the resident's impaired skin.</p> <p>A face-to-face interview with Employee #3 was conducted on October 2, 2008 at 8:50 AM. He/she acknowledged that he/she failed to initiate a care plan with appropriate goals and approaches for the above cited impaired skin conditions. The record was reviewed October 2, 2008.</p> <p>2. Facility staff failed to initiate a care plan for Resident #10 for the use of a seatbelt.</p> <p>Resident #10 was observed on October 1, 2008 at approximately 12:00 PM in the day room on the first floor, seated in a wheelchair and wearing a seat belt.</p> <p>A face-to-face interview was conducted with Employees #6, #7 and the resident on October 1, 2008, at approximately 1:25 PM. Employees #6, #7 and the resident were asked if the resident was able to release the seat belt. The resident</p>	{F 279}	<p>F279</p> <p>#1.</p> <ol style="list-style-type: none"> 1. Unit Manager initiated an impaired skin integrity care plan on Resident #6. 2. Other residents identified with potential for impaired skin integrity were reviewed and care plan was initiated and as indicated. 3. Unit Managers and charge nurses were in-serviced on the CBL Skin Integrity Program by DON. <p>Staff was in-serviced on reporting change in skin condition by Educator.</p> <ol style="list-style-type: none"> 4. A documentation audit will be completed monthly by the Unit Managers of residents with impaired skin integrity and report provided to the CQI Committee of problems identified and corrective actions implemented. 	<p>10/02/08</p> <p>10/24/08</p> <p>10/28/08 On-going</p> <p>Monthly 3rd Thurs.</p>	

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{F 279}	Continued From page 7 tugged at the seat belt, shook his/her head and stated, "No." Employees #6 and #7 added, "The seatbelt is for the resident's safety." The resident's record lacked evidence that a care plan was initiated for the use of a seatbelt. A face-to-face interview was conducted with Employee #3 on October 2, 2008 at approximately 10:50 AM. He/she acknowledged that the resident's record lacked evidence that a care plan was initiated for the use of a seatbelt for Resident #10. The record was reviewed October 2, 2008.	{F 279}	F 279 #2. 1. Unit Manager removed Resident #10 from the wheelchair on the day of survey and placed her in a wheelchair without a seatbelt. Request for OT/PT to screen resident #10 for safety needs when out of bed in wheelchair. Resident #10 was placed on OT/PT caseload.	10/02/08
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	{F 280}	2. Other residents identified with restraints records were reviewed for appropriate documentation and corrected as indicated. 3. Staff will be in-serviced by Educator on Restraint Assessment Protocol. 4. A random audit will be completed monthly by the unit managers of residents observed with restraints, a report will be provided to the CQI Committee of problems identified and corrective actions implemented.	10/29/08 Monthly 3 rd Thurs.

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{F 280}	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to updated care plans with additional goals and approaches for three (3) residents with multiple falls. Residents #3, 7 and 9.</p> <p>This is a repeat deficiency from the annual recertification survey completed July 25, 2008.</p> <p>The findings include:</p> <p>1. Facility staff failed to update Resident #3's care plan for multiple falls.</p> <p>A review of Resident #3's record revealed the following nurses' notes:</p> <p>September 14, 2008 at 12:30 PM: "Called to unit to assess resident who was found sitting on floor in bathroom ...Range of motion to all extremities within normal limits, no bruises or lacerations noted ..."</p> <p>September 25, 2008 at 11:00 AM: "Resident was observed sitting on the floor ...no redness, no swelling observed ...c/o left hip pain ...bilateral hip x-rays ordered..."</p> <p>September 26, 2008 at 11:00 AM: "...X-ray results came back negative ..."</p> <p>A review of the resident's care plan entitled, "Fall Prevention Care Plan" revealed that the two (2) above cited falls were recorded under the "Evaluation" column. There was no evidence that additional goals and approaches were initiated for</p>	{F 280}		

