

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

Received
10/18/07
Pa
11/19/07

PRINTED: 10/05/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS An annual re-certification survey was conducted from September 24 through September 26, 2007. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 15 residents based on a census of 69 residents on the first day of survey and seven (7) supplemental residents.	F 000		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to ensure that Resident #5 could self-administer medications. The findings include: The facility's policy #2.2, " Self Administering Medications ", stipulate, "Each customer is given the opportunity to self-administer his/her medication if the interdisciplinary team, upon evaluation of a customer's ability to safely self-administer medications, has determined that this practice is safe." On September 24, 2007, at approximately 12:10 PM, the following medications were observed Resident #5's room: Afrin nasal spray	F 176	#1 F- Tag 176 (D) Self Administration of Drugs 1. <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> Resident #5 has been assessed for this ability to self administer his medication. Resident's care plan has been updated. 10/12/2007 2. <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> An independent audit was conducted on all residents to determine if there are any residents who wish to take their own medications and could be administered the self medication test. 10/12/2007 A check in all residents rooms to see if there are any medications that are at bedside without an order. 10/12/2007 	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/18/07</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM			STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015	
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F 176	Continued From page 1 Neo-Synephrine Nasal spray Nasal spray (generic brand) Immunity Support tablet Anti-itch cream (generic brand) Aspercreme tube Employee #6 stated that nursing staff administered medications to Resident #5. On September 26, 2007, at approximately 12:10 PM, the following medications were observed in Resident #5's room: Nyquil Sinus tablet Afrin Nasal spray Neo-Synephrine nasal spray Sinus Congestion & Severe Pain tablet On September at approximately 12:10 PM a face-to-face interview was conducted with Employee # 6 who stated, "The resident is non-compliant and she/he will call the physician regarding the resident's noncompliance."	F 176	3. <u>Measures put in place</u> <ul style="list-style-type: none"> Any resident who desires to give their own medications will be issued the pharmacy "Self- Administration Test" to assess their ability to self administer. 10/19/2007 All licensed staff will be educated on the Self-Administration Process 10/19/2007 4. <u>QA</u> <ul style="list-style-type: none"> All deficient practices will be monitored, discussed and reviewed during monthly QA meeting. 	<i>Review Requested</i> 11/09/2007
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility failed to consistently assess Resident #9 for restraint reduction. The findings include:	F 221	#2F Tag- 221 (d) Physical Restraints 1. <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> Resident #9 has been reassessed by therapy for sitting and falls. 2. <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> No other residents have restraints within the facility 10/1/2007 	

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*Revised 11/7/07
Updated 11/9/07*

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F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility failed to consistently assess Resident #9 for restraint reduction. The findings include:	F 221	#2F Tag- 221 (d) Physical Restraints 1. <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> Resident #9 has been reassessed by the IDT team and Rehabilitation Therapy for restraints. 2. <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> No other residents have restraints within the facility 10/1/2007 	

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F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that the facility failed to consistently assess Resident #9 for restraint reduction. The findings include:	F 221	#2F Tag- 221 (d) Physical Restraints 1. <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> Resident #9 has been reassessed by therapy for restraints. 2. <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> No other residents have restraints within the facility 10/1/2007 	
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F 221	Continued From page 2 Resident #9 was initially assessed for a break-away lap buddy on May 12, 2006 as an intervention for falls. According to the instructions on the "Physical Restraint Elimination Assessment" form directed, "Restrained individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures or total restraint elimination." A review of Resident # 9's record revealed that the "Physical Restraint Elimination Assessment" was completed on November 12, 2006 and May 7, 2007. There was no evidence that a "Physical Restraint Elimination Assessment" was completed after February of August, 2007. According to the May 7, 2007 assessment, the resident scored 25 points. The legend located on the "Physical Restraint Elimination Assessment" directed that a score of 21-35 indicated that the resident was a "Good Candidate" for restraint reduction. There was no evidence in the record that a restraint reduction was attempted. A face-to-face interview was conducted with the Employee #1 on September 26, 2007 at approximately 1:45 PM. He/She acknowledged that there was no quarterly assessment for February or August, 2007 and that there was no attempt to change the type of restraint. The record was reviewed on September 25, 2007.	F 221	3. <u>Measures put in place</u> <ul style="list-style-type: none"> Licensed Nurses and therapy will be educated on the restraint policy and procedure 10/19/2007 Restraint policy has revised 10/12/2007 4. <u>QA</u> <ul style="list-style-type: none"> The QA team will review, monitor and discuss residents that may require a restraint to insure that the policy and procedures are followed. QA team will recommend appropriate action for deficient practice. <i>revised report</i>	11/09/2007
F 241 SS=D	483.15(a) DIGNITY	F 241		

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F 221	<p>Continued From page 2</p> <p>Resident #9 was initially assessed for a break-away lap buddy on May 12, 2006 as an intervention for falls.</p> <p>According to the instructions on the "Physical Restraint Elimination Assessment" form directed, "Restrained individuals should be reviewed at least quarterly to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures or total restraint elimination."</p> <p>A review of Resident # 9's record revealed that the "Physical Restraint Elimination Assessment" was completed on November 12, 2006 and May 7, 2007. There was no evidence that a "Physical Restraint Elimination Assessment" was completed after February or August, 2007.</p> <p>According to the May 7, 2007 assessment, the resident scored 25 points. The legend located on the "Physical Restraint Elimination Assessment" directed that a score of 21-35 indicated that the resident was a "Good Candidate" for restraint reduction.</p> <p>There was no evidence in the record that a restraint reduction was attempted.</p> <p>A face-to-face interview was conducted with the Employee #1 on September 26, 2007 at approximately 1:45 PM. He/She acknowledged that there was no quarterly assessment for February or August, 2007 and that there was no attempt to change the type of restraint. The record was reviewed on September 25, 2007.</p>	F 221	<p>3. <u>Measures put in place</u></p> <ul style="list-style-type: none"> Licensed Nurses and therapy will be educated on the restraint policy and procedure 10/19/2007 Restraint policy has revised 10/12/2007 <p>4. <u>QA</u></p> <ul style="list-style-type: none"> The QA team will review, the Unit Manager will monitor all residents that have the potential for restraints. The QA team will review and discuss the residents that may required a restraint to insure that that the policy and procedures are followed. QA team will recommend appropriate action for deficient practice. 	<p><i>Review received 11/1/07</i></p> <p>11/09/2007</p>
F 241 SS=D	483.15(a) DIGNITY	F 241		

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F 241	<p>Continued From page 3</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the tour of the first floor nursing unit, it was determined that the facility staff failed to maintain residents' dignity. Residents #2, #3 and H1</p> <p>The findings include:</p> <p>The following observations were made during :</p> <p>1. On September 24, 2007 at approximately 10:00 AM and September 25, 2007 at approximately 11:00 AM, Resident #2 was observed in the day room with facial gray hairs on his/her chin.</p> <p>A face-to-face interview was conducted with Employee #2 on September 25, 2007 at approximately 11:10 AM. He/she stated, "We shave [Resident #2] when we can. Sometimes he/she is not cooperative." After asking the staff if an attempt was made to shave Resident #2 the past two (2) mornings, Employee #2 stated, "The staff didn't try yesterday or today (September 24 and 25, 2007)."</p> <p>2. On September 24 and 25, 2007 at approximately 9:30 AM, Resident #3 was observed in the dining room eating breakfast alone. The resident expressed to the surveyor the desire to eat breakfast with other residents. Resident #3 was asked if he/she expressed this</p>	F 241	<p>#3 F-Tag 241 Dignity (D)</p> <p>1. <u>Residents found to have been affected by the deficient practice.</u></p> <ul style="list-style-type: none"> Resident H1 - A battery was placed in her clock Resident #2 Facial hair was removed Resident #3 - Soiled clothes changed. <p>2. <u>Other residents identified having the potential to be affected by the same practice.</u></p> <ul style="list-style-type: none"> Residents on all units were assessed for soiled clothes, items not working in their rooms, and all residents were shaved that needed to be shaved. 10/5/2007 <p>3. <u>Measures put in place</u></p> <ul style="list-style-type: none"> Managers will do a random weekly audit on all residents to check for adequate hygiene, and condition of clothing, and for items not working in the residents rooms. 10/21/2007 Charge nurses will check daily all residents for adequate hygiene, condition of clothing, and for items not working in residents rooms. 10/21/2007 All nursing staff will be educated on Dignity in regards to resident care 10/21/2007 <p>4. <u>QA</u></p> <ul style="list-style-type: none"> Managers weekly random audits will be reviewed during monthly QA meeting. QA committee 	
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F 241	<p>Continued From page 3</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the tour of the first floor nursing unit, it was determined that the facility staff failed to maintain residents' dignity. Residents #2, #3 and H1</p> <p>The findings include:</p> <p>The following observations were made during:</p> <p>1. On September 24, 2007 at approximately 10:00 AM and September 25, 2007 at approximately 11:00 AM, Resident #2 was observed in the day room with facial gray hairs on his/her chin.</p> <p>A face-to-face interview was conducted with Employee #2 on September 24, 2007 at approximately 11:10 AM. He/she stated, "We shave [Resident #2] when we can. Sometimes he/she is not cooperative." After asking the staff if an attempt was made to shave Resident #2 the past two (2) mornings, Employee #2 stated, "The staff didn't try yesterday or today (September 24 and 25 2007)."</p> <p>2. On September 24 and 25, 2007 at approximately 9:30 AM, Resident #3 was observed in the dining room eating breakfast alone. The resident expressed to the surveyor the desire to eat breakfast with other residents. Resident #3 was asked if he/she expressed this</p>	F 241	<p>#3 F-Tag 241 Dignity (D)</p> <p>1. <u>Residents found to have been affected by the deficient practice.</u></p> <ul style="list-style-type: none"> Resident H1 - A battery was placed in her clock Resident #2 Facial hair was removed Resident #3 - Soiled clothes changed. <p>2. <u>Other residents identified having the potential to be affected by the same practice.</u></p> <ul style="list-style-type: none"> Residents on all units were assessed for soiled clothes, items not working in their rooms, and all residents were shaved that needed to be shaved. 10/5/2007 <p>3. <u>Measures put in place</u></p> <ul style="list-style-type: none"> Managers will do a random weekly audit on all residents to check for adequate hygiene, and condition of clothing, and for items not working in the residents rooms. 10/21/2007 Charge nurses will check daily all residents for adequate hygiene, condition of clothing, and for items not working in residents rooms. 10/21/2007 All disciplines will be educated on Dignity in regards to resident care 10/21/2007 <p>4. <u>QA</u></p> <ul style="list-style-type: none"> Managers weekly random audits will be reviewed during monthly QA meeting. QA committee 	
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F 241	Continued From page 4 request to the staff. Resident #3 stated, "Yes, but they get me up too late to eat with the others." 3. On September 25, 2007 at approximately 12:00 PM Resident #3 was observed in the dining area with soiled clothes and untrimmed toe nails. 4. On September 24, 25, and 26, 2007, the clock in Resident H1's room remained at 7:35. The clock was a battery operated device. There was no evidence that staff attempted to replace the battery. On September 26, at approximaltely 11:00 AM a face-to-face interview was conducted with Employee #2 who acknowledged that the clock was not operable. These observations were made in the presence of Employee #2 on September 24, 25, and 26, 2007 between 9:30 AM and 12:00 PM.	F 241	during monthly QA meeting. QA committee will recommend appropriate plans of action to correct deficient practice.	11/09/2007
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 environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: soiled baseboards, floors and carpeting, furniture and ceiling tiles; marred and/or damaged walls.	F 253	F253 1. No residents were affected. • Soiled baseboards observed on the first level dayroom and dining room ; lower level dayroom and activity/ dining room and room 178 were cleaned as of 10/01/2007. • Soiled floors and carpeting throughout the first and lower levels nursing units and the clean linen room on the first floor in the clean linen rooms were cleaned as of 10/01/2007.	

