

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

PRINTED: 12/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2009
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NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010
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F 000	INITIAL COMMENTS A recertification survey and investigation of Complaint 09-069/DC00001758 were conducted November 3 through 9, 2009. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 24 residents based on a census of 159 residents on the first day of survey and nine(9) supplemental residents.	F 000	<u>Resident #12</u> 1. The attending physician was notified on 6/6/09 regarding resident's skin integrity and orders were received on 6/6/09.	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	2. All other residents with high risk for impaired skin integrity were assessed by the licensed staff and physician notified if necessary. 3. Existing policy on skin integrity was amended to reflect standing order treatment for care of stage 1 skin integrity concern. Licensed staff were provided in-service on Resident Skin Integrity and Change in Resident Assessment on 12/17/09, 12/18/09, 12/19/09, 12/20/09. 4. Resident Skin Integrity will be monitored weekly and through CQI quarterly. 5. Completion date 12/24/09.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X8) DATE **12/29/09**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that the facility staff failed to notify the physician of Resident #12 ' s impaired skin integrity.</p> <p>The findings included:</p> <p>A review of the clinical record for Resident #12 revealed that facility staff failed to notify the physician that Resident #12 was admitted with an alteration in skin integrity.</p> <p>A nurse's note dated June 2, 2009 at 2:00 PM, revealed "Resident re-admission note ...Resident is an 82 year old admitted to (facility). Readmission diagnoses are as follows: Diabetes Mellitus, Hypertension, Lung Cancer, Bilateral Lower Extremities Amputation, and Peripheral Vascular Disease.</p> <p>The facility's skin assessment sheet entitled "Skin Assessment" sheet dated June 2, 2009 revealed a photo that was taken of the resident ' s perineal area. The photograph revealed areas of redness on the perineal area.</p> <p>A review of the clinical record for Resident #12 revealed a nurse's note dated June 6, 2009 at 10:30 PM " Redness in peri area noted. Dr. made aware. Order was given to clean peri area, with soap, rinse well, pat dry, apply Calmoseptine ointment after each incontinent episode."</p>	F 157	0.	

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F 157	Continued From page 2	F 157	F 158	
F 158 SS=D	<p>A period of approximately four (4) days passed before the physician was informed regarding the resident's impaired skin.</p> <p>A face-to-face interview was conducted with Employee #8 on November 5, 2009 at approximately 10:30 AM. He/she acknowledged that the resident's physician was not notified on June 2, 2009 regarding redness in the perineal area. The record was reviewed on November 5, 2009.</p> <p>483.10(c)(1) PROTECTION OF RESIDENT FUNDS</p> <p>The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview it was determined that facility staff failed to allow a resident the right to manage his/her personal funds. Resident M3</p> <p>Through record review and interview it was determined that on or about October 16, 2008 a check payable exclusive to the order of the resident was negotiated without the resident's knowledge or permission and the funds were deposited to the Facilities Resident Fund Account and transferred back to the resident by way of a credit towards his/her unpaid outstanding balance due to the facility.</p> <p>A face to face interview was held with Employee #</p>	F 158	<ol style="list-style-type: none"> 1. Resident M3 was refunded and amount credited to balance. 2. All residents with checks payable exclusively to the resident were audited to determine if any checks were negotiated without the resident's knowledge. There were no other residents identified in this similar situation. 3. Resident funds payable exclusively to the resident will be forwarded to the resident. Mail with resident funds received in the Business Office will be turned over to the Social Services Department who will deliver the unopened mail to the resident. In-service provided to Finance and Social Services staff on 12/17/09. 4. Social Services Department will interview residents regarding their rights to manage their financial affairs and report to CQI monthly. 5. Completion date 12/24/09. 	