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{F 280}	<p>Continued From page 9 fall prevention.</p> <p>A face-to-face interview with Employee #8 was conducted on October 1, 2008 at 12:30 PM. He/she acknowledged that additional goals and approaches were not initiated for fall prevention after the above cited two (2) falls. The record was reviewed October 1, 2008.</p> <p>2. Facility staff failed to update Resident #7's care plan for multiple falls.</p> <p>A review of Resident #7's record revealed the following nurses' notes:</p> <p>September 11, 2008 at 2:30 PM: "Resident observed sitting on the floor in dayroom in front of his/her w/c [wheelchair] ...No swelling or bleeding resident denies any pain or discomfort. ROM [range of motion] WNL [within normal limits] ... "</p> <p>September 28, 2008 at 10:00 PM: "Called to the day room to observe the resident sitting on the floor in a sitting position. ROM WNL ... "</p> <p>A review of the resident's care plan entitled, "Fall Prevention Care Plan" revealed that the fall of September 11, 2008 was recorded under the "Evaluation" column. However, there was no evidence that additional goals and approaches were initiated for fall prevention.</p> <p>The record lacked evidence that the fall incident of September 28, 2008 was evaluated.</p> <p>There was no evidence that facility staff updated the care plan with additional goals and approaches for fall prevention for either fall.</p>	{F 280}	<p>F 280</p> <p>#1, #2 & #3</p> <ol style="list-style-type: none"> 1. Unit Manager updated the Fall Prevention care plan with new approaches and goals for Resident #3 on 10/24/08, Resident #7 on 09/20/08 and Resident #9 on 10/02/08. 2. Residents identified that have sustained a fall were reviewed and care plans updated with new approaches and goals as indicated. 3. Unit Managers in-serviced by the Educator on Updating Fall Prevention Care Plans with new approaches and goals. 4. Charts of resident with falls will be audited monthly by the Unit Managers, MDS Coordinator and DON for appropriate documentation. A report of findings and corrective actions will be reported to the CQI Committee. 	<p>10/02/08</p> <p>10/28/08 On-going</p> <p>Monthly 3rd Thurs.</p>

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

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{F 280}	<p>Continued From page 10</p> <p>A face-to-face interview with Employee #3 was conducted on October 2, 2008 at 9:10 AM. He/she acknowledged that additional new goals and approaches were not initiated for fall prevention after the above cited two (2) falls. The record was reviewed October 2, 2008.</p> <p>3. Facility staff failed to update Resident #9's care plan for multiple falls.</p> <p>A review of Resident #9's record revealed the following nurses' notes:</p> <p>September 22, 2008 at 9:00 PM: "Resident was observed on the floor sitting by [his/her] bedside in [his/her] room ...Neuro check initiated, WNL. ROM to all extremities WNL. Denies pain or discomfort ..."</p> <p>October 1, 2008 at 9:50 AM: "Writer called to Resident's room. Resident was lying on the FI [Floor] mat unable to say what happened. Writer assisted [with/] physical [assessment] c/o [complaint of] discomfort to LT [Left] hip. Limited ROM ...Resident transported via 911..."</p> <p>October 1, 2008 at 8:00 PM: "Resident returned to facility at 3:55 PM S/P [Status Post] fall ..."</p> <p>A review of the resident's care plan entitled, "Fall Prevention Care Plan" lacked evidence that the above cited falls were evaluated. Facility staff failed to initiate additional goals and approaches for fall prevention.</p> <p>A face-to-face interview with Employee #3 was conducted on October 2, 2008 at 9:30 AM. He/she acknowledged that additional goals and</p>	{F 280}		

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{F 280}	Continued From page 11 approaches were not initiated for fall prevention after the above cited fall. The record was reviewed October 2, 2008.	{F 280}		
{F 286} SS=E	<p>483.20(d) RESIDENT ASSESSMENT - USE</p> <p>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 15 sampled residents and 11 of 14 supplemental residents, it was determined that facility staff failed to follow the plan of correction from the annual recertification survey completed July 25, 2008 to place the Minimum Data Set (MDS) assessments on resident records in a timely manner. Residents #4, 10, 15, S1, S2, S3, S4, S5, S6, S7, S8, S9, S10, and S11.</p> <p>The findings include:</p> <p>According to the plan of correction for the annual recertification survey completed July 25, 2008, "3. Administrator met with Director of Nursing in regards to placing MDSs on charts in a timely manner."</p> <p>A list of residents with recently completed MDS assessments was compiled by Employee #5. 30 residents were listed.</p> <p>The following 14 residents identified by facility staff with recently completed MDS assessments were not on the residents' records but had transmitted to the State data base as follows:</p>	{F 286}		

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{F 309}	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for three (3) of 15 sampled residents, one (1) of 14 supplemental residents, and two (2) of five (5) residents observed during medication pass, it was determined that facility staff failed to follow up on one (1) resident's continued complaint of left hip pain after medication was administered, on psychiatric and ophthalmology consults for one (1) resident, follow physician's orders for padding a splint for one (1) resident, obtain physician's order for the use of seatbelt for one (1) resident and follow physician's orders for a nutritional supplement for two(2) residents. Residents F2, 1, 8, 10, S4 and JH2. The findings include: 1. Facility staff failed to follow up on Resident F2's continued complaint of left hip pain after medication was administered. The findings include: A review of Resident F2's record revealed no night shift (11:00 PM through 7:30 AM) nursing note regarding the status of the resident for the night of September 19 into September 20, 2008. According to a late entry night shift nurse's note for September 20, 2008 at 7:00 AM, dated September 20, 2008 at 5:00 PM; " CNA told writer that resident c/o [complained of] pain when turning resident for care. On assessment resident c/o pain when moving L [left] leg.	{F 309}	F 309 #1 1. Day shift Charge Nurse called resident #F2 Physician on 09/20/08 and informed him of resident's change in condition. Staff member was educated on resident assessment and change in condition, Physician notification, accurate documentation and pain management. 2. Other residents identified with a change in condition records were reviewed for notification of a change in condition and notification was made as indicated. 3. Licensed staff was re-educated on resident assessment, change in condition, physician notification, accurate documentation and pain management by the Educator. Licensed staff was re-educated on a concurrent review sheet. 4. Orders written and reviewed daily in the clinical trace methodology meeting. Problems identified and correction action implemented will be reported to the CQI Committee monthly.	10/28/08 Monthly 3 rd Thurs.