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F 253	<p>Continued From page 5.</p> <p>baseboards, doors, ceiling, floor tiles, furniture and cabinets; broken furniture; odors; and clutter. These observations were made in the presence of the Housekeeping Director, Maintenance Manager and/or nursing staff on September 25, 2007 between 8:45 AM and 11:00 AM.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Soiled baseboards were observed in the following areas: First level-dayroom and dining room; Lower level-dayroom and activity/dining room and room 178. 2. Soiled floors and carpeting were observed in the following areas: Soiled carpet throughout the first and lower level nursing units in 10 of 10 observed areas and the clean linen room on the first floor in one (1) of two (2) clean linen rooms observed. 3. Soiled furniture was observed in the following areas: First floor dayroom and wheel chair pad soiled in first floor and dining room. 4. Soiled ceiling tiles were observed in the first floor dayroom and first floor pantry. 5. Walls with marred and/or damaged surfaces were observed in the first floor dining room and lower level dayroom. 6. Baseboards with marred and/or damaged surfaces were observed in the following areas: First floor pantry cabinet, first floor dining room and lower level dayroom. 7. Doors with marred and/or damaged surfaces were observed in the first floor dining room and 	F 253	<ul style="list-style-type: none"> • Soiled furniture in the first floor dining room and wheel chair pads soiled on the first floor and dining room were cleaned as of 10/01/2007. • Soiled ceiling tiles observed in the first floor dayroom and first floor pantry were replaced as of 10/01/2007. • Walls with marred and/or damaged surfaces observed on the first floor dining room and lower level dayroom repaired as of 10/30/2007. • Baseboards with marred and/or damaged surfaces observed in the first floor pantry cabinet first floor dining room and lower level dayroom were repaired or replaced as of 10/30/2007. • Doors with marred and/or damaged surfaces observed in the first floor dining room and the lower level dining room and the first floor storage room were repaired or replaced as of 10/30/2007. • Damaged ceiling tile observed in room 092 will be repaired or replaced as of 10/30/2007. • The cracked tile in the first floor dining room is due to the expansion and contraction of the concrete floor. has been inspected by a consulting structural engineer. The finding were that no repair was necessary. • Furniture marred worn and/or damaged observed in the first floor dayroom and on the first floor, across from the nursing station and in the lower level dayroom (arm chairs) will be cleaned or replaced as of 11/1/2007. • The cabinet in the first floor pantry will be repaired or replaced as of 11/01/2007. 	
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*Reported
11/2/07*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 253	<p>Continued From page 5</p> <p>baseboards, doors, ceiling, floor tiles, furniture and cabinets; broken furniture; odors; and clutter. These observations were made in the presence of the Housekeeping Director, Maintenance Manager and/or nursing staff on September 25, 2007 between 8:45 AM and 1:00 AM.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Soiled baseboards were observed in the following areas: First level-dayroom and dining room; Lower level-dayroom and activity/dining room and room 178. 2. Soiled floors and carpeting were observed in the following areas: Soiled carpet throughout the first and lower level nursing units in 10 of 10 observed areas and the clean linen room on the first floor in one (1) of two (2) clean linen rooms observed. 3. Soiled furniture was observed in the following areas: First floor dayroom and wheel chair pad soiled in first floor and dining room. 4. Soiled ceiling tiles were observed in the first floor dayroom and first floor pantry. 5. Walls with marred and/or damaged surfaces were observed in the first floor dining room and lower level dayroom. 6. Baseboards with marred and/or damaged surfaces were observed in the following areas: First floor pantry cabinet, first floor dining room and lower level dayroom. 7. Doors with marred and/or damaged surfaces were observed in the first floor dining room and 	F 253	<ul style="list-style-type: none"> • Soiled furniture in the first floor dining room and wheel chair pads soiled on the first floor and dining room were cleaned as 10/01/2007. • Soiled ceiling tiles observed in the first floor dayroom and first floor pantry were replaced as of 10/01/2007. • Walls with marred and/or damaged surfaces observed on the first floor dining room and lower level dayroom repaired as of 10/30/2007. • Baseboards with marred and/or damaged surfaces observed in the first floor pantry cabinet first floor dining room and lower level dayroom were repaired or replaced as of 10/30/2007. • Doors with marred and/or damaged surfaces observed in the first floor dining room and the lower level dining room and the first floor storage room were repaired or replaced as of 10/30/2007. • Damaged ceiling tile observed in room 092 will be repaired or replaced as of 10/30/2007. • The cracked tile in the first floor dining room is due to the expansion and contraction of the concrete floor. Tile will be repaired or replaced during the 2008 fiscal year. • Furniture marred worn and/or damaged observed in the first floor dayroom and on the first floor, across from the nursing station and in the lower level dayroom (arm chairs) will be cleaned or replaced as of 11/1/2007. • The cabinet in the first floor pantry will be repaired or replaced as of 11/01/2007. 	
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Survey received 11/7/07 and

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F 253	Continued From page 6 the lower level dining room and the first floor storage room. 8. Damaged areas to the ceiling was observed in room 092 in one (1) of 12 areas observed. 9. Cracked floor tile in the first floor dining room measuring approximately 17 ft long. 10. Furniture marred worn and/or damaged observed in the following areas: 10 of 10 arm chairs observed in the first floor dayroom and first floor across from the nursing station area and four (4) of four (4) arm chairs in the lower level dayroom. 11. The cabinet in the first floor pantry failed to close and rubber bands were looped around the cabinet handles to prevent the doors from opening 12. Missing knobs -first floor dining room beverage station cabinet. 13. A broken over the bed table and a broken drawer on a side table was observed in the First Floor dayroom. 14. Odors were present in room 188 in one (1) of 12 rooms observed. 15. Clutter observed in the lower level dayroom and room 188.	F 253	<ul style="list-style-type: none"> • The cabinet in the first floor pantry will be repaired or replaced as of 11/01/2007. • Missing knobs on the first floor dining room beverage station cabinet will be replaced as of 10/30/2007. • Broken over the bed table and a broken drawer on a side table in the first floor dayroom were removed as of 10/30/2007. • The odor in room 188 was sanitized and cleaned as of 10/30/2007. • Clutter in the lower level dayroom and in room 188 was cleaned up as of 10/30/2007. <p>2. Environmental Rounds were conducted 10/12/2007 and no other deficiencies were noted.</p> <p>3. The Maintenance Supervisor or designee will conduct monthly preventive maintenance rounds. All work generated will be completed within 48 - 72 hours with written affirmation.</p> <p>4. The Facility Management Director will conduct random audits and will be presented monthly to the QA committee.</p>	11/09/2007
F 280 SS=E	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	F 280		

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F 280	<p>Continued From page 7</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for six (6) of 15 sampled residents and six (6) supplemental residents reviewed, it was determined that facility staff failed to initiate additional goals and approaches for fall prevention for 12 residents with multiple falls. Residents # 2, 4, 5, 9, 13, 14, F1, F2, F3, F4, F5 and F6.</p> <p>The findings include:</p> <p>The facility's falls program is entitled "Leaping Deer Program," policy number C-105, effective date April, 2007.</p> <p>Under "Procedure - 8. Implement interventions as needed to prevent falls. Possible interventions:</p>	F 280	<p>#5 F- Tag 280 (E) Comprehensive Care Plans</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> Residents 2,4,5,9,13,14,F1,F2, F3, F4, F5, F6 care plans were reviewed and new implementations put in place. 10/15/2007 <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> All residents who have fallen in the last 90 days will have their care plans reviewed and updated with appropriate new interventions 10/14/ 2007 <u>Measure put in place</u> <ul style="list-style-type: none"> Licensed nurses will be educated on comprehensive care planning, and applying appropriate interventions 10/19/2007 All residents who have fallen the previous day will be brought to the daily interdisciplinary team meeting for recommendations, and review of new interventions. Falls policy and procedures (Leaping Deer Program) has been revised to include comprehensive care planning for falls. 10/1/2007 The Falls Committee will meet weekly x 90 days to review all falls for compliance with policy and procedures 	

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F 280	<p>Continued From page 8</p> <p>Call bell within reach Bed in lowest position Low bed Brakes locked on wheelchair Safe and appropriate footwear Rearranging room furniture Night light for nighttime trips to the bathroom Assistive devices within reach Toileting Schedules. Personalized. Medication assessment Assessment of vision/hearing Monitor during shift change Identify "sundowners" Assess for orthostatic hypotension Restorative Nursing OT/PT consult and intervention Mat beside the bed Assessment of equipment used by the resident that may put resident at risk.</p> <p>1. Facility staff failed to initiate new interventions for Resident #2 after multiple falls.</p> <p>The review of nurses' progress notes dated June 20, 2007 at 6:30 PM indicated, " Resident was sitting in the TV room at 4:30 PM resident was noted on the floor slid out of her wheel chair MD notified no new orders."</p> <p>June 21, 2007 12:15 PM a nurse' s note indicated, " Resident alert and verbally responsive; was found on the floor in a sitting position in front of her bed. She said she just slide out ..."</p> <p>June 27, 2007 10:55 PM a nurse' s note indicted, " Resident was in bed at about 10:00 PM The writer was called to the resident' s room and the writer noticed resident sitting on the floor mate</p>	F 280	<p>4. <u>QA</u></p> <ul style="list-style-type: none"> All deficient practices will be monitored, discussed and reviewed during monthly QA meeting. The QA committee will recommend appropriate plans of action to correct deficient practice. 	11/09/2007
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F 280	<p>Continued From page 9 near resident' s bed ..."</p> <p>On August 8, 2007 7:40 PM nurses noted indicated, " Resident was noted about 3:15 PM on the floor in the TV room in a supine position. Assessment done no physical injury noted..."</p> <p>The resident had a physician' s order dated January 26, 2007, " Leaping Deer Program, and February 2, 2007, Bed/chair alarm in use at all times."</p> <p>There was no evidence that the bed/chair alarm was in place at the time of the aforementioned falls.</p> <p>The resident had rehabilitation screens on June 22, 28, and August 10, 2007. The therapist notes indicated, " Not a rehab. candidate at this time. No change in level of functioning. Nursing observing precautions and monitoring oversight to decrease risk for falls"</p> <p>According to the "Falls Prevention Care Plan" a bed/chair alarm was added as an approach on December 12, 2006. There were no additional interventions initiated after the above cited falls. The record was reviewed on September 24, 2007.</p> <p>2. Facility staff failed to implement approaches/interventions listed on the "Falls Prevention Care Plan" for Resident #4 who had multiple falls with one (1) injury.</p> <p>A review of Resident 4's record revealed the following nurses' notes:</p> <p>April 12, 2007 at 6:40 AM: " ...Resident was seen lying down to the side of her bed, states she was</p>	F 280		
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F 280	<p>Continued From page 10</p> <p>trying to get to the phone and fell. She denied pain. ...Resident sustained skin tear to right forearm and elbow ... "</p> <p>June 25, 2007 at 7:00: " AM Late entry ...Resident observed on floor on buttocks at 7:25 AM. "</p> <p>July 01, 2007 at 6:00 PM: " ...Resident found on kneeling position in her room near her bed. Abrasion noted in both knees. "</p> <p>July 27, 2007 at 5:30 PM: " Resident observed sitting on the floor in her room near her bed... "</p> <p>A review of the "Fall Risk Assessment" included the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>February 16, 2007</td> <td>11</td> </tr> <tr> <td>March 6, 2007</td> <td>10</td> </tr> <tr> <td>April 12, 2007</td> <td>9</td> </tr> <tr> <td>July 1, 2007</td> <td>10</td> </tr> <tr> <td>August 1, 2007</td> <td>14</td> </tr> </tbody> </table> <p>Instruction accompanying the assessment indicated: " If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls."</p> <p>A review of the Physician 's Order Form signed and dated July 12, 2007 revealed an order for " chair and bed alarm in use at all times. " The order was first initiated on April 12, 2007.</p> <p>The " Falls Prevention Care Plan " was initiated March 5, 2007. In the Approaches/Interventions column on the care plan, item #28 revealed " Bed and Chair Alarm in use at all times. "</p>	Date	Score	February 16, 2007	11	March 6, 2007	10	April 12, 2007	9	July 1, 2007	10	August 1, 2007	14	F 280		
Date	Score															
February 16, 2007	11															
March 6, 2007	10															
April 12, 2007	9															
July 1, 2007	10															
August 1, 2007	14															