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F 158	Continued From page 3 22 on November 6, 2009 around 5:00 PM. He/she acknowledged that the check was negotiated and applied to the resident 's outstanding balance.	F 158			
F 226 SS=D	<p>483.13(c) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the facility occurrence reports, it was determined that facility staff failed to report an alleged assault [staff-to-resident] to the state agency in one (1) of one (1) alleged abuse occurrences.</p> <p>The findings include:</p> <p>The policy entitled: Prohibition of Resident Abuse. Policy No: 99-12, stipulates "VII. Reporting/Response- ...All incidents of physical abuse (staff-resident, resident-resident), will be reported to the Police Department by calling 911.</p> <p>As required by law, the following people will be notified. DC Regulatory Agency..."</p> <p>A review of the "September 2009 Occurrence Report" revealed, "...September 7, 2009... Other-alleged assault...non-apparent /visible injury..."</p> <p>A face-to-face interview was conducted with Employee #3 on November 6, 2009 at __. He/she stated, "The occurrence of alleged assault</p>	F 226	<ol style="list-style-type: none"> 1. Identified occurrence report of 11/6/09 was re-faxed to the Department of Health on 12/24/09. 2. All other occurrence reports were reviewed to ensure that all appropriate occurrence reports were faxed to the Department of Health with confirmation fax sheet. 3. The Operations Coordinator will be responsible effective 12/23/09 for sending, tracking and validating distribution reports to the Department of Health. A log will be maintained in Administration. Nursing leadership provided training on revised process on 12/22/09. 4. Occurrence Reporting will be monitored monthly through CQI. 5. Completion date 12/24/09. 		

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F 226	Continued From page 4 from staff-to-resident was not reported to the state agency."	F 226		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	1. Reassessment of resident records #1, 3, 4, 5, 6, 7, 8, 12, 22, D1 and W1 were corrected and transmitted on 12/18/09. 2. All MDS assessments were reviewed for accuracy. There were no other MDSs found with similar findings. 3. MDS Coordinators were provided in-service on Accurate MDS Coding on 12/21/09. MDS Coordinators will continue to attend all Interdisciplinary Care Plan meetings. 4. Accuracy of MDS coding will be monitored monthly through CQI. 5. Completion date 12/24/09.	

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F 278	<p>Continued From page 5</p> <p>Based on observations, record review and staff interview for nine (9) of 24 sampled residents and two (2) of nine (9) supplemental residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) assessment for: locomotion for four (4) residents, correctly date the attestation statement for one (1) resident, catheter use for one (1) resident, falls for one (1) resident, nutrition for one (1) resident, weight loss for one (1) resident, pressure ulcers for three (3) residents, restraints for two (2) residents, vision for one (1) resident and Discharge Summary for one (1) resident. Residents #1, 3, 4, 5, 6, 7, 8, 12, 22, D1 and W1.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of the clinical record for Resident #1 revealed facility staff failed to accurately code the annual Minimum Data Set (MDS) for enteral intake and mode of locomotion. Additionally, the annual and quarterly MDS ' were inconsistently coded for appliances and programs. <p>According to the history and physical examination signed February 8, 2009, Resident #1's diagnoses included Dementia, Hypothyroidism, Chronic Renal Insufficiency, history of Colon Cancer and Deep Vein Thrombosis. A colostomy and ureterostomy was in place for bowel and bladder elimination and the resident received nutrition/hydration via gastrostomy tube.</p> <p>A. The annual MDS signed December 17, 2008 revealed Section K, Oral/Nutritional status was coded as " leaves 25% or more of food uneaten at most meals. "</p> <p>According to the nutritional evaluation dated</p>	F 278		