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{F 309}	<p>Continued From page 14</p> <p>Resident was grimacing. Pain was rated 6 on scale of 0-10 (where 0 is no pain and 10 the worst she can experience.) ...No visible injury note on bilateral legs-two tabs of Tylenol 650 mg po (oral) were given @ 7:05 AM - L hip was warm to touch. Reevaluation pain at 7:45 AM, resident had some relief. Pain rated at that time 7:45 AM at 3 on the same scale 0 to 10. Will continue to monitor. "</p> <p>There was no evidence in the record that the night shift nurse initiated a further assessment regarding the resident's left hip. Additionally, the night shift nurse failed to inform the day shift nurse (7:00 AM through 3:30 PM) and the physician of Resident F2's continued complaint of left hip pain.</p> <p>According to a nurse's note dated September 20, 2008 at 9:20 AM, "It was brought to my attention per CNA assigned on nights that resident has pain when turning. The writer assessed resident 's hip and noted swelling and hot to touch ...PMD (private medical doctor) called and responded. Orders given for x-rays of both hips. Tylenol 325 mg tabs 2, given for elevated temperature and comfort. "</p> <p>According to the "X-ray Examination Report" dated September 20, 2008, "Left Subcapital Fracture."</p> <p>A face-to-face interview was conducted with Employee #10 on October 2, 2008 at approximately 2:00 PM. He/she acknowledged that the night shift nurse failed to initiate a further assessment of the resident's left hip and failed to inform the day shift nurse and the physician of the resident's status. The record was reviewed October 2, 2008.</p>	{F 309}		

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{F 309}	<p>Continued From page 15</p> <p>2. Facility staff failed to follow-up on psychiatric and ophthalmology consults for Resident #1.</p> <p>A. Review of Resident #1's record revealed the following nurse's note: September 12, 2008, [no time indicated]: "Resident was observed by CNA inappropriately touching another resident while sitting in dining room eating breakfast. Resident removed from area ..."</p> <p>A review of Resident #1's record revealed the following physician's order dated September 12, 2008 at 3:30 PM: "Psyc consult for behavior."</p> <p>There was no evidence in the record that Resident #1 had been seen by the psychiatrist since September 12, 2008, date of the above cited order.</p> <p>A face-to-face interview was conducted with Employee #12 on October 1, 2008 at 10:45 AM. He/she stated that the resident had not been scheduled for an appointment with the psychiatrist.</p> <p>B. A pharmacy "Consultation Report" dated September 17, 2008, commented, "[Resident #1] currently received duplicate therapy of Lumigan and Travatan. Recommendation: Please re-evaluate the need for both agents ..."</p> <p>Under "Physician's Response: I decline the recommendation ...Refer to Ophthalmology" and was dated September 27, 2008.</p> <p>There was no evidence in the record that the resident had seen the ophthalmologist since</p>	{F 309}	<p>F 309</p> <p>#2 A&B</p> <p>1. Psychiatrist was called on 10/02/08 by Unit secretary for psychiatric consult evaluation for resident #1 and completed on 10/07/08. Resident #1 ophthalmology appointment was made for 10/24/08 and seen on 10/29/08.</p> <p>2. Other residents identified to have orders for consults charts were reviewed and appointments scheduled as needed.</p> <p>3. Charge nurses and unit secretaries were re-educated on 10/28/08 by DON on the importance of scheduling and follow-up on appointments for residents.</p> <p>4. Orders written for the past 24 hours are reviewed daily via the clinical trace methodology meeting. Problems identified and corrective actions implemented will be reported to the CQI committee monthly.</p>	<p>10/07/08</p> <p>10/28/08</p> <p>Monthly 3rd Thurs.</p>