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F 280	Continued From page 11 On September 24, 2007 at about 1:15 PM, the resident was observed seated in his/her wheelchair in the dining room eating dinner. The chair alarm was not in use. On September 24, 2007 at about 3:00 PM, the resident was observed seated in his / her room. The chair alarm was not in use. On September 25, 2007 at about 8:50 AM, during a wound treatment observation, the resident was in bed. The bed alarm was not in use. A face-to-face interview was conducted with the Resident Care Coordinator on September 25, 2007 at about 2:30 PM. He /she acknowledged that facility staff failed to implement the " Falls Prevention Care Plan: Approaches/Interventions " "#28: Bed and Chair Alarm in use at all times " , for Resident #4 who had multiple falls with one (1) injury. The record was reviewed September 24, 2007. 3. Facility staff failed to update Resident #5' s care plan with appropriate goals and approaches after multiple falls. The resident was admitted to the facility on November 22, 2006. According to the nurses' notes the resident was found on the floor the following dates: December 5, 11, and 28, 2007; January 22; February 15; March 22; May 20 and 25; July 10 and 29; and August 2, 2007. No injury was sustained from any of the above identified falls. The " Fall Prevention Care Plan" was initiated November 26, 2006. Under the "Evaluation"	F 280		
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F 280	<p>Continued From page 12 column, hand written entries document the resident's falls. However, there was no evidence that additional goals and approaches were initiated after any of the above cited falls.</p> <p>According to a physician's order dated April 1, 2007, " Fall Precautions and Bed/Chair Alarm" were initiated. A review of the May, June, July, and August 2007 monthly orders, signed by the physician but undated, did not include an order for the " Bed/chair alarm" .</p> <p>Observations of the resident were conducted on September 24, 2007 at 1:45 PM, September 25, 2007 at 9:30 AM, 11:45 AM, 2:20 PM and 4:45 PM and on September 26, 2007 at 10:10 AM. There was no chair or bed alarm being used for the resident at the above cited times.</p> <p>There was no evidence that the resident was enrolled into the facility's falls program, "Leaping Deer" .</p> <p>A face-to-face interview was conducted with Employee #2 on September 24, 2007 at 4:30 PM. He/she acknowledged that the falls care plan was not updated after the above cited falls. The record was reviewed September 25, 2007.</p> <p>4. Facility staff failed to update Resident #9' s care plan with appropriate goals and approaches after multiple falls.</p> <p>A review of the nurses' notes revealed the following:</p> <p>April 25, 2007 at 10:00 PM: "At about 8:30 PM, after care, resident was assisted to bed. Caregiver reported that...observed resident on</p>	F 280		
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F 280	<p>Continued From page 13</p> <p>E-Z mattress at about 9:00 PM in a left side lying position with a small wooden night stand lying on [Resident]...On assessment, noted a bruise on right corner of right eye..."</p> <p>August 10, 2007 at 7:30 PM: "Resident observed on back lying position...no apparent injury noted."</p> <p>September 23, 2007 at 3:00 PM: "Resident slid out of wheelchair and sat on wheelchair foot rest with head against wheelchair cushion at 11:45 AM...no injury noted."</p> <p>The " Fall Prevention Care Plan" was initiated May 5, 2003. Under the "Evaluation" column, hand written entries documented the resident' s falls. However, there was no evidence that additional goals and approaches were initiated after any of the above cited falls.</p> <p>The resident was placed on the "Leaping Deer Program" on June 24, 2003.</p> <p>A review of a Rehab. (Rehabilitation) Screen note dated August 20, 2007 stated " No intervention or eval (evaluation) necessary. Rec: (Recommend) Maintain oversight. Assist pt. (patient) with changing positioning to decrease restlessness."</p> <p>A face- to- face interview was conducted with the DON on September 25, 2007 at approximately 1:45 PM and she/he acknowledged that there were no new goals and approaches to the care plan. The record was reviewed on September 25, 2007.</p> <p>5. Facility staff failed to initiate additional goals and approaches for Resident #13, who had multiple falls with injury.</p>	F 280		
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F 280	<p>Continued From page 14</p> <p>A review of Resident #13' s record revealed that the resident was admitted to the facility on September 12, 2007. An interim plan of care was initiated the same day. The problem area of " Falls" was identified with interventions initiated for " identifying the need for assistance and side rails." Admission orders dated September 12, 2007, included " Initiate Leaping Deer Program. Resident at risk for falls."</p> <p>According to the nurses' notes, the resident was found on the floor on September 12 and 21, 2007 and sustained no injury.</p> <p>On September 23, 2007 the resident was found on the floor and subsequently sustained a fractured left scapula.</p> <p>There was no evidence that additional goals and approaches were initiated after the resident fell on September 12 and 21, 2007.</p> <p>The physical therapist screened Resident #13 on September 15, 2007 and began treatment for gait training and balance. There was no evidence that additional screenings occurred after the fall on September 21 and 23, 2007.</p> <p>A face-to-face interview was conducted with Employee #2. He/she acknowledged that the care plan was not amended after the falls. The record was reviewed September 25, 2007.</p> <p>6. Facility staff failed to initiate new goals and approaches to the care plan for Resident #14 after a fall.</p> <p>Resident #14 was admitted to the facility on May</p>	F 280		
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F 280	<p>Continued From page 15</p> <p>24, 2007. According to the nurses' notes, the resident was found on the floor on May 25, 2007 with no injuries. On June 16, 2007, the resident sustained a fall, was transferred to the hospital and returned on June 26, 2007.</p> <p>A "Fall Prevention Care Plan" was initiated on June 11, 2007. No new goals and approaches were added to the care plan after the resident returned to the facility.</p> <p>The "Leaping Deer Program" was initiated on May 24 and June 26, 2007.</p> <p>A face-to-face interview with Employee #1 was conducted on September 26, 2007 at 9:30 AM. He/she acknowledged that the care plan was not updated with new goals and approaches after the resident returned from the hospital. The record was reviewed on September 26, 2007.</p> <p>7. Facility staff failed to initiate additional goals and approaches for Resident F1, who had multiple falls with injury.</p> <p>A review of Resident F1's nurses' notes revealed the following:</p> <p>July 25, 2007 at 3:45 PM: "Resident observed ...on the floor on back ...no injuries."</p> <p>July 28, 2007 at 8:10 PM: "Resident observed on the bathroom floor. On assessment observed blood at the back of head. Noted an open area ...with slight swelling ..."</p> <p>The physical therapist screened the resident on August 18, 2007 noting that the resident was, "Not a rehabilitation candidate at this time"</p>	F 280		
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F 280	<p>Continued From page 16</p> <p>According to a physician's order dated September 5, 2006, "Initiate Leaping Deer Program."</p> <p>The " Falls Prevention Care Plan" was initiated on September 9, 2006. The above cited falls were written in the " Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated after the three (3) above cited falls.</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that the care plan was not updated after the above cited falls. The record was reviewed September 25, 2007.</p> <p>8. Facility staff failed to initiate additional goals and approaches for Resident F2, who had multiple falls with injury. On June 25, 2003, the resident was placed on the "Leaping Deer Program."</p> <p>A review of Resident F2's nurses' notes revealed that following:</p> <p>July 15, 2007 at 10:45 PM: "...Abrasions noted to left shin ..." A note dated July 18, 2007 at 7:00 AM documented that the resident had fallen on the above cited date.</p> <p>July 29, 2007 at 3:50 PM: "...Resident noted on the floor in sitting position ...no injury noted ..."</p> <p>September 24, 2007 at 1:10 PM: " Resident was observed sliding to the floor by nursing staff while trying to sit on a chair. No apparent injuries ..."</p> <p>The physical therapist screened the resident on</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>July 31 and August 9, 2007. The physical therapist documented that the resident was, " Not a rehabilitation candidate at this time" for both screenings.</p> <p>The " Falls Prevention Care Plan" was initiated August 5, 2003. The above cited falls were written in the " Evaluation" column on the care plan. However, there was no evidence that facility staff initiated additional goals or approaches after the above cited falls.</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that the care plan was not amended after the above cited falls. The record was reviewed September 25, 2007.</p> <p>9. Facility staff failed to initiate additional goals and approaches for Resident F3, who had multiple falls with injury. On December 1, 2005, the resident was placed on the "Leaping Deer Program."</p> <p>A review of Resident F3 nurses' notes revealed the following:</p> <p>November 26, 2006 at 7:00 AM: " Observed in a sitting position on the floor mat in room with right elbow stuck in the side rail."</p> <p>January 14, 2007 at 3:00 PM: " Resident slid out of wheelchair and sat on the floor in the day room at 10:00 AM. No visible injury."</p> <p>March 23, 2007 at 10:00 PM: " CNA assigned to resident-called writer at 9 PM that resident was on the floor in the room. Noted on assessment with laceration and swelling on the left forehead at</p>	F 280		
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F 280	<p>Continued From page 18</p> <p>upper eye lid and complained of painful right hand /shoulder ..."</p> <p>May 3, 2007 at 5:55 PM: "...Observed on the [bedside] mattress on the floor ...no observed injuries at this time ..."</p> <p>August 8, 2007 at 8:00 PM: " At 3:15 PM resident was noted on the floor in a sitting position, slid out of the chair ...no physical injury ..."</p> <p>September 24, 2007 at 7:30 PM: " Resident slid out of the couch while trying to sleep on it and knelt down ...No injury noted."</p> <p>The physical therapist screened Resident F3 on January 24, March 6, March 26, June 26 and August 9, 2007. All screenings documented that the resident was not a candidate for physical or occupational therapy.</p> <p>The " Falls Prevention Care Plan" was initiated on November 29, 2007. The falls were documented under the " Evaluation" column of the care plan. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>a face-to-face interview was conducted with Employee #2 on September 25, 2007 at 3:05 PM. He/she acknowledged that the care plan was not amended after the above cited falls. The record was reviewed September 25, 2007.</p> <p>10. Facility staff failed to update Resident F4' s care plan with appropriate goals and approaches after multiple falls. There was no evidence that the resident was placed on the "Leaping Deer Program."</p>	F 280		
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F 280	<p>Continued From page 19.</p> <p>A review of Resident F4's record revealed that he/she was admitted to the facility on July 23, 2007. A review of the nurses' notes revealed the following:</p> <p>August 15, 2007 at 4:00 PM: " Resident alert and verbally responsive was seen in a sitting position in her room ...sustained a skin tear on left hand ..."</p> <p>August 29, 2007 at 12:10 PM: Resident was observed sitting in an upright position on the floor in the TV area near wheelchair. Sustained a skin tear on right arm near elbow ..."</p> <p>September 3, 2007 at 7:00 PM: " Resident found sitting on the floor near the bed in room ...No injury ..."</p> <p>The " Fall Prevention Care Plan" was initiated August 6, 2007. The falls were documented under the " Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated by facility staff after the above cited falls.</p> <p>The physical therapist screened Resident F4 on August 15, August 29, August 31 and September 3, 2007. All screenings documented that the resident was not a candidate for physical therapy.</p> <p>A review of the July (admission), August and September 2007 physician's orders revealed that the resident was not placed on the facility's fall prevention program, " Leaping Deer."</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 11:30</p>	F 280		
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F 280	<p>Continued From page 20</p> <p>AM. He/she acknowledged that there were no additional goals and approaches initiated after the above cited falls. The record was reviewed September 26, 2007.</p> <p>11. Facility staff failed to update Resident F5' s care plan with appropriate goals and approaches after multiple falls. According to physician's orders dated August 17 and August 30, 2007, the resident was not placed on the "Leaping Deer Program."</p> <p>A review of Resident F5' s record revealed the following nurses' notes:</p> <p>March 30, 2007 at 7:00 AM: " Resident was observed on the floor in a sitting position ...no injuries ..."</p> <p>July 9, 2007 at 2:30 PM: " Resident observed on the floor in the room ...no injuries ..."</p> <p>July 16, 2007 at 7:00 PM: " At about 3:30 PM resident was observed on the bathroom floor in a sitting position ...complained of left wrist pain ...x-ray scheduled for 7/17/07 ..." The x-ray was negative for fracture of the left wrist.</p> <p>August 28, 2007 at 6:00 PM: " Resident was observed on [floor] at about 5 pm in a sitting position ...no complaints voiced ..."</p> <p>The " Falls Prevention Care Plan" was initiated on October 30, 2006. The above cited falls were listed under the " Evaluation" column. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>The occupational therapist screened the resident</p>	F 280		
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F 280	<p>Continued From page 21</p> <p>on August 3 and September 10, 2007 and began treatment for balance and transfers. The physical therapist screened the resident and began treatment for gait training and balance on September 7, 2007.</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 3:00 PM. He/she acknowledged that there were no additional goals and approaches initiated after the July 9 and July 16, 2007 falls. The record was reviewed September 26, 2007.</p> <p>12. Facility staff failed to update Resident F6's care plan with appropriate goals and approaches after multiple falls. According to a physician's order dated February 13, 2007, the resident was placed on the "Leaping Deer Program."</p> <p>A review of the nurse's notes revealed the following:</p> <p>March 2, 2007 at 9:00 PM: "Resident was found sitting on the floor near wheelchair in room."</p> <p>May 27, 2007 at 3:30 PM: "...Observed on floor in front of wheelchair in room."</p> <p>The " Falls Prevention Care Plan" was initiated on December 5, 2005 and reviewed May 29, 2007. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>A face-to-face interview was conducted with Employee #2 on September 25, 2007 at 2:50 PM. He/she acknowledged that the care plan was not amended after the above cited falls. The record was reviewed September 25, 2007.</p>	F 280		
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F 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 15 sampled residents, it was determined that facility staff failed to follow the physician's orders for the use of a bed/chair alarm for residents with multiple falls. Residents #2 and 4.</p> <p>The findings include:</p> <p>1. Facility staff failed to utilize the bed/chair alarm as per physician's orders for Resident #2.</p> <p>A physician's order dated February 2, 2007, and renewed on June 14, 2007 directed "Bed/chair alarm in use at all times."</p> <p>The resident was observed on September 24, 2007 sitting in the wheelchair at 10:00 AM in the TV room with no chair alarm present.</p> <p>On September 25, 2007 at 7:30 AM the resident was observed in bed with no bed alarm present.</p> <p>According to the September 2007 Treatment Administration Record, the nurse signed on the day shift (7:00 AM through 3:30 PM) for September 24, 2007 that the alarm was in place.</p>	F 309	<p>#6 F- Tag 309 (D0 Quality of Care)</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> Residents #2 and #4 have bed and chair alarms in place as ordered, 10/26/2007 <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> All residents that have orders for bed and chair alarms have been checked for compliance. All bed and chair alarms are in place for those that have orders. 10/1/2007 <u>Measures put in place</u> <ul style="list-style-type: none"> Shift supervisors will make a bed and chair alarm audit daily on each shift for alarm placement. The audit is to be turned in to the DON daily. Nursing staff will be educated on the importance of alarms being in place as a part of prevention of falls. Falls Committee will review, discuss and monitor audits for bed/chair alarms. <u>QA</u> <ul style="list-style-type: none"> All deficient practices will be discussed during monthly QA. QA <i>person requested</i> Committee will recommend appropriate plans of action to correct deficient practice. <p style="text-align: right;">11/09/2007</p>	
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<p>F 309 SS=D</p>	<p>483.25 QUALITY OF CARE:</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 15 sampled residents, it was determined that facility staff failed to follow the physician's orders for the use of a bed/chair alarm for residents with multiple falls. Residents #2 and 4.</p> <p>The findings include:</p> <p>1. Facility staff failed to utilize the bed/chair alarm as per physician's orders for Resident #2.</p> <p>A physician's order dated February 2, 2007, and renewed on June 14, 2007 directed "Bed/chair alarm in use at all times."</p> <p>The resident was observed on September 24, 2007 sitting in the wheelchair at 10:00 AM in the TV room with no chair alarm present.</p> <p>On September 25, 2007 at 7:30 AM the resident was observed in bed with no bed alarm present.</p> <p>According to the September 2007 Treatment Administration Record, the nurse signed on the day shift (7:00 AM through 3:30 PM) for September 24, 2007 that the alarm was in place.</p>	<p>F 309</p>	<p>#6 F- Tag 309 (DO Quality of Care)</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> Residents #2 and #4 have bed and chair alarms in place as ordered. 10/26/2007 <u>Other residents identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> All residents that have orders for bed and chair alarms have been checked for compliance. All bed and chair alarms are in place for those that have orders. 10/1/2007 <u>Measures put in place</u> <ul style="list-style-type: none"> Shift supervisors will make a bed and chair alarm audit daily on each shift for alarm placement. The audit is to be turned in to the DON daily. Nursing staff will be educated on the importance of alarms being in place as a part of prevention of falls. Falls Committee will review, discuss and monitor audits for bed/chair alarms. <u>QA</u> <ul style="list-style-type: none"> The Unit Manager and Supervisor will monitor for deficient practices. The QA committee will discuss the deficient practice and recommend appropriate plan of action. <p style="text-align: right;"><i>review received 11/7/07</i></p>	<p>11/09/2007</p>
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F 309	Continued From page 23 A face-to-face interview was conducted with Employee #2 on September 25, 2007 at approximately 9:30 AM. He/she acknowledged that a bed/chair alarm should have been in place for Resident #2. the record was reviewed September 24, 2007. 2. Facility staff failed to implement the physician's order for a chair and bed alarm for a resident with multiple falls. Resident #4. A review of Resident #4's record revealed the following nurses' notes: April 12, 2007 at 6:40 AM: "Resident was seen lying down to the side of the bed, states was trying to get to the phone and fell. [He/She] denied pain. ... Resident sustained skin tear to ...right forearm and elbow ..." June 25, 2007 at 7:00 AM: " Late entry ...Resident observed on floor on buttocks at 7:25 AM. " July 1, 2007 at 6:00 PM: "...Resident found on kneeling position in [his/her] room near bed. Abrasion noted in both knees." July 27, 2007 at 5:30 PM: "Resident observed sitting on the floor in [his/her] room near bed ... " A review of the resident's record revealed a physician's order signed and dated July 12, 2007 that included an order for "Chair and bed alarm in use at all times." The order was first initiated on April 12, 2007. On September 24, 2007 at approximately 1:15	F 309		
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 309	Continued From page 24 PM, the resident was observed seated in his/her wheelchair in the dining room eating dinner. The chair alarm was not in use. On September 24, 2007 at approximately 3:00 PM, the resident was observed seated in his/her room. The chair alarm was not in use. On September 25, 2007 at approximately 8:50 AM, during a wound treatment observation, the resident was in bed and no bed alarm was observed.	F 309		
F 323 SS=G	A face-to-face interview was conducted with the Employee # 2 on September 25, 2007 approximately 2:30 PM. He/she acknowledged that the physician's order for a chair and/or bed alarm was not implemented since the resident was transferred to the upper level in June 2007. The record was reviewed September 24, 2007. 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review for five (5) of 15 sampled residents and six (6) supplemental residents, it was determined that facility staff failed to provide adequate supervision for nine (9) residents with multiple falls, some with injuries and failed to	F 323		