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F 278	<p>Continued From page 6</p> <p>December 1, 2008 the resident was NPO (nothing by mouth) and received bolus gastrostomy tube (g-tube) feedings four (4) times daily.</p> <p>A face-to-face interview was conducted with Employee #9 on November 4, 2009 at approximately 11:00 AM. In response to a query regarding Resident #1 's nutritional status, he/she acknowledged that the MDS was coded inaccurately and that the resident received nothing by mouth.</p> <p>B. The annual MDS signed December 17, 2008 revealed Section G, Modes of locomotion was coded as " wheeled self. "</p> <p>Additionally, Section G, "Physical Functioning and Structural Problems" of the same assessment revealed the resident was coded as totally dependent for transfer and locomotion and had limited range of motion of both legs and feet.</p> <p>A face-to-face interview was conducted with Employee #7 on November 3, 2009 at approximately 2:30 PM. He/she revealed that Resident #1 was totally dependent for transfer and unable to wheel him/herself. A Gerichair was utilized for transport and seating purposes. He/she confirmed that this was the case during the period of December 2008.</p> <p>A face-to-face interview was conducted with Employee #9. He/she acknowledged the inaccuracy of the assessment during an interview on November 4, 2009 at approximately 11:00 AM.</p> <p>C. The annual MDS signed December 17, 2008 revealed Section H, Continance was coded as "ostomy present." The quarterly MDS assessment</p>	F 278		
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F 278	<p>Continued From page 7</p> <p>signed September 16, 2009 revealed Section H was coded as "ostomy present and indwelling catheter."</p> <p>The history and physical examination dated February 8, 2009 revealed the resident had a ureterostomy in place for genitourinary elimination.</p> <p>A face-to-face interview was held with Employee #9 on November 3, 2009 at approximately 2:30 PM. In response to a query regarding the presence of Resident #1 ' s ureterostomy during the most recent annual and quarterly MDS assessments, he/she responded that the catheter was present and functioning during the assessment review periods. He/she stated that the presence of ureterostomy was coded as "ostomy " in Section H, not as indwelling catheter.</p> <p>The quarterly assessment revealed the resident was coded as ostomy and indwelling catheter and the annual assessment was coded as ostomy. In each instance, the resident had an ureterostomy for genitourinary elimination. The record revealed inconsistencies in the coding of the Section H, Continence, appliances and programs. The record was reviewed on November 3, 2009.</p> <p>2. Facility staff failed to accurately code Resident #3 for locomotion and weight loss.</p> <p>A. Facility staff failed to accurately code Resident #3 for locomotion.</p> <p>Resident #3 admitted with the following diagnoses: Multiple Sclerosis, Neurogenic Bladder, Gastroesophageal Reflux Disease</p>	F 278			

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F 278	<p>Continued From page 8</p> <p>(GERD), Depression, Bilateral Lower Extremity weakness with pain, Spasticity, History of falls, Fracture/Left Ulnar and pain, Deep Vein thrombosis (DVT), fall risk, protocol status post falls.</p> <p>Review of the significant change MDS completed August 11, 2009 revealed that in Section G5(b) Modes of locomotion the resident was coded as wheeled self. "</p> <p>A review of the Nurse Practitioner's note dated July 25, 2009 revealed in section: "assessment and plan: Resident with Multiple Sclerosis leading to end-stage disease with global decline ... "</p> <p>A review of the Nurse Practitioner's note dated August 3, 2009 revealed in the history of present illness section that the, "resident in no added distress (NAD), no change in baseline, over the past few months resident had fluctuating p.o. (oral) intake, he/she is s/p peg placement. In the review of systems section: resident is dependent for activities of daily living (ADL's) d/t progression of disease. "</p> <p>A face-to-face interview was conducted on November 3, 2009 at approximately 3:30 PM with Employee #8. He/she stated that Resident #3 has never wheeled self since being on that unit.</p> <p>A face-to-face interview on November 4, 2009 with Employee #9 revealed that the coding was incorrect. The record was reviewed on November 4, 2009.</p> <p>B. Facility staff accurately coded the Minimum Data Set (MDS) for weight loss for Resident # 3.</p>	F 278		