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{F 309}	<p>Continued From page 16 September 27, 2008.</p> <p>A face-to-face interview was conducted with Employee #12 on October 1, 2008 at 10:45 AM. He/she stated that the resident had not been scheduled for an appointment with the ophthalmologist at the time of this review. The record was reviewed October 1, 2008.</p> <p>3. Facility staff failed to follow the physician's order to use ABD (abdominal) pad between Resident #8's skin and the immobilizer.</p> <p>A review of Resident #8's record reveal an interim physician's order that directed: "ABD pad between Immobilizer to relieve Pressure, change q [every] day. Monitor heels ..."</p> <p>Resident #8 was observed in bed on October 2, 2008 at approximately 11:45 AM in the presence of Employee #11. The lower extremity the (right leg) lacked an ABD pad between the immobilizer and the resident's skin.</p> <p>Employee #11 acknowledged that facility staff failed to follow the physician's order to use ABD pad between the immobilizer and the resident's skin. The record was reviewed on October 2, 2008.</p> <p>4. Facility staff failed to obtain a physician's order for the use of a restraint (seatbelt) for Resident #10.</p> <p>Resident #10 was observed on October 1, 2008 at approximately 12:00 AM in the day room on the first floor, seated in a wheelchair and wearing a padded seat belt.</p>	{F 309}	<p>F309 #3</p> <ol style="list-style-type: none"> 1. Charge nurse placed a ABD pad as ordered between resident #8 right leg immobilizer and skin on 10/02/08 during the day of survey. 2. Residents identified to have orthotic devices were evaluated and corrective actions implemented as needed. 3. Charge nurses was re-educated by the Educator on the facility skin care program and following the physician's orders. 4. Orders written for the past 24 hours are reviewed daily via the clinical trace methodology meeting. Problems identified and corrective actions implemented will be reported to the CQI committee monthly. 	<p>10/27/08 Monthly 3rd Thurs.</p>

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{F 309}	<p>Continued From page 17</p> <p>A face-to-face interview was conducted with Employees #6, #7 and resident on October 1, 2008, at approximately 1:25 PM: Employees #6, #7 and the resident were asked if the resident was able to release the seat belt. The resident tugged at the seat belt, shook his/her head and stated, "No." Employees #6 and 7 added, "The seatbelt is for the resident's safety."</p> <p>There was no evidence of a physician's order for the use of a seatbelt in the resident's record.</p> <p>A face-to-face interview was conducted on October 2, 2008 at approximately 9:25 AM with Employees #3. He/she acknowledged that the resident's record lacked evidence of the physician's order for the use of the seat belt. The record was reviewed on October 2, 2008.</p> <p>5. Facility staff failed to administer a nutritional supplement as per physician's orders for Resident S4 during medication pass.</p> <p>Physician's orders, signed September 30, 2008, directed, "Prosource two [2] scoops by mouth twice daily for low albumin" for Resident S4.</p> <p>The label on the Prosource container indicated that [1] scoop was equal to 7.5 g [½ Tablespoon] of Prosource powder.</p> <p>On October 1, 2008, at approximately 10:30 AM, during the morning medication pass, Employee #11 poured two (2) Tablespoonfuls of Prosource into a medication cup. He/she repeated this process giving a total of four (4) Tablespoonfuls of the nutritional supplement to the resident to Resident S4. The resident received 60 g of Prosource powder. 15g was ordered by the</p>	{F 309}	<p>F-309</p> <p>#4</p> <ol style="list-style-type: none"> 1. Unit Manager removed Resident #10 from the wheelchair on the day of survey and placed her in a wheelchair without a seatbelt. Resident was screened by OT/PT for safety needs when out of bed in wheelchair and was evaluated for the least restrictive device. 2. Other residents identified with restraints records were reviewed for appropriate documentation and corrected as indicated. 3. Staff will be re-educated by the Educator on Restraint Assessment Protocol. 4. A Random audit will be completed monthly by the unit managers of residents observed with restrictive devices. A report will be provided to the CQI Committee of problems identified and corrective actions implemented. 	<p>10/01/08</p> <p>10/29/08</p> <p>On-going</p> <p>Monthly 3rd Thurs.</p>

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{F 309}	<p>Continued From page 18 physician in the above cited order.</p> <p>According to the facility's reference book, "Pharmacology in Nursing 8th Edition, Metric Dosage and Apothecary Equivalence Chart" on the front cover of book, lists that 7.5 g is equivalent to ½ Teaspoon.</p> <p>A face-to-face interview was conducted on October 1, 2008, at approximately 3:00 PM with Employee #1. He/she stated, "I gave one ounce for 1 scoop." The record was reviewed on October 1, 2008.</p> <p>A face-to-face interview was conducted with Employee #10. He/she acknowledged the facility's conversion chart revealed that 7.5 g is equivalent to ½ Teaspoon and too much Prosource was given. The record was reviewed October 1, 2008.</p> <p>6. Facility staff failed to administer a nutritional supplement as per physician's orders for Resident JH2 during medication pass.</p> <p>Physician's orders signed September 31, 2008 directed, "Prosource two [2] scoops by mouth twice daily secondary to low albumin" for Resident JH2.</p> <p>On October 1, 2008 at approximately 11:00 AM during the morning medication pass, Employee #9 used a tongue depressor to measure one (1) scoop of the nutritional supplement for Resident JH2.</p> <p>A face-to-face interview was conducted on October 1, 2008 at approximately 11:15 AM with Employee #9. He/she stated that one (1) heap of</p>	{F 309}	<p>F309</p> <p>#5 & #6</p> <ol style="list-style-type: none"> 1. Charge nurse called resident #S4 and #JH2 physician on 10/5/08 and made him aware of the medication error with Pro-source and that no adverse reaction occurred to the resident. 2. Records of other residents identified on Pro-source were reviewed and orders were obtained and changed to pre-mixed liquid Pro-source. 3. Charge nurses were re-educated on following the physician's orders and usage of pre-mixed liquid Pro-source by the Educator. 4. Random medication pass observation by the Educator, DON and Unit Manager will be conducted monthly and findings will be reported to the CQI Committee. 	<p>10/27/08</p> <p>Monthly 3rd Thurs. On-going</p>	