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM			STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 25</p> <p>maintain a hazard free environment as evidenced by: an electrical wire out of the wall, damaged skid strips, unsecured laundry detergent and medication in resident room, an unlocked oxygen room, unsecured oxygen tanks, broken covering of an electrical outlet, extension cords in residents rooms and a portable heater in a resident's room. Residents #13, 4, 9, F1, F2, F3, F4, 2, 5, F5 and F6.</p> <p>The findings include:</p> <p>1. Facility staff failed to provide adequate supervision for Resident #13, who had multiple falls with one (1) injury.</p> <p>According to the nurses' notes, the resident was found on the floor on September 12 and 21, 2007 and sustained no injury. On September 23, 2007 the resident was found on the floor and subsequently sustained a fractured left scapula as per the hospital discharge summary dated September 24, 2007.</p> <p>A review of Resident #13's record revealed that the resident was admitted to the facility on September 12, 2007. An interim plan of care was initiated the same day. The problem area of " Falls" was identified with interventions initiated for " identifying the need for assistance and side rails." The care plan was not updated after the aforementioned falls.</p> <p>The physical therapist screened Resident #13 on September 15, 2007 and began treatment. There was no evidence that rehabilitation goals changed after the falls on September 21 and 23, 2007.</p> <p>The "Fall Risk Assessment" was completed as</p>	F 323		

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request
11/2/07 *revised* *11/7/07*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION <i>my</i> A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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F 323	<p>Continued From page 26 follows:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>September 12, 2007</td> <td>17</td> </tr> <tr> <td>September 23, 2007</td> <td>17</td> </tr> <tr> <td>September 23, 2007</td> <td>17</td> </tr> </tbody> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>On Septmeber 13, 2007, the resident was placed on the "Leaping Deer Program."</p> <p>Facility staff identified that Resident #13 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>A face-to-face interview was conducted on September 25, 2007 at 11:40 AM with Employee #2. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 25, 2007.</p> <p>2. Facility staff failed to provide adequate supervision for Resident #4, who had multiple falls with one (1) injury.</p> <p>A review of Resident 4's record revealed the following nurses' notes:</p> <p>April 12, 2007 at 6:40 AM: "...Resident was seen lying down to the side of her bed, states she was trying to get to the phone and fell. She denied pain. ...Resident sustained skin tear to right forearm and elbow ..."</p>	Date	Score	September 12, 2007	17	September 23, 2007	17	September 23, 2007	17	F 323	<p>#7 F- Tag 323 Accidents and Supervision (G)</p> <p>1. Residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> • Resident 4,2,5,9,13 F1, F2, F4, F5, F6 have all been reassessed ,care plans updated with new interventions, environments checked for hazards and hazards removed • Exposed wires have been fixed as of 09/26/2007 • Laundry detergent has been removed as of 09/26/2007 • Medications have been removed from residents room as of 09/26/2007 • Oxygen room has been locked and oxygen secured as of 10/01/2007 • Broken cover on electrical outlet has been fixed as of 10/01/2007 • Extension cords have been removed as of 09/26/2007 • Portable heater has been removed as of 09/26/2007 	
Date	Score											
September 12, 2007	17											
September 23, 2007	17											
September 23, 2007	17											

reassessed

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11/1/07*

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F 323	<p>Continued From page 26</p> <p>Follows:</p> <table border="1"> <tr> <th>Date</th> <th>Score</th> </tr> <tr> <td>September 12, 2007</td> <td>17</td> </tr> <tr> <td>September 23, 2007</td> <td>17</td> </tr> <tr> <td>September 23, 2007</td> <td>17</td> </tr> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>On September 13, 2007, the resident was placed on the "Leaping Deer Program."</p> <p>Facility staff identified that Resident #13 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>A face-to-face interview was conducted on September 25, 2007 at 11:40 AM with Employee #2. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 25, 2007.</p> <p>2. Facility staff failed to provide adequate supervision for Resident #4, who had multiple falls with one (1) injury.</p> <p>A review of Resident 4's record revealed the following nurses' notes:</p> <p>April 12, 2007 at 6:40 AM: "...Resident was seen lying down to the side of her bed, states she was trying to get to the phone and fell. She denied pain. ...Resident sustained skin tear to right forearm and elbow ..."</p>	Date	Score	September 12, 2007	17	September 23, 2007	17	September 23, 2007	17	F 323	<p>#7 F- Tag 323 Accidents and Supervision (G)</p> <p>1. Residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> Resident 4, 2, 5, 9, 13, F1, F2, F4, F5, F6 have all been reassessed care plans updated with new interventions, environments checked for hazards and hazards removed. Exposed wires have been fixed as of 09/26/2007 Damaged skid strips were replaced as of 10/01/2007. Laundry detergent has been removed as of 09/26/2007 Medications have been removed from residents room as of 09/26/2007 Oxygen room has been locked and oxygen secured as of 10/01/2007 Broken cover on electrical outlet has been fixed as of 10/01/2007 Extension cords have been removed as of 09/26/2007 Portable heater has been removed as of 09/26/2007 	<p><i>not reviewed 11/7/07</i></p> <p><i>reviewed 11/7/07</i></p>
Date	Score											
September 12, 2007	17											
September 23, 2007	17											
September 23, 2007	17											

27A

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F 323	<p>Continued From page 27</p> <p>June 25, 2007 at 7:00: " AM Late entry ...Resident observed on floor on buttocks at 7:25 AM. "</p> <p>July 1, 2007 at 6:00 PM: "...Resident found on kneeling position in her room near her bed. Abrasion noted in both knees. "</p> <p>July 27, 2007 at 5:30 PM: "Resident observed sitting on the floor in her room near her bed..."</p> <p>A review of the " Fall Risk Assessment " included the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>February 16, 2007</td> <td>11</td> </tr> <tr> <td>March 6, 2007</td> <td>10</td> </tr> <tr> <td>April 12, 2007</td> <td>9</td> </tr> <tr> <td>July , 2007</td> <td>10</td> </tr> <tr> <td>August 1, 2007</td> <td>14</td> </tr> </tbody> </table> <p>Instruction accompanying the assessment indicated: " If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls."</p> <p>A review of the Physician's Order Form signed and dated July 12, 2007 revealed an order for " chair and bed alarm in use at all times." The order was first initiated on April 12, 2007.</p> <p>The resident was placed on the "Leaping Deer Program" was July 25, 2007.</p> <p>The "Falls Prevention Care Plan" was initiated March 5, 2007. In the Approaches/Interventions column on the care plan, item #28 revealed "Bed and Chair Alarm in use at all times."</p>	Date	Score	February 16, 2007	11	March 6, 2007	10	April 12, 2007	9	July , 2007	10	August 1, 2007	14	F 323	<p>2. <u>Other residents identified having the potential to be affected by the same practice.</u></p> <ul style="list-style-type: none"> All residents assessed for a fall potential will be monitored, who have fallen in the last 90 days have been reassessed to insure compliance with the Leaping Deer Protocol 10/18/2007. All resident rooms and common areas have been checked for environmental hazards. Any deficient practice has been reported to the appropriate department to be resolved. 10/19/2007 All licensed staff has been reeducated on their responsibility in supervising residents and nursing assistance on the prevention of accidents. <p>3. <u>Measures put in place</u></p> <ul style="list-style-type: none"> All Health Center staff (housekeeping, maintenance, dietary, administration) will be educated on maintaining an accident free environment) and how to report any issues that require attention from other departments All nursing staff will be educated on the prevention of accidents and supervision of residents who are on the Leaping Deer Program, implementing new goals and approaches and how to properly complete a Falls Risk Assessment and how to use the Assessment to add or make changes to the care plan. 	<p><i>Reviewed</i> <i>11/2/07</i> <i>aw</i></p>
Date	Score															
February 16, 2007	11															
March 6, 2007	10															
April 12, 2007	9															
July , 2007	10															
August 1, 2007	14															