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F 278	<p>Continued From page 9</p> <p>The quarterly MDS dated and signed July 14, 2009 identified in section K2 resident height as 65 inches and the weight 118 pounds.</p> <p>A Report of Consultation form dated July 14, 2009 [for G-tube assessment] revealed, "Please assess for G-tube placement. Resident has had weight loss of 13 pounds over the past seven months. He/she is on megace, antidepressants, calorie count, assist with feeding, refused to eat. Past medical history of Multiple Sclerosis, and Seizure. "</p> <p>A review of the significant change MDS completed August 11, 2009 Section K Oral/Nutritional status K2 identified the resident as height 65 inches and weight 113 pounds.</p> <p>The MDS was coded as a weight gain on the significant change MDS completed August 11, 2009. However, the resident had weight loss.</p> <p>A face-to-face interview was conducted with Employee #8 on November 5, 2009 at approximately 1:00 PM. He/she acknowledged that the resident had sustained weight loss. And acknowledged that the MDS was inaccurately coded. The record was reviewed on November 5, 2009.</p> <p>3. A review of the clinical record for Resident #4 revealed facility staff failed to accurately code the MDS for vision, modes of locomotion and falls.</p> <p>A. According to the physician certification and recertification signed May 13, 2009, certified that Resident #4 requires nursing care for the following reasons: HTN, Blind.</p>	F 278		
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F 278	<p>Continued From page 10</p> <p>A review of the quarterly MDS completed October 14, 2009 revealed that Section D3 "Visual Appliances" was coded as " Yes " .</p> <p>On November 5, 2009 at approximately 1:00 PM Resident #4 was observed in the 2nd Floor dining area without eyeglasses.</p> <p>A face-to-face interview was conducted with Employee #9 on November 6, 2009 at approximately 1:50 PM. In response to a query regarding Resident #4's vision, he/she stated the resident is blind and does not wear eyeglasses. Additionally, Employee #9 acknowledged that MDS was coded inaccurately. The record was reviewed November 6, 2009.</p> <p>B. A review of the significant change MDS completed January 21, 2009 revealed Section G1(b) and G1(c) was coded as " 4/2-total dependence/one person physical assist. "</p> <p>A review of the significant change MDS completed January 21, 2009 revealed Section G5, Modes of Locomotion was coded as " (a) cane/walker/crutch. "</p> <p>A review of the initial physical exam and chart review dated August 9, 2009 by the CRNP(Certified Registered Nurse practitioner), Resident #2 " Mobility ADL 's: Dependent: bathing, dressing, toileting, transfers, eating, mobility status and equipment: Assistive Devices used: Gerichair. "</p> <p>A face -to- face interview was conducted with Employee #9 on November 6, 2009 at approximately 3:05 PM. In response to a query regarding Resident #4's functional ability, he/she stated that the resident was totally dependent,</p>	F 278		

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F 278	<p>Continued From page 11 and lacked the ability to move independently. He/she acknowledged the MDS was inaccurately coded for the resident 's mode of locomotion. The record was reviewed November 6, 2009.</p> <p>C. A review of the quarterly MDS completed October 14, 2009 revealed Section J4 "Accidents" was coded for " a fall in past 30 days "</p> <p>A review of the clinical record revealed a nursing note dated September 16, 2009 at 9:00 PM: " At 7:15 PM responsible parties of the above resident reported to the writer that resident in Room... reported to them that he/she fell yesterday. Resident said he/she could not remember telling them that, I remember telling them about my ankle that is aching which resident has started treatment for. "</p> <p>A face-to-face interview was conducted with Employee #7 on November 6, 2009 at approximately 3:05 PM. In response to a query regarding Resident #4's fall, he/she stated that the resident did not fall, it was an " alleged fall. "</p> <p>A face-to-face interview was conducted with Employee #9 on November 6, 2009 at approximately 3:55 PM. He/she acknowledged the MDS was inaccurately coded for falls. The record was reviewed November 6, 2009.</p> <p>4. Facility staff failed to accurately code the MDS for restraint use for Resident # 5</p> <p>A review of section P4 of the MDS dated and signed October 08, 2009 indicates that it was coded a 2- the resident used a trunk restraint daily.</p>	F 278			

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F 278	<p>Continued From page 12</p> <p>Physician's orders dated October 21, 2009 directed " Seatbelt while in wheelchair for safety- release every 2 hours and reposition. O. T. For . "</p> <p>An observation of and interview with the resident was conducted on November 5, 2009 approximately 12:30 PM in the residents room. The resident responded to a greeting by surveyor but was unresponsive to most questions. When the resident was asked if he could open the self releasing seat belt he/she was able to push the release and open the seat belt.</p> <p>Through interview with Employee #3 and review of documentation provided by the facility it was determined that the resident wore a self release seatbelt as a deterrent for falls that was not considered a restraint. The record was reviewed on November 5, 2009.</p> <p>5. Facility staff failed to accurately code the skin condition for Resident #6.</p> <p>A review Resident #6's quarterly MDS dated September 30, 2009 revealed that the resident was coded for a Stage 2 Pressure Ulcer in Section M1. A review of the "Weekly Skin Assessment Sheet" revealed documentation dated August 30, 2009 which stated " Rt[right] buttock resolved. "</p> <p>An observation of the resident ' s buttocks at 11:10 AM on November 5, 2009 failed to reveal any open areas.</p> <p>A face-to-face interview was conducted with Employee #9 at approximately 2:00 PM on November 5, 2009. He/she stated that the ulcer</p>	F 278			