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{F 309}	Continued From page 19 powder on the tongue depressor was equivalent to one (1) scoop of Prosource. There was no way to determine how much Prosource was given to the resident. According to the facilities reference book, "Pharmacology in Nursing 8th Edition, Metric Dosage and Apothecary Equivalence Chart" on the front cover of book, lists that 7.5 g is equivalent to ½ Tablespoon. A face-to-face interview was conducted with Employee #10. He/she acknowledged the facility's conversion chart revealed that 7.5 g is equivalent to ½ Tablespoon. The record was reviewed on October 1, 2008.	{F 309}		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for two (2) of 15 sampled residents, it was determined that facility staff failed to ensure that residents who enter the facility without pressure sores did not develop pressure sores for Residents F1 and #8. The findings include:	F 314		

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F 314	<p>Continued From page 20</p> <p>1. Facility staff failed to prevent Resident F1 from developing pressure sores to bilateral heels.</p> <p>On October 1, 2008 at approximately 10:30 AM, Resident F1 was observed with eschar to bilateral heels. An immobilizer was applied to the right leg in accordance with the physician's order dated August 11, 2008 subsequent to a fracture of unknown origin to the right distal femoral metaphysis identified on August 6, 2008.</p> <p>A review of the annual MDS completed September 23, 2008, Resident F1 had short and long term memory loss and was moderately impaired in making decisions in Section B. He/she was coded as totally dependent and required one (1) person physical assist in bed mobility, transferring, dressing, eating, toilet use and personal hygiene in Section G1 and was coded for limitation on both sides partial loss to leg and foot in Section G4; Section M1 was coded as two (2) stage 4 pressure ulcers.</p> <p>The Physician's Order Form signed September 3, 2008 directed, "Immobilizer to R [right] knee with splint at all times"; "ABD (abdominal) pad under Rt [right] heel at all times [initiated August 15, 2008]."</p> <p>The Braden Pressure Ulcer Risk Assessment completed June 23, 2008 and September 16, 2008 scores were "12", indicating that Resident F1 was at high risk for pressure ulcers.</p> <p>According to a nurse's note dated September 24, 2008 9:50 AM, "Resident observed to have necrotic area on rt (right) heel with opening at edge. Very small amount of drainage noted.</p>	F 314	<p>F314</p> <p>#1 & #2</p> <ol style="list-style-type: none"> 1. Physician's orders were clarified to include skin assessment for residents # 8 and #F1. 2. Residents identified to have orthotic devices were evaluated and corrective actions implemented as needed. 3. Charge nurses were re-educated by the Educator on the facility's skin care program and following the physician's orders. 4. Orders written for the past 24 hours are reviewed daily via the clinical trace methodology meeting. Problems identified and corrective actions implemented will be reported to the CQI Committee monthly. 	<p>10/27/08</p> <p>Monthly 3rd Thurs.</p>	