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F 323	<p>Continued From page 28</p> <p>A face-to-face interview was conducted with the Resident Care Coordinator on September 25, 2007 at about 2:30 PM. He/she acknowledged that facility staff failed to implement the " Falls Prevention Care Plan: Approaches/Interventions " "#23: Bed and Chair Alarm in use at all times," for Resident #4 who had multiple falls with one (1) injury. The record was reviewed September 24, 2007.</p> <p>3. Facility staff failed to provide adequate supervision for Resident #9, who had multiple falls</p> <p>April 25, 2007 at 10:00 PM: " At about 8:30 PM, after care, resident was assisted to bed. Caregiver reported that...observed resident on E-Z mattress at about 9:00 PM in a left side lying position with a small wooden night stand lying on [Resident]...On assessment, noted a bruise on right corner of right eye..."</p> <p>August 10, 2007 at 7:30 PM: "Resident observed on back lying position...no apparent injury noted."</p> <p>September 23, 2007 at 3:00 PM: "Resident slid out of wheelchair and sat on wheelchair foot rest with head against wheelchair cushion at 11:45 AM...no injury noted."</p> <p>The " Fall Prevention Care Plan" was initiated May 8, 2003. Under the "Evaluation" column, hand written entries documented the resident's falls. However, there was no evidence that additional goals and approaches were initiated after any of the above cited falls.</p> <p>A rehabilitation screen was conducted on August 20, 2007 and documented that the resident</p>	F 323	<ul style="list-style-type: none"> • Shift Supervisors will be required to do a bed/chair alarm audit daily on each shift. Audits to be turned into the DON daily. • Nursing Staff will be required to do rounds and document rounding times. Licensed nursing staff will do rounds hourly to insure alarms are in place and residents are safe. • Licensed Nursing Staff will report daily and shift by shift to the nursing assistants who the residents are who are at risk for falls. • The Leaping Deer Protocol has been revised 10/1/2007 • All falls will be reviewed at the daily interdisciplinary team meeting offering recommendations • A Falls Investigation Form will be required to be completed by the licensed nursing staff after each fall. This information will be reviewed by the Falls Committee • Maintenance will make weekly rounds with nursing to assess for safety hazards. • Safety Committee will meet weekly x 90days to discuss and resolve safety and hazardous conditions. 	<p><i>Review received 11/7/07</i></p> <p>11/9/2007</p>
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F 323	<p>Continued From page 29</p> <p>was "Not a candidate for Rehabilitation Services"</p> <p>Facility nursing staff completed the "Fall Risk Assessment" as follows:</p> <table border="1"> <tr> <th>Date</th> <th>Score</th> </tr> <tr> <td>April 25, 2007</td> <td>15</td> </tr> <tr> <td>July 30, 2007</td> <td>11</td> </tr> <tr> <td>August 20, 2007</td> <td>13</td> </tr> <tr> <td>September 23, 2007</td> <td>13</td> </tr> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>The resident was placed on the "Leaping Deer Program" on June 28, 2003.</p> <p>Facility staff identified that Resident #9 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>A face-to-face interview was conducted with Employee #1 on September 15, 2007 at approximately 1:45 PM who acknowledged that there was no change in the supervision of the resident. The record was reviewed on September 25, 2007</p> <p>4. Facility staff failed to provide adequate supervision for Resident F1, who had multiple falls with two (2) injuries.</p> <p>A review of Resident F1's nurses' notes revealed the following:</p> <p>July 25, 2007 at 3:45 PM: "Resident observed ...on the floor on back ...no injuries."</p>	Date	Score	April 25, 2007	15	July 30, 2007	11	August 20, 2007	13	September 23, 2007	13	F 323	<p>4. QA</p> <ul style="list-style-type: none"> The Unit Manager will monitor alarms. All deficient practice will be discussed at the monthly QA meeting. The QA Committee will recommend appropriate plans of action to correct deficient practice. Reports from Safety Committee will be reviewed and recommendations given for improvement at the monthly QA meeting. 	<p><i>Received 11/7/07</i></p>
Date	Score													
April 25, 2007	15													
July 30, 2007	11													
August 20, 2007	13													
September 23, 2007	13													

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F 323	<p>Continued From page 30</p> <p>July 28, 2007 at 8:10 PM: " Resident observed on the bathroom floor. On assessment observed blood at the back of head. Noted an open area ...with slight swelling ..."</p> <p>The "Falls Prevention Care Plan" was initiated on September 9, 2006. The above cited falls were written in the " Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated after the three (3) above cited falls.</p> <p>The physical therapist screened the resident on August 18, 2007 noting that the resident was, " Not a rehabilitation candidate at this time"</p> <p>The "Fall Risk Assessment" completed as follows:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>January 30, 2007</td> <td>14</td> </tr> <tr> <td>April 24, 2007</td> <td>16</td> </tr> <tr> <td>July 24, 2007</td> <td>18</td> </tr> <tr> <td>August 20, 2007</td> <td>20</td> </tr> </tbody> </table> <p>Facility staff identified that Resident F1 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>According to a physician's order dated September 5, 2006, "Initiate Leaping Deer Program."</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 26, 2007.</p>	Date	Score	January 30, 2007	14	April 24, 2007	16	July 24, 2007	18	August 20, 2007	20	F 323		
Date	Score													
January 30, 2007	14													
April 24, 2007	16													
July 24, 2007	18													
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F 323	<p>Continued From page 31</p> <p>5. Facility staff failed to provide adequate supervision for Resident F2, who had multiple falls with one (1) injury.</p> <p>A review of Resident F2's nurses' notes revealed that following:</p> <p>July 15, 2007 at 10:45 PM: "...Abrasions noted to left shin ..." A note dated July 18, 2007 at 7:00 AM documented that the resident had fallen on the above cited date.</p> <p>July 29, 2007 at 3:50 PM: "...Resident noted on the floor in sitting position ...no injury noted ..."</p> <p>September 24, 2007 at 1:10 PM: " Resident was observed sliding to the floor by nursing staff while trying to sit on a chair. No apparent injuries ..."</p> <p>The " Falls Prevention Care Plan" was initiated August 5, 2003. The above cited falls were written in the " Evaluation" column on the care plan. However, there was no evidence that facility staff initiated additional goals or approaches after the above cited falls.</p> <p>The "Fall Risk Assessment" was completed as follows:</p> <table border="0"> <tr> <td>Date</td> <td>Score</td> </tr> <tr> <td>January 30, 2007</td> <td>9</td> </tr> <tr> <td>May 2, 2007</td> <td>12</td> </tr> <tr> <td>August 29, 2007</td> <td>16</td> </tr> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>On June 25, 2007, the resident was placed on the "Leaping Deer Program."</p>	Date	Score	January 30, 2007	9	May 2, 2007	12	August 29, 2007	16	F 323		
Date	Score											
January 30, 2007	9											
May 2, 2007	12											
August 29, 2007	16											

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323	<p>Continued From page 32</p> <p>Facility staff identified that Resident F2 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>The physical therapist screened the resident on July 31, 2007. The physical therapist documented that the resident was, "Not a rehabilitation candidate at this time."</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 25, 2007.</p> <p>6. Facility staff failed to provide adequate supervision for Resident F3, who had multiple falls with one (1) injury.</p> <p>A review of Resident F3 nurses' notes revealed the following:</p> <p>November 26, 2006 at 7:00 AM: " Observed in a sitting position on the floor mat in room with right elbow stuck in the side rail."</p> <p>January 14, 2007 at 3:00 PM: " Resident slid out of wheelchair and sat on the floor in the day room at 10:00 AM. No visible injury."</p> <p>March 23, 2007 at 10:00 PM: " CNA assigned to resident-called writer at 9 PM that resident was on the floor in the room. Noted on assessment with laceration and swelling on the left forehead at upper eye lid and complained of painful right hand /shoulder..."</p>	F 323		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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F 323	<p>Continued From page 33</p> <p>May 3, 2007 at 5:55 PM: "...Observed on the [bedside] mattress on the floor ...no observed injuries at this time ..."</p> <p>August 8, 2007 at 8:00 PM: " At 3:15 PM resident was noted on the floor in a sitting position, slid out of the chair ...no physical injury ..."</p> <p>September 24, 2007 at 7:30 PM: " Resident slid out of the couch while trying to sleep on it and knelt down ...No injury noted."</p> <p>The " Falls Prevention Care Plan" was initiated on November 29, 2006. The falls were documented under the " Evaluation" column of the care plan. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>The "Fall Risk Assessment" was completed as follows;</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>January 14, 2007</td> <td>12</td> </tr> <tr> <td>March 6, 2007</td> <td>12</td> </tr> <tr> <td>May 3, 2007</td> <td>14</td> </tr> <tr> <td>June 5, 2007</td> <td>13</td> </tr> <tr> <td>August 9, 2007</td> <td>13</td> </tr> <tr> <td>September 4, 2007</td> <td>13</td> </tr> </tbody> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>On December 1, 2005, the resident was placed on the "Leaping Deer Program."</p> <p>Facility staff identified that Resident F3 continued to be at high risk for falls. There was no evidence</p>	Date	Score	January 14, 2007	12	March 6, 2007	12	May 3, 2007	14	June 5, 2007	13	August 9, 2007	13	September 4, 2007	13	F 323		
Date	Score																	
January 14, 2007	12																	
March 6, 2007	12																	
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F 323	<p>Continued From page 34</p> <p>that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>The physical therapist screened Resident F3 on January 24, March 6, March 26, June 26 and August 9, 2007. All screenings documented that the resident was not a candidate for physical or occupational therapy.</p> <p>A face-to-face interview was conducted with Employee #2 on September 25, 2007 at 3:05 PM. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 25, 2007.</p> <p>7. Facility staff failed to provide adequate supervision for Resident F4, who had multiple falls with two (2) injuries.</p> <p>A review of Resident F4's revealed that he/she was admitted to the facility on July 23, 2007 with the following nurses' notes:</p> <p>August 15, 2007 at 4:00 PM: " Resident alert and verbally responsive was seen in a sitting position in her room ...sustained a skin tear on left hand ..."</p> <p>August 29, 2007 at 12:10 PM: Resident was observed sitting in an upright position on the floor in the TV area near wheelchair. Sustained a skin tear on right arm near elbow ..."</p> <p>September 3, 2007 at 7:00 PM: " Resident found sitting on the floor near the bed in room ...No injury ..."</p> <p>The " Fall Prevention Care Plan" was initiated</p>	F 323		
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Continued From page 35

August 6, 2007. The falls were documented under the "Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated by facility staff between the above cited falls.

A "Fall Risk Assessment" form was in the record with information as follows:

Date	Score
July 23, 2007	16
July 30, 2007	16
August 14, 2007	16
August 29, 2007	17

According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."

The physical therapist screened the resident on August 15, August 29, August 31 and September 3, 2007. The physical therapist documented for each above cited screen that the resident was, "Not a candidate for rehabilitation at this time."

There was no evidence that the resident was placed on the "Leaping Deer Program."

Facility staff identified that Resident F4 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.

A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 9:00 AM. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 26, 2007.