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F 314	<p>Continued From page 21</p> <p>Other areas were assessed with no openings noted ... knee immobilizer in place ... "</p> <p>A review of the physician's progress notes revealed the following:</p> <p>"August 22, 2008 F/u [follow up] fx [fracture] femur distal, no heel pad in place ... "</p> <p>" September 1, 2008 Ortho-immobilizer in place ... no heel blisters ... "</p> <p>" September 11, 2008 Ortho F/u fx femur, heel pad off. However, no blister ... "</p> <p>" September 24, 2008 Ortho Flu Fx Femur, Immobilizer adjusted, was pulled up into place. Heel breakdown of skin is present on both sides- greater on Rt side may need debridement. Suggest wound nurse follow up. "</p> <p>" September 24, 2008 at 3:00 PM NP [nurse practitioner] Asked to eval Resident heels; #1 Right heel 5 x 5.5 cm, unstagable ulcer collapsed blister. Pressure related 99% avascular (eschar black) tissue and open lesion at edge (1%) - 100% pink granulation with scant exudate. #2 Left heel intact [unable to read] 1.4 cm x 2.5 cm, unstagable pressure related ulcer collapsed blister. No exudate 100% avascular tissue ..."</p> <p>The "Wound Report" dated September 24, 2008 revealed, "Site- rt [right] heel; Measurement- 8 x 8 cm opening 2 cm edge of ulcer, description- dark black hard necrotic pink in color on edge."</p> <p>The care plan entitled, "Splint Use/Prosthesis" initiated August 11, 2008 revealed the following: Approaches/Interventions ... 3. Check skin beneath and adjacent to splint for pressure or</p>	F 314		
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F 314	<p>Continued From page 22</p> <p>iritation every day ... 7. Check Injured extremity for swelling, capillary reflex and discoloration Q [every] 2 hours and as needed. Document changes and call physician ..."</p> <p>Evaluation ...September 19, 2008 Staff continue to apply ABD pad to decrease pressure to rt heel. "</p> <p>According to the September 2008 Treatment Administration Record (TAR), the order for the immobilizer- right knee with splint at all times and the ABD pad under right heel at all times, was initialed/signed every shift, indicating that the immobilizer and the ABD pad were in place.</p> <p>The record lacked evidence that facility staff assessed the skin beneath and adjacent to the splint prior to observing and assessing Resident F1's bilateral heels with eschar on September 24, 2008.</p> <p>Additionally, the annual MDS completed on September 23, 2008 coded Resident F1 to have to two (2) Stage 4 pressure ulcers that were identified during September 12 through 19, 2008 (assessment reference date September 19, 2008). However, the nursing and physician progress notes, wound report, physician orders and the " Resident at Risk for Pressure Ulcers " care plan reflected an identification date of September 24, 2008.</p> <p>There was no evidence in the record that facility staff initiated care of the bilateral heel pressure ulcers when the pressure ulcers were identified on September 19, 2008.</p> <p>A face-to-face interview was conducted on October 1, 2008 with Employees #3 and 4. They</p>	F 314		

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F 314	<p>Continued From page 23</p> <p>acknowledged that the bilateral heel ulcers for Resident F1 were first observed with eschar on September 24, 2008. The record was reviewed on October 1, 2008.</p> <p>2. Facility staff failed to prevent Resident #8 from developing a pressure sore to the left heel.</p> <p>According to the quarterly Minimum Data Set [MDS] completed July 9, 2008, Resident #8 had short and long term memory loss and was moderately impaired in making decisions (Section B - Cognitive Patterns). He/she was coded as independent in most of his/her activities of daily living and required limited assistance with dressing, toilet use and personal hygiene (Section G1 -Physical Functioning and Structural Problems). The resident was coded for no pressure sores in Section M - Skin Condition.</p> <p>According to a nurse's note dated September 16, 2008 at 6:00 AM, "...Observed an open skin area on LT [left] heel...on assessment (LT) heel has intact with red outer edge and dark center measuring (3cm x 4cm x 0cm) and reddened area measuring (1cm x 1cm x 0cm)."</p> <p>According to the nurse practitioner's note dated September 26, at 1:30 PM, "Wound assessment :...(L) heel stage IV 10% black Eschar and edge 90% granulation. 1.5 cm x 1.5 cm....Add santyl dsg for (L) heel ulcer obs. Observe for (R) heel..."</p> <p>A physician's order form dated September 16, 2008 at 2:00 PM directed, " T.O...Cleanse (L) left heel [with] NS [Normal Saline]. Pat dry and apply curafil gel qd [daily] & reassess x 14 days..."</p> <p>A physician's order dated September 26, 2008 at</p>	F 314		

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F 314	Continued From page 24 1:30 PM directed, "(L) heel wound - cleanse with NSS pat dry then apply santyl ointment with dry dsq [dressing] QD & PRN [daily and as needed] x 14 days then evaluate..." A face-to-face interview was conducted on October 2, 2008 with Employee #3. He/she acknowledged that the left heel ulcer for Resident #8 was first observed with eschar. The record was reviewed on October 2, 2008.	F 314			
F 323 SS=D	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 record review and staff interview for three (3) of 15 sampled residents, it was determined that adequate supervision was not provided for residents with multiple falls. Residents #3, #7 and #9. The findings include: 1. Facility staff failed to provide adequate supervision for Resident #3 to prevent multiple falls. A review of Resident #3's record revealed the following nurses' notes: September 14, 2008 at 12:30 PM: "Called to unit to assess resident who was found sitting on floor	F 323			