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F 323	<p>Continued From page 36</p> <p>8. Facility staff failed to provide adequate supervision for Resident #2, who had multiple falls.</p> <p>The review of nurses' progress notes revealed the following:</p> <p>June 20, 2007 at 6:30 PM indicated, "Resident was sitting in the TV room at 4:30 PM resident was noted on the floor slide out of her wheel chair MD notified no new orders."</p> <p>June 21, 2007 12:15 PM a nurse's note indicated, " Resident alert and verbally responsive; was found on the floor in a sitting position in front of her bed. She said she just slide out ..."</p> <p>June 27, 2007 10:55 PM a nurse's note indicted, " Resident was in bed at about 10:00 PM The writer was called to the resident' s room and the writer noticed resident sitting on the floor mate near resident' s bed ..."</p> <p>On August 8, 2007 7:40 PM nurses noted indicated, " Resident was noted about 3:15 PM on the floor in the TV room in a supine position. Assessment done no physical injury noted ..."</p> <p>The "Fall Prevention Care Plan" was initiated on December 4, 2006. The above cited falls were listed under the " Evaluation" column. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>A "Fall Risk Assessment" form was in the record with information as follows:</p> <p>Date Score</p>	F 323		
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F 323	<p>Continued From page 37</p> <p>January 26, 2007 12 February 13, 2007 14 May 8, 2007 14 June 21, 2007 14 June 28, 2007 16 July 5, 2007 16</p> <p>On January 26, 2007, the resident was placed on the "Leaping Deer Program."</p> <p>The resident had rehabilitation screens on June 22, 28, and August 10, 2007. The therapist note indicated, " Not a rehabilitation candidate at this time." The record was reviewed September 25, 2007.</p> <p>9. Facility staff failed to adequately supervise Resident #5, who had multiple falls.</p> <p>The resident was admitted to the facility on November 22, 2006. According to the nurses' notes the resident was found on the floor the following dates: December 5, 11, and 28, 2007; January 22; February 15; March 22; May 20 and 25; July 10 and 29; and August 2, 2007. No injury was sustained from any of the above identified falls.</p> <p>Rehabilitation screens were conducted on December 6 and December 12, 2006; March 6, March 23, March 26, May 23, July 12, and August 3, 2007. The aforementioned screens documented that the resident was, "Not a candidate for Rehab at this time."</p> <p>Facility nursing staff completed the "Fall Risk Assessment" as follows: Date Score November 22, 2006 11</p>	F 323		

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F 323	<p>Continued From page 38</p> <p>December 5, 2006 15 December 11, 2006 15 December 12, 2006 15 January 1, 2007 14 January 20, 2007 14 February 17, 2007 14 March 22, 2007 14 May 20, 2007 13 August 14, 2007 16 August 29, 2007 17</p> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>A review of the resident's care plan problem, "Falls Prevention Care Plan" initiated November 26, 2007, revealed that facility staff failed to initiate additional goals and approaches after falls.</p> <p>There was no evidence that the resident was placed on the "Leaping Deer Program."</p> <p>Facility staff identified that Resident #5 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to assist the resident or adequately supervise the resident.</p> <p>A face-to-face interview was conducted with Employee #2 on September 4, 2007 at 4:30 PM. He/she stated, "[Resident #5] is a challenge. [He/she] is very non-compliant in asking for help especially when transferring. There isn't anymore we can do." The record was reviewed September 24, 2007.</p>	F 323		

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F 323	<p>Continued From page 39</p> <p>10. Facility staff failed to provide adequate supervision for Resident F5, who had multiple falls.</p> <p>A review of Resident F5's record revealed the following nurses' notes:</p> <p>March 30, 2007 at 7:00 AM: " Resident was observed on the floor in a sitting position ...no injuries ..."</p> <p>July 9, 2007 at 2:30 PM: " Resident observed on the floor in the room ...no injuries ..."</p> <p>July 16, 2007 at 7:00 PM: " At about 3:30 PM resident was observed on the bathroom floor in a sitting position ...complained of left wrist pain ...x-ray scheduled for 7/17/07 ..." The x-ray was negative for fracture of the left wrist.</p> <p>August 28, 2007 at 6:00 PM: " Resident was observed on [floor] at about 5 pm in a sitting position ...no complaints voiced ..."</p> <p>The physical therapist completed a rehabilitation screen on April 24, July 26 and August 13, 2007. The recommendation for all the above cited screens was, "Not a candidate for rehabilitation at this time."</p> <p>The occupational therapist screened the resident on August 3, 2007 and began treatment for balance and transfers. The physical therapist screened the resident on September 7, 2007 and began treatment for gait training and balance.</p> <p>The " Falls Prevention Care Plan" was initiated on October 30, 2006. The above cited falls were listed under the " Evaluation" column. There was</p>	F 323		
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F 323	<p>Continued From page 40</p> <p>no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>The "Falls Risk Assessment" was completed as follows:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>April 23, 2007</td> <td>16</td> </tr> <tr> <td>July 9, 2007</td> <td>16</td> </tr> <tr> <td>July 19, 2007</td> <td>16</td> </tr> <tr> <td>July 24, 2007</td> <td>16</td> </tr> <tr> <td>July 26, 2007</td> <td>14</td> </tr> <tr> <td>August 23, 2007</td> <td>16</td> </tr> <tr> <td>August 28, 2007</td> <td>14</td> </tr> </tbody> </table> <p>According to the legend on the "Fall Risk Assessment" form, "a total score of 10 or above represents High Risk."</p> <p>There was no evidence that the resident was placed on the "Leaping Deer Program."</p> <p>Facility staff identified that Resident F5 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 3:00 PM. He/she acknowledged that there was no change in the supervision of the resident. The record was reviewed September 26, 2007.</p> <p>11. Facility staff failed to provide adequate supervision for Resident F6, who had multiple falls. According to a physician's order dated February 13, 2007, the resident was placed on the "Leaping Deer Program."</p>	Date	Score	April 23, 2007	16	July 9, 2007	16	July 19, 2007	16	July 24, 2007	16	July 26, 2007	14	August 23, 2007	16	August 28, 2007	14	F 323		
Date	Score																			
April 23, 2007	16																			
July 9, 2007	16																			
July 19, 2007	16																			
July 24, 2007	16																			
July 26, 2007	14																			
August 23, 2007	16																			
August 28, 2007	14																			

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F 323	<p>Continued From page 41</p> <p>A review of the nurse's notes revealed the following:</p> <p>March 2, 2007 at 9:00 PM: "Resident was found sitting on the floor near wheelchair in room."</p> <p>May 27, 2007 at 3:30 PM: "...Observed on floor in front of wheelchair in room."</p> <p>The " Falls Prevention Care Plan" was initiated on December 5, 2005 and reviewed May 29, 2007. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>The "Falls Risk Assessment" was completed as follows:</p> <table border="0"> <tr> <td>Date</td> <td>Score</td> </tr> <tr> <td>February 27, 2007</td> <td>17</td> </tr> <tr> <td>May 29, 2007</td> <td>17</td> </tr> </table> <p>Facility staff identified that Resident F6 continued to be at high risk for falls. There was no evidence that facility staff utilized the information from the fall risk assessments to initiate changes in the plan of care to adequately supervise the resident.</p> <p>On February 13, 2007, the resident was placed on the "Leaping Deer Program."</p> <p>The " Falls Prevention Care Plan" was initiated on December 5, 2005 and reviewed May 29, 2007. There was no evidence that additional goals and approaches were initiated after the above cited falls.</p> <p>A face-to-face interview was conducted with Employee #2 on September 25, 2007 at 2:50 PM. He/she acknowledged that there was no change</p>	Date	Score	February 27, 2007	17	May 29, 2007	17	F 323		
Date	Score									
February 27, 2007	17									
May 29, 2007	17									

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F 323	Continued From page 42 in the supervision of the resident. The record was reviewed September 25, 2007. The environmental tour was conducted on September 24, 2007 between 8:30 AM and 2:30 PM in the presence of Employees #10 and 11. 1. It was observed that electrical wires were not in the wall and unsecured above the floor. 2. The skid strips on the shower room on the first floor level were observed to be damaged and did not adhere to the shower floor. 3. A container of laundry detergent was observed unsecured on a shelf in room 188. 4. The oxygen room door on the lower level was unlocked. Three (3) of five (5) oxygen tanks were observed unsecured on the first floor nursing unit. 5. Medication [Combivent, Nystop and three (3) nasal inhalers [Neo-synephrine, Afrin, Nasal spray], Anbesol, anti-itch cream, Immunity Support tablets and Aspercreme was observed at residents bedside in room 188 and 090 in two (2) of 12 rooms observed. 6. The plastic covering of an electrical outlet was broken in the soiled utility room on the first level on the nursing unit in one (1) of two (2) soiled utility rooms. 7. Extension cords were observed in rooms 072, 087, 195 and a cable cord was observed across the floor of resident's room 174. 8. A portable heater was observed in room 169A.	F 323		
F 371	483.35(i)(2) SANITARY CONDITIONS - FOOD	F 371		

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F 371 SS=F	<p>Continued From page 43 PREP & SERVICE</p> <p>The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during a tour of the main kitchen on September 24, 2007 between 8:50 AM and 12:30 PM, it was determined that facility staff failed to prepare, store and serve food in a safe and sanitary manner as evidenced by the following: soiled floors, wall, hand sinks, appliances, baking pans, storage bins; perishable food delivery stored on the floor and out of required temperature range, food stored in the salad cold box at 52 degrees F. These observations were made in the presence of Employees #8 and 9.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The floor throughout the main kitchen was observed with accumulated grease, food spillages and debris in one (1) of one (1) floor observed in the main kitchen. 2. The walls throughout the main kitchen were observed soiled with accumulated food spillages, grease and debris in one (1) of one (1) wall observed in the main kitchen. 3. Hand washing sinks were observed soiled with accumulated grease and debris in three (3) of three (3) hand washing sinks in the main kitchen. 	F 371	<p>F 371</p> <ol style="list-style-type: none"> 1. No resident was affected by this deficiency. 1) Floors cleaned completed as of 10-20-07 2) Walls cleaned completed as of 10-24-07 3) Hand washing sink cleaned completed as of 10-15-07 4) Equipment cleaned completed as of 10-30-07 5) Muffin Tins replaced as of 10-20-07 6) Hotel Pans cleaned completed as of 10-16-07 7) Sheet Pans cleaned as of 10-16-07 8) Plastic Bin Covers cleaned as of 10-18-07 9) Loaf Pans cleaned as of 10-18-07 10) Bulk Storage Bins cleaned as of 10-24-07 11) Utensil Bins cleaned as of 10-19-07 12) The 27 cartons of perishable food that were observed stored on the floor near 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB NO. 0938-0391

Requested 11/1/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 371	Continued From page 44 4. In the main kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease, food and debris: top surfaces of the gas oven, grill surface and drip pans, fry master including the gas lines, upper and lower convection ovens, hot box, steamer kettle, steamer, freezer, salad cold box, and the exterior of the dish machine in 10 of 12 appliances observed. In the Suites kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease, food and debris: steam kettles, convection oven, and gas oven in three (3) of five (5) appliances observed. 5. Muffin tins were observed stored and ready for reuse soiled and with a greasy residue in 10 of 10 muffin tins observed in both kitchens. 6. 24 inch hotel pans were stored with accumulated debris and a greasy residue in three (3) of three (3) 24 inch hotel pans observed in the main kitchen. 7. Metal sheet pans were observed stored wet and ready for reuse in nine (9) of nine (9) metal sheet pans observed in both kitchens. 8. Plastic bin covers were observed stored wet and ready for reuse in 26 of 27 plastic bin covers observed in the main kitchen. 9. Loaf pans were observed stored and ready for reuse with a greasy residue on the exterior surface in five (5) of five (5) loaf pans in the suites kitchen. 10. Four (4) storage bins used for flour, sugar,	F 371	the back entrance to the kitchen were discarded as of 09/24/2007 13) All items on the salad cold box observed at 52 degrees F were discarded as of 09/24/2007. 2. The Dining Service Director or designee in each of the Ingleside kitchens will conduct a sanitation audit monthly. The Service Manager or designee will conduct weekly audits. 3. The Dining Service Director will monitor daily and corrective action will be taken to maintain compliance with standards as needed based on the results of the audits. 4. Sanitation audits and need action plans will be reported at the QA committee meeting monthly, 11/07	11/09/2007
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never's audit

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 371	<p>Continued From page 44</p> <p>4. In the main kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease food and debris: top surfaces of the gas oven, grill surface and drip pans, fry master including the gas lines, upper and lower convection ovens, hot box, steamer kettle, steamer, freezer, salad cold box, and the exterior of the dish machine in 10 of 12 appliances observed.</p> <p>In the Suites kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease, food and debris: steam kettles, convection oven, and gas oven in three (3) of five (5) appliances observed.</p> <p>5. Muffin tins were observed soiled and ready for reuse soiled and with a greasy residue in 10 of 10 muffin tins observed in both kitchens.</p> <p>6. 24 inch hotel pans were stored with accumulated debris and a greasy residue in three (3) of three (3) 24 inch hotel pans observed in the main kitchen.</p> <p>7. Metal sheet pans were observed stored wet and ready for reuse in nine (9) of nine (9) metal sheet pans observed in both kitchens.</p> <p>8. Plastic bin covers were observed stored wet and ready for reuse in 26 of 27 plastic bin covers observed in the main kitchen.</p> <p>9. Loaf pans were observed stored and ready for reuse with a greasy residue on the exterior surface in five (5) of five (5) loaf pans in the suites kitchen.</p> <p>10. Four (4) storage bins used for flour, sugar,</p>	F 371	<p>the back entrance to the kitchen were discarded as of 09/24/2007</p> <p>13) All items on the salad cold box observed at 52 degrees F were discarded as of 09/24/2007.</p> <p>2. Sanitation rounds were performed in each of the Ingleside kitchens and no other deficiencies were found. 09/30/2007</p> <p>3. The Dining Service Director or designee in each of the Ingleside kitchens will conduct a sanitation audit monthly. The Service Manager or designee will conduct weekly audits. The Dining Service Director will monitor daily and corrective action will be taken to maintain compliance with standards as needed based on the results of the audits.</p> <p>4. Sanitation audits and need action plans will be reported at the QA committee meeting monthly. 11/07</p>	<p>11/09/2007</p> <p><i>Reviewed 11/17/07 ad</i></p>
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45A

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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F 371

Continued From page 45
pasta and rice were observed soiled on the exterior with accumulated debris in four (4) of four (4) bins observed.

11. Storage bins used for clean utensils and dessert dishes were observed soiled with an accumulated white substance on the bottom of the bin in two (2) of two (8) eight bins observed.

12. 27 cartons of perishable food were observed stored on the floor near the back entrance to the main kitchen. The food was delivered between 6:00 AM and 7:00 AM on September 24, 2007. Temperatures of the food were as follows:

Wild berry pie was 22 degrees Fahrenheit (F), with the manufacturer's directions printed on the top of the box to "Keep Frozen" in eight (8) of eight (8) cartons of pies observed.

Blueberry yogurt was 45.5 degrees F in two (2) of two (2) cartons of yogurt observed.

Liquid eggs were 41 degrees F and 46 degrees F with the manufacturer's directions printed on the box "Store at 33-40 F" in two (2) of four (4) cartons observed.

Cartons of cranberry and orange juice manufacturer's directions printed on the box "Keep Frozen". When examined, the juices were in liquid form in four (4) of four (4) cartons of juice observed.

Muffins were 20 degrees F with manufacturer's directions printed on the box to "Keep Frozen" in four (4) of four (4) cases.

The temperature of the other seven (7) cartons

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM			STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015	
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F 371	Continued From page 46. was within the safe temperature range. 13. The temperature of the salad cold box was observed at 52 degrees F. The following items were stored in the salad cold box: Sliced Mushrooms- 9/23 (date opened) Tomato Puree - 9/23 Tartar Sauce - 6/28 Honey Dijon Dressing - 7/16 Sesame Dressing - 7/23 Raspberry Vinaigrette - 7/26 Pickle Relish - 8/9 Duck Sauce - 8/1 Salsa - 8/12 Fahini dip - 8/14 Olives - 8/14 Mayonnaise - 8/19 French Dressing - 8/20 Thousand Island Dressing - 8/20 BBQ Sauce - 8/27 Caesar Dressing - 8/30 Vinaigrette Dressing - 9/1 Blue Cheese Dressing - 9/6 Ranch Dressing - 9/10 Raspberry Vinaigrette Dressing -9/11 Mayonnaise - 9/13 Cottage Cheese - 9/17 Cocktail Sauce - no open date Peach Yogurt - no open date Grey Pupon Mustard - no open date Village Garden Cole Slaw Dressing - no open date Employees #8 and 9 acknowledged the above findings at the time of the observations.	F 371		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of	F 431		

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F 431	<p>Continued From page 47</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's staff failed: to label four (4) of four (4) Lorazepam injections with the appropriate expiration date, store expired medications with</p>	F 431	<p>#9 F- 431 9D0 Pharmacy Services.</p> <p>1. Residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> All carts involved during survey were inspected and all expired medications were removed and unlabeled medications dated and labeled correctly. 9/26/2007 Pharmacy faxed over the in-service information to comply with the 2 in-services a year requirement <p>2. <u>Other potential involvement</u></p> <ul style="list-style-type: none"> All medication carts have been audited for expired medications and unlabeled medications. 10/1/2007 <p>3. <u>Measure put in place</u></p> <ul style="list-style-type: none"> All licensed nurses will be educated on storage of medication, dating, and handling of expired medications protocol 10/26/2007 Random medication cart audits will be conducted weekly by the 11-7 shift to insure compliance 10/12/2007 Staff Development Coordinator will be educated on the requirement to have the handout for proof of in-service <p>4. <u>QA</u></p> <ul style="list-style-type: none"> Audits will be discussed and reviewed during QA meeting. Deficient practice will be discussed, reviewed and recommendations given during monthly QA meeting. 	11/9/2007
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Review required

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 431	<p>Continued From page 47</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's staff failed to label four (4) of four (4) Lorazepam injections with the appropriate expiration date, store expired medications with</p>	F 431	<p>#9 F- 431 9DO Pharmacy Services.</p> <p>1. Residents found to have been affected by the deficient practice.</p> <ul style="list-style-type: none"> All carts involved during survey were inspected and all expired medications were removed and unlabeled medications dated and labeled correctly. 9/26/2007 Pharmacy faxed over the in-service information to comply with the 2 in-services a year requirement <p>2. <u>Other potential involvement</u></p> <ul style="list-style-type: none"> All medication carts have been audited for expired medications and unlabeled medications. 10/1/2007 <p>3. <u>Measure put in place</u></p> <ul style="list-style-type: none"> All licensed nurses will be educated on storage of medication, dating, and handling of expired medications protocol 10/26/2007 Random medication cart audits will be conducted weekly by the 11-7 shift to insure compliance 10/12/2007 Staff Development Coordinator will be educated on the requirement to have the handout for proof of in-service <p>4. <u>QA</u></p> <ul style="list-style-type: none"> The Unit Manager and supervisor will monitor for expired medications. Audits will be discussed and reviewed during QA meeting. Deficient practice will be discussed, reviewed and recommendations given during monthly QA meeting. 	11/9/2007
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Review received 11/9/07 ad

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 431	<p>Continued From page 48</p> <p>currently dated medications, and date and initial 22 of 24 multi-dose medication vials when first opened.</p> <p>The findings include:</p> <p>1. The facility staff failed to label medication vials appropriately.</p> <p>Based on observation and staff interview, the facility's staff failed to label four (4) of four (4) Lorazepam injections with the appropriate expiration date and store expired medications with currently dated medications.</p> <p>The findings include:</p> <p>1. The facility staff failed to label medication vials appropriately.</p> <p>According to The Drug Information Handbook for Nursing, stipulates, under Storage, " Intact vial should be refrigerated, protected from light; do not use discolored ... May be stored at room temperature for up to 60 days. "</p> <p>On September 25, 2007, at 2:30 PM, the medication carts were inspected, four (4) of four (4) Lorazepam Injection 2mg/ml vial were found undated in the controlled substance drawer. This medication requires an expiration date on the container when stored at room temperature.</p> <p>Employee #15 acknowledged that the Lorazepam 2mg/ml injection vials were stored undated in the medication cart at the time of the inspection.</p> <p>2. The facility staff failed to remove expired medication from the currently dated medication.</p>	F 431		
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F 431	<p>Continued From page 49</p> <p>The facility 's policy #5.3, " Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles " stipulates, (3) " Drugs and biological that have an expired date on the label or are after manufacturer/supplies guidelines/recommendations, or if contaminated ... are stored separately, away from use, until destroyed or returned to the provider. "</p> <p>A. On September, 24 2007, at 2:30 PM, during the inspection of the Lower Level ' s medication storage area, nine (9) containers were observed stored in the medication refrigerator. Two (2) of nine (9) opened insulin containers were stored beyond the 30 day expiration date.</p> <p>The following Insulins were observed:</p> <p>Lantus insulin - Expiration date - 8/22/2007. Novolin N Insulin - Expiration date - 8/16/2007</p> <p>During a face-to face interview, on September 24, 2007, at approximately 2:40 PM with Employee #20, he/she acknowledged that the insulin was given to the resident that morning and the bottles of insulin had expired. No untoward effects were noted per nursing documentation.</p> <p>B. On September 25, 2007, at during the inspection of the medication carts, blister package of Hydrocodone/APAP 5mg/500 mg, was observed with an expiration date of July 30, 2007.</p> <p>During a face-to-face interview, on September 25, 2007, at approximately 2:30 PM, Employee #15</p>	F 431		
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F 431	<p>Continued From page 50</p> <p>acknowledged that the medication was expired.</p> <p>According to The Drug Information Handbook for Nursing, stipulates, under Storage, " Intact vial should be refrigerated, protected from light; do not use discolored ... May be stored at room temperature for up to 60 days. "</p> <p>On September 25, 2007, at 2:30 PM, the medication carts were inspected, four (4) of four (4) Lorazepam Injection 2mg/ml vial were found undated in the controlled substance drawer. This medication requires an expiration date on the container when stored at room temperature.</p> <p>Employee #15 acknowledged that the Lorazepam 2mg/ml injection vials were stored undated in the medication cart at the time of the inspection.</p> <p>3. The facility staff failed to date and initial 22 of 24 multi-dose medication vials when first opened.</p> <p>The facility's policy # 5.3, 3.1, " Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles " stipulates, " Once any drug or biological package is opened, follow manufacturer/supplier guidelines for in use expiration dating. "</p> <p>On September 24 and 25, 2007, between 2:30 PM and 3:30 PM, the medication carts and refrigerators were inspected on each unit. The facility staff failed to date and initial opened multi-dose medication vials.</p> <p>The medication included:</p>	F 431		
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F 431	<p>Continued From page 51</p> <p>Upper Level Unit Xalatan ophthalmic drops five (5) vials PPD 5 TU/0.1ml (1ml vial) three (3) vials Lantus insulin 10 ml three (3) vials Regular Novolin insulin 10 ml one (1) vial Lidocaine 1% 10 ml two (2) vials</p> <p>Employees #5 and #14 acknowledged that the medications listed above were not dated and/or initiated at the time of the observations.</p> <p>Lower Level Unit Xalatan ophthalmic drops two (2) vials Lantus insulin 10 ml three (3) vials Novolog insulin 10 ml one (1) vial Novolin Regular insulin 10 ml one (1) vial</p> <p>Employees #3 and #20 acknowledged that the vials listed above were not dated and/or initiated at the time of the observations.</p> <p>Rehabilitation Unit Tuberculin Purified protein Derivate 5TU/0.1ml 5ml one (1) vial</p> <p>Employee #20 acknowledged that the above vial were not dated and/or initiated at the time of the observations.</p>	F 431		
F 441 SS=D	<p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 52</p> <p>isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to provide a safe and sanitary environment as evidenced by residents' bathing basins stored on closet floors and failure to post signs indicating which residents required special isolation precautions. These observations were made in the presence of Employees #10 and #11.</p> <p>The findings include:</p> <p>1. Facility staff stored residents' bathing basins containing personal grooming items on closet floors.</p> <p>During the initial environmental tour, bathing basins containing personal care items, such as dentures cups, deodorant, and a kidney basin, were observed stored on the floor in rooms 166 and 178 on September 24, 2007 at approximately 9:30 AM for two (2) of 12 rooms observed.</p> <p>2. Facility staff failed to post signs to notify visitors and staff which residents required special isolation precautions.</p> <p>During the initial tour, it was observed that isolation signs were not posted on rooms 79, 97 and 181, to notify visitors and staff that those residents required special isolation precautions and should not be entered prior to speaking to nursing staff on September 24, 2007 between</p>	F 441	<p>#10 F- 441 Infection Control (LJ)</p> <p>1. <u>Residents found to have been affected by the deficient practice.</u></p> <ul style="list-style-type: none"> Items stored on the floor were removed immediately 9/26/2007 Isolation signs were posted immediately 10/24/2007 <p>2. <u>Other resident identified having the potential to be affected by the same practice.</u></p> <ul style="list-style-type: none"> All residents in isolation has signage posted .10/26/2007 All residents with items on the floor we are working with the residents and families to resolve these issues 10/26/2007 <p>3. <u>Measure put into place.</u></p> <ul style="list-style-type: none"> All nursing staff will be educated on isolation control procedures All residents requiring isolation will be put on the 24 hour report The Infection Control Nurse will do random weekly audits for compliance of isolation precautions. QA committee will discuss, review and monitor Infection Control data during monthly QA / QA Committee will recommend appropriate plans of action to correct deficient practice. <p>4. <u>QA</u></p> <ul style="list-style-type: none"> Isolation audits will be discussed, reviewed and monitored during the monthly QA meeting. QA committee will recommend appropriate plans of action to correct deficient practice. 	
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request

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 441	<p>Continued From page 52</p> <p>isolation should be applied to an individual resident, and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to provide a safe and sanitary environment as evidenced by residents' bathing basins stored on closet floors and failure to post signs indicating which residents required special isolation precautions. These observations were made in the presence of Employees #10 and #11.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Facility staff stored residents' bathing basins containing personal grooming items on closet floors. <p>During the initial environmental tour, bathing basins containing personal care items, such as dentures cups, deodorant, and a kidney basin, were observed stored on the floor in rooms 166 and 178 on September 24, 2007 at approximately 9:30 AM for two (2) of 12 rooms observed.</p> <ol style="list-style-type: none"> 2. Facility staff failed to post signs to notify visitors and staff which residents required special isolation precautions. <p>During the initial tour, it was observed that isolation signs were not posted on rooms 79, 97 and 161, to notify visitors and staff that those residents required special isolation precautions and should not be entered prior to speaking to nursing staff on September 24 2007 between</p>	F 441	<p>#10 F- 441 Infection Control (U)</p> <ol style="list-style-type: none"> 1. <u>Residents found to have been affected by the deficient practice.</u> <ul style="list-style-type: none"> • Items stored on the floor were removed immediately 9/26/2007 • Isolation signs were posted immediately 10/24/2007 2. <u>Other resident identified having the potential to be affected by the same practice.</u> <ul style="list-style-type: none"> • All residents in isolation has signage posted 10/26/2007 • All residents with items on the floor we are working with the residents and families to resolve these issues 10/26/2007 3. <u>Measure put into place.</u> <ul style="list-style-type: none"> • All nursing staff will be educated on isolation control procedures • All residents requiring isolation will be put on the 24 hour report • The Infection Control Nurse will do random weekly audits for compliance of isolation precautions. • QA committee will discuss, review and monitor Infection Control data during monthly QA / QA Committee will recommend appropriate plans of action to correct deficient practice. 4. <u>QA</u> <ul style="list-style-type: none"> • The Infection control coordinator will monitor for deficient infection control practices. QA committee will recommend appropriate plans of action to correct deficient practice. 	
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Review received 11/7/07