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F 323	<p>Continued From page 25</p> <p>in bathroom ...Range of motion to all extremities within normal limits, no bruises or lacerations noted ..."</p> <p>September 25, 2008 at 11:00 AM: "Resident was observed sitting on the floor ...no redness, no swelling observed ...c/o left hip pain ...bilateral hip x-rays ordered.."</p> <p>A review of the resident's care plan entitled, "Fall Prevention Care Plan" revealed that the two (2) above cited falls were recorded under the "Evaluation" column. However, there was no evidence that additional goals and approaches were initiated for fall prevention.</p> <p>A face-to-face interview with Employee #8 was conducted on October 1, 2008 at 12:30 PM. He/she acknowledged that Resident #1 lacked adequate supervision to prevent falls. The record was reviewed October 1, 2008.</p> <p>2. Facility staff failed to provide adequate supervision for Resident #7 to prevent multiple falls.</p> <p>A review of Resident #7's record revealed the following nurses' notes:</p> <p>September 11, 2008 at 2:30 PM: "Resident observed sitting on the floor in dayroom in front of his/her w/c [wheelchair] ...No swelling or bleeding resident denies any pain or discomfort. ROM WNL ..."</p> <p>September 28, 2008 at 10:00 PM: "Called to the day room to observe the resident sitting on the floor in a sitting position. ROM WNL ..."</p>	F 323	<p>F 323</p> <p>#1, #2 & #3</p> <ol style="list-style-type: none"> 1. Resident #3, #7 & #9 were assessed for injury at the time of the fall and care provided as needed. 2. A review of records have been conducted of residents that have fallen in the past 30 days and appropriate interventions and approaches implemented as needed. 3. Staff have been re-educated on resident supervision and fall assessment. 4. A review of falls will be conducted monthly and a report provided to the CQI Committee of problems identified and corrective actions implemented. 	<p>10/30/08</p> <p>Monthly 3rd Thurs.</p>
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F 323	<p>Continued From page 26</p> <p>A review of the resident's care plan entitled, "Fall Prevention Care Plan" revealed that only one (1) of the above cited falls was recorded under the "Evaluation" column. However, there was no evidence that additional goals and approaches were initiated for fall prevention. The record lacked evidence that the fall incident of September 28, 2008 was evaluated. Facility staff failed to initiate additional goals and approaches for fall prevention.</p> <p>A face-to-face interview with Employee #3 was conducted on October 2, 2008 at 9:10 AM. He/she acknowledged that facility staff failed to provide adequate supervision for Resident #7 to prevent multiple falls. He/she acknowledged that Resident #7 lacked adequate supervision to prevent falls. The record was reviewed October 2, 2008.</p> <p>3. Facility staff failed to provide adequate supervision for Resident #9 to prevent multiple falls.</p> <p>A review of Resident #9's record revealed the following nurses' notes:</p> <p>September 22, 2008 at 9:00 PM: "Resident was observed on the floor sitting by [his/her] bedside in [his/her] room ...Neuro check initiated, WNL [Within normal limits]. ROM [Range of Motion] to all extremities WNL. Denies pain or discomfort ... "</p> <p>October 1, 2008 at 9:50 AM: "Writer called to Resident's room. Resident was lying on the Fl [Floor] mat unable to say what happened. Writer assisted [with] physical [assessment] c/o [complaint of] discomfort to LT [Left] hip. Limited</p>	F 323			

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F 323	Continued From page 27 ROM ...Resident transported via 911 ..." October 1, 2008 at 8:00-PM: "Resident returned to facility at 3:55 PM S/P [Status Post] fall ... " A review of the resident's care plan entitled, "Fall Prevention Care Plan" lacked evidence that the above cited falls were evaluated. Facility staff failed to initiate additional goals and approaches for fall prevention. A face-to-face interview with Employee #3 was conducted on October 2, 2008 at 9:10 AM. He/she acknowledged that facility staff failed to provide adequate supervision for Resident #9 to prevent multiple falls. He/she acknowledged Resident #9 lacked adequate supervision to prevent falls. The record was reviewed October 2, 2008.	F 323			
{F 469} SS=E	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that the facility failed to maintain a pest free environment. These observations were made in the presence of Employees #1 and 2. The findings include: Flying insects were observed in the following	{F 469}			

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{F 469}	<p>Continued From page 28 areas:</p> <p>1st Floor: October 1, 2008 at 9:21 AM hallway across from the nurse's station. October 1, 2008 at 11:05 AM near room 145. October 1, 2008 at 2:40 PM hallway near the medication room.</p> <p>2nd Floor: October 1, 2008 at 9:47 AM in the dining room. October 1, 2008 at 10:20 AM at the nurse's station.</p> <p>3rd Floor: October 1, 2008 at 9:15 AM near room 328. October 1, 2008 at 10:15 AM near room 315.</p> <p>This is a repeat deficiency from the recertification surveys completed December 6, 2007 and July 25, 2008.</p> <p>These findings were acknowledged at the time of the observations by Employees #1 and 2.</p>	{F 469}	<p>F 469</p> <ol style="list-style-type: none"> The areas identified on survey were cleaned and trash cans were disinfected. Environmental rounds were conducted in other areas and were treated as indicated. A new Pest Control contract will be implemented. The Environmental Services Director and the Maintenance Director will conduct weekly rounds to ensure that the environment is in compliance. Monthly Environmental rounds will be conducted by the infection control coordinator and the administrative team. Results/Findings of the rounds will be reported to the CQI Committee monthly of problems identified and corrective actions implemented. 	<p>11/30/08</p> <p>On-going</p> <p>Monthly 3rd Thurs.</p>
F 514 SS=D	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>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.</p> <p>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.</p>	F 514		