53A

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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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F 441	Continued From page 53 8:30 AM and 10:00 AM for three (3) of three (3) residents in isolation.	F 441		
F 490 SS=D	<p>Employees #10 and #11 acknowledged these findings at the time of the observations.</p> <p>483.75 ADMINISTRATION</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administrative staff failed to integrate, coordinate and monitor the facility's practices related to residents' care and safety.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The review of residents' records revealed that facility staff failed to provide adequate supervision for residents who had multiple falls some with injuries. Cross reference CFR 483.25 Quality of Care F323. The facility staff failed to ensure that residents environment remained as free of accidents hazards as is possible. Cross reference CFR 483.25 F323 The review of records revealed that facility staff failed to initiate additional goals and approaches for residents with multiple falls and injuries. Cross reference 483.20 F280 	F 490	<p>F 490</p> <ol style="list-style-type: none"> Staff will provide adequate supervision for all residents who had multiple falls. Cross reference CFR 483.25 F323 in this document. The facility will ensure that the residents environment remain as free of accidents hazards as possible. Cross reference CRF 483.25 F323 in this document. The staff will initiate additional goals and approaches for residents with multiple falls and injuries. Cross reference CRF 483.20 F280 <p><i>Revisions requested</i></p>	11/9/2007

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F 441	Continued From page 53 8:30 AM and 10: 00 AM for three (3) of three (3) residents in isolation.	F 441		
F 490 SS=D	Employees #10 and #11 acknowledged these findings at the time of the observations. 483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administrative staff failed to integrate, coordinate and monitor the facility's practices related to residents' care and safety. The findings include: 1. The review of residents' records revealed that facility staff failed to provide adequate supervision for residents who had multiple falls some with injuries. Cross reference CFR 483.25 Quality of Care F323. 2. The facility staff failed to ensure that residents environment remained as free of accidents hazards as is possible. Cross reference CFR 483.25 F323 3. The review of records revealed that facility staff failed to initiate additional goals and approaches for residents with multiple falls and injuries. Cross reference 483.20 F280	F 490	F 490 1. Staff will provide adequate supervision for all residents who had multiple falls. Cross reference CFR 483.25 F323 in this document. • The facility will ensure that the residents environment remain as free of accidents hazards as possible. Cross reference CFR 483.25 F323 in this document. • The staff will initiate additional goals and approaches for residents with multiple falls and injuries. Cross reference CFR 483.20 F280	11/9/2007

*Received
11/7/07
no revision*

54A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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request 11/2/07

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F 492 SS=E	<p>483.75(b) ADMINISTRATION</p> <p>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to: failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees and maintain current licenses for Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certifications for Certified Nurse Aides (CNA).</p> <p>The findings include:</p> <p>1. The facility failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees.</p> <p>According to the 22DCMR 3211.2 (d), "The facility shall have at least the following employees: A minimum of two (2) nursing employees per nursing unit, per shift."</p> <p>On September 24, 2007 at approximately 9:00 AM during the tour of the rehabilitation unit, it was observed that one (1) licensed practical nurse (LPN) was caring for five (5) residents. There were no other nursing employees on the Rehabilitation unit at the time of the observation.</p> <p>A face-to-face interview was conducted at 9:05 AM with Employee #4. He/she stated, "The CNA</p>	F 492	<p>F492 Administration</p> <ol style="list-style-type: none"> No residents were affected by this deficiency. <ul style="list-style-type: none"> The facility will ensure that a minimum of two nursing employees be on a nursing unit, per shift. The facilities Human Resources department will maintain current licenses and certificates for RN's, LPN's and C.N.A.'s. The staffing patterns were observed on each unit for each shift to ensure that a minimum of two nursing employees was met. The employee files for the RN's, LPN's, and C.N.A.'s were checked by the Human Resources department for current licenses and certificates. The staffing coordinator will monitor the staffing patterns on the units daily. The Human Resource Director or designee will review/ audit the renewal dates of the licensed nursing staff and c.n.a.'s employed by the facility monthly. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec., & Jan. 2008. 	<p><i>Review requested</i></p> <p>11/09/2007</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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F 492 SS=E	<p>483.75(b) ADMINISTRATION</p> <p>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to: failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees and maintain current licenses for Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certifications for Certified Nurse Aides (CNA).</p> <p>The findings include:</p> <p>1. The facility failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees.</p> <p>According to the 22DCMR 3211.2 (d), "The facility shall have at least the following employees: A minimum of two (2) nursing employees per nursing unit, per shift."</p> <p>On September 24, 2007 at approximately 9:00 AM during the tour of the rehabilitation unit, it was observed that one (1) licensed practical nurse (LPN) was caring for five (5) residents. There were no other nursing employees on the Rehabilitation unit at the time of the observation.</p> <p>A face-to-face interview was conducted at 9:05 AM with Employee #4. He/she stated, "The CNA</p>	F 492	<p>F492 Administration</p> <ol style="list-style-type: none"> No residents were affected by this deficiency. <ul style="list-style-type: none"> The facility will ensure that a minimum of two nursing employees be on a nursing unit, per shift. The facilities Human Resources department will maintain current licenses and certificates for RN's, LPN's and C.N.A.'s. The staffing patterns were observed on each unit for each shift to ensure that a minimum of two nursing employees was met. The employee files for the RN's, LPN's, and C.N.A.'s were checked by the Human Resources department for current licenses and certificates. The staffing coordinator will monitor the staffing patterns on the units daily. The Human Resource Director or designee will review/ audit the renewal dates of the licensed nursing staff and c.n.a.'s employed by the facility monthly. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec., & Jan. 2008. 	<p>received 11/7/07 no revision aw</p> <p>11/09/2007</p>
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55A

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

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F 492	<p>Continued From page 55 (certified nurse aide) called in sick at one o'clock this morning and wasn't replaced."</p> <p>2. Facility staff failed to maintain current licenses and certifications for RNs, LPNs and CNAs.</p> <p>According to 22DCMR 3203.2, "A list of employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director."</p> <p>A review of the licenses for currently employed RNs revealed that eight (8) of 10 licenses had expired.</p> <p>A review of the licenses for currently employed LPNs revealed that 17 of 17 licenses had expired.</p> <p>A review of the licenses for currently employed CNAs revealed that 12 of 29 licenses had expired.</p> <p>The staff of the Human Resource department immediately obtained a copy of a current licenses and certifications for all the above cited employees from appropriate web sites.</p> <p>A face-to-face interview was conducted on September 25, 2007 at 12:30 PM with Employee #13. He/she stated, "In the past, the staff educator kept the licenses. The staff educator is new and didn't know [he/she] was responsible for keeping a copy of current licenses. We (Human Resources) will own it now. We will maintain the licenses from now on."</p>	F 492		
F 520 SS=D	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE	F 520		

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F 520	<p>Continued From page 56</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the facility's Quality Assurance committee failed to adequately implement plans of action to correct identified deficient practices facility wide.</p> <p>The findings include: On September 26, 2007 at approximately 11:00 AM, a face- to- face interview was conducted with Employee # 17, who was identified as the Quality Assurance (QA) coordinator.</p>	F 520	<p>#13 F- Tag 520 Quality Assessment and Assurance</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> The DON and the QA Coordinator reviewed with the Survey Team leader our process for monitoring falls. <u>Other resident identified having the potential to be affected by the same practice</u> <ul style="list-style-type: none"> All residents that fell within the last 90 days will be reviewed with care plan updates. <u>Measures put in place</u> <ul style="list-style-type: none"> Falls Committee has been developed. The first meeting is 10/12/2007 to review recent falls and those residents who <u>QA</u> <ul style="list-style-type: none"> The monthly QA meeting will review all deficient practices and will recommend appropriate plans of action to correct deficient practice. 	11/9/2007
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Residents Requested

Revision 11/3/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 520	<p>Continued From page 56</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the facility's Quality Assurance committee failed to adequately implement plans of action to correct identified deficient practices facility wide.</p> <p>The findings include:</p> <p>On September 26, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Employee # 17, who was identified as the Quality Assurance (QA) coordinator.</p>	F 520	<p>#13 F- Tag 520 Quality Assessment and Assurance</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> All residents identified during the survey were reviewed by the IT team, care plans updated, falls risk updated and interventions added as needed. 10/30/2007 <u>Other resident identified having the potential to be affected by the same practice</u> <ul style="list-style-type: none"> All residents that fell within the last 90 days will be reviewed with care plan updates. <u>Measure put in place</u> <ul style="list-style-type: none"> Falls Committee has been developed. The first meeting is 10/12/2007 to review recent falls and those residents who have fallen in the last 90 days. <u>QA</u> <ul style="list-style-type: none"> The DON will present the falls data at the monthly QA meeting for review & recommendations. 	11/9/2007
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB NO. 0938-0391

request 11/26/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2007
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NAME OF PROVIDER OR SUPPLIER INGLESIDE PRESBYTERIAN RETIREM	STREET ADDRESS, CITY, STATE, ZIP CODE 3050 MILITARY ROAD NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 520	<p>Continued From page 56</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the facility's Quality Assurance committee failed to adequately implement plans of action to correct identified deficient practices facility wide.</p> <p>The findings include:</p> <p>On September 26, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Employee # 17, who was identified as the Quality Assurance (QA) coordinator.</p>	F 520	<p>#13 F- Tag 520 Quality Assessment and Assurance</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> The DON and the QA Coordinator reviewed our process for monitoring falls. 10/30/2007 <u>Other resident identified having the potential to be affected by the same practice</u> <ul style="list-style-type: none"> All residents that fell within the last 90 days will be reviewed with care plan updates. <u>Measures put in place</u> <ul style="list-style-type: none"> Falls Committee has been developed. The first meeting is 10/12/2007 to review recent falls and those residents who have fallen in the last 90 days. QA <ul style="list-style-type: none"> The monthly QA meeting will review all deficient practices and will recommend appropriate plans of action to correct deficient practice. 	<p><i>received 11/7/07 and #17 & #9 not reviewed</i></p> <p>11/9/2007</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 520	<p>Continued From page 56</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the facility's Quality Assurance committee failed to adequately implement plans of action to correct identified deficient practices facility wide.</p> <p>The findings include:</p> <p>On September 26, 2007 at approximately 11:00 AM, a face-to-face interview was conducted with Employee # 17, who was identified as the Quality Assurance (QA) coordinator.</p>	F 520	<p>#13 F- Tag 520 Quality Assessment and Assurance</p> <ol style="list-style-type: none"> <u>Residents found to have been affected by the deficient practice</u> <ul style="list-style-type: none"> All residents identified during the survey were reviewed by the IIT team, care plans updated, falls risk updated and interventions added as needed. 10/30/2007 <u>Other resident identified having the potential to be affected by the same practice</u> <ul style="list-style-type: none"> All residents that fell within the last 90 days will be reviewed with care plan updates. <u>Measure put in place</u> <ul style="list-style-type: none"> Falls Committee has been developed. The first meeting is 10/22/2007 to review recent falls and those residents who have fallen in the last 90 days. <u>QA</u> <ul style="list-style-type: none"> The DON will present the falls data at the monthly QA meeting for review & recommendations. 	11/9/2007	

Review received 11/14/07

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F 520	<p>Continued From page 57</p> <p>Based on on-going surveyor concerns, the QA coordinator was asked if the committee monitored falls in the facility. The coordinator explained that she/he did not monitor falls in the facility. Employee# 1 monitored the falls.</p> <p>On September 26, 2007 at approximately 12:30 PM, a face-to-face interview was conducted with Employee # 1. He/she stated, "We were looking at falls and decided that we needed to develop a falls committee. That is something we will do soon. Falls are discussed at the morning meetings. The Nurse Managers investigate the fall and make the decision of what to do. We have the Leaping Deer program, but we do not formally track fall incidents."</p> <p>There was no evidence that the quality assurance committee developed or implemented appropriate plans of action to correct identified deficiencies for residents with multiple falls in the facility.</p>	F 520		
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