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F 514	<p>Continued From page 29</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff failed to maintain accurate and complete records as evidenced by: incomplete dialysis communication sheets for one (1) resident, lack of a pacemaker report for one (1) resident, lack of documentation of behavior management interventions for one (1) resident, and lack of documentation for one (1) resident with a left hip fracture. Residents #2, 5, and 11.</p> <p>The findings include:</p> <p>1. Facility staff failed to ensure that dialysis communication sheets were complete for Resident #2.</p> <p>A review of Resident #2's record revealed a physician's order dated September 5, 2008, directing, "Dialysis three times per week, Tue Thurs and Sat."</p> <p>A "Resident Dialysis Communication Sheet" accompanied the resident to each dialysis treatment. The top half of the sheet was consistently completed by the facility and described the resident's vital signs, weight, and assessment before dialysis.</p> <p>The bottom half of the sheet was entitled "Dialysis Center" and described the vital signs, weight and assessment of the resident during the dialysis treatment.</p> <p>The bottom half of the "Resident Dialysis Communication Sheet" was blank for treatments</p>	F 514	<p>F 514</p> <p>#1</p> <ol style="list-style-type: none"> 1. A new dialysis binder has been created for resident #2 for communicating with dialysis center. 2. A review has been completed on dialysis resident in the facility and a new binder created. 3. Staff will be re-educated to check residents and their binders upon return from dialysis for communication regarding treatment and care. 4. A review of this process will be conducted monthly and a report provided to the CQI Committee monthly of problems identified and corrective actions implemented. 	<p>10/29/08</p> <p>Monthly 3rd Thurs.</p>
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F 514	<p>Continued From page 30 that occurred on September 13, 16, 18, 23, 25, and 30, 2008.</p> <p>A face-to-face interview was conducted with Employee #8 on October 1, 2008 at 12:30 PM. He/she stated that the facility nurse should have called back to the dialysis center to obtain the missing information. The record was reviewed October 1, 2008.</p> <p>2. Facility staff failed to ensure that a pacemaker check report was on Resident #5's record.</p> <p>A review of Resident #5's record revealed the following nurse's note: September 15, 2008 at 4:00 PM: "Resident out to [hospital] for pacemaker check-up. Returned to unit at 3:30 PM. Report will be sent to facility ..."</p> <p>The pacemaker report was not present in the record at the time of this review.</p> <p>A face-to-face interview was conducted with Employee #12 on October 1, 2008 at 10:15 AM. He/she acknowledged that the pacemaker check report was not in the record and contacted the [hospital]. The pacemaker check report was immediately faxed from the [hospital] and documented that the pacemaker had normal function. The record was reviewed October 1, 2008.</p> <p>3. Facility staff failed to document the behavior management interventions for Resident #11 on his/her care plan.</p> <p>A review of the clinical record for Resident #11 revealed documentation in the "Inappropriate Behaviors Care Plan" dated September 11, 2008.</p>	F 514	<p>F 514</p> <p>#2</p> <ol style="list-style-type: none"> 1. Unit Manager obtained pacemaker check results for resident #5 and placed on chart. 2. A review has been completed of residents with pacemakers to assure that pacemaker check has been completed and the results are on the charts. 3. Staff will be educated on the process of pacemaker check. 4. Review of the pacemaker check process will be conducted monthly and a reported to the CQI Committee of problems identified and corrective actions implemented. 	<p>10/02/08</p> <p>10/29/08 On-going</p> <p>On-going</p> <p>Monthly 3rd Thurs.</p>	

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F 514	<p>Continued From page 31</p> <p>which stated "On 8/ 30/ 08 Res. [Resident] stabbed Security Guard with a fork in his neck in his room."</p> <p>A review of the physician's orders revealed a telephone order from the attending physician dated September 13, 2008 at 5:00 PM which stated "Get psych [Psychiatric] Consult ASAP [As soon as possible]."</p> <p>A review of a Report of Consultation from the psychiatrist revealed that the consultation was completed on September 23, 2008 and treatment was ordered.</p> <p>A review of the Interdisciplinary Care Plan failed to reveal documentation of the interventions that were carried out for the management of the resident's behavior.</p> <p>A face-to-face interview was conducted with Employee #5 at approximately 3:30 PM on October 1, 2008. He/she acknowledged that the interventions were not documented on the care plan. The record was reviewed on October 1, 2008.</p>	F 514	<p>F 514</p> <p>#3</p> <ol style="list-style-type: none"> Care plan was updated to reflect the appropriate intervention for Resident #11. Assessment has been completed on residents with behavior concerns to assure that the care plans are in compliance. Staff will be educated on the completion of the care plan process. A review will be completed monthly on behavior care plans and residents with behavior concerns and report findings monthly times three and in quarterly CQI. 	<p>10/02/08</p> <p>Monthly x 3 Quarterly</p>	