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F 278	<p>Continued From page 13</p> <p>was coded because, "The staff apply Calmoseptine to the buttocks every shift to prevent breakdown. There is a dot there and they are treating it so we have to code it." The record was reviewed on November 5, 2009.</p> <p>6. Facility staff failed to code Resident #7 for skin condition.</p> <p>A review of the quarterly MDS assessment for Resident #7 completed September 6, 2009 revealed that Section M Skin Condition, M1 number of ulcers in stage 2 (2). M2: Type of Ulcer Pressure (2.)</p> <p>According to the CMS's RAI Version 2.0 Manual, Chapter 3 MDS Items [M] Page 3-161 M2. Type of Ulcer (7-day look back)</p> <p>Definition:</p> <p>a. "Pressure Ulcer - Any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers"</p> <p>b. "Stasis Ulcer - A skin ulcer, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD)."</p> <p>Review of the Primary Physicians Order Form dated August 21, 2009 revealed," Cardiology appointment secondary diagnosis A-fib/chronic lower extremity edema. (2) include Peripheral Vascular Disease (PVD) as a Diagnosis."</p>	F 278			

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F 278	<p>Continued From page 14</p> <p>A review of the Report of Consultation form dated August 26, 2009 findings revealed" reddened edema +3 abrasion with right ankle oozing. Recommendation: keep legs elevated during day time ... "</p> <p>A review of the "Assessment Sheet "[for skin], lacked evidence to identify a pressure ulcer.</p> <p>A review of the Treatment Order Sheet for September 2009 lacked evidence to identify a pressure ulcer. A review of progress notes lacked evidence that identified the resident as having a pressure ulcer.</p> <p>A face-to-face interview on November 5, 2009 with Employee # 7 identified that the quarterly assessment dated and signed September 6, 2009 did identify Section M2 ulcer type as coded as pressure.</p> <p>A face-to-face interview on November 5, 2009 with Employee # 9 identified that the quarterly assessment was coded incorrectly. The record was reviewed on November 5, 2009.</p> <p>7. Facility staff failed to code Resident #8 for restraints.</p> <p>A review of the clinical record for Resident #8 revealed facility staff failed to accurately code the quarterly MDS signed July 15, 2009 for restraints.</p> <p>Physician's orders dated October 17, 2009 directed " Easy release belt/alarm while in wheelchair, release every 2 hours for exercise and care. "</p> <p>Resident #8 was observed self propelling his/her</p>	F 278		
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F 278	<p>Continued From page 15</p> <p>wheelchair on November 4, 2009 at approximately 10:00 AM. When asked by facility staff to demonstrate the release of the seatbelt, the resident was observed releasing the belt.</p> <p>A face-to-face interview with Employee #7 on November 4, 2009 at approximately 11:30 AM, revealed that restraints were not utilized for Resident #8.</p> <p>A face-to-face interview was held with Employee #9 who acknowledged the MDS was inaccurately coded for restraints. The record was reviewed on November 4, 2009.</p> <p>8. A review of the admission assessment MDS completed April 7, 2009 revealed that the interdisciplinary team failed to date attestation statements in Section AA (9) after the RN signed that the assessment was completed and failed to accurately code for pressure ulcers for Resident #12.</p> <p>A. Review of the admission assessment signed April 7, 2009 revealed Section AA (9) was signed by Employee #9 and 12 and not dated. Employee #20 signed and dated Section AA (9). All sections that were completed were not listed.</p> <p>A face-to-face interview was conducted on November 6, 2009 with Employee #9 at approximately 3:55 PM. Employee #9 acknowledged that the MDS should have been reviewed for completeness. The record was reviewed November 6, 2009.</p> <p>B. A review of the admission assessment completed April 7, 2009, significant change completed June 6, 2009, and the quarterly MDS</p>	F 278		

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F 278	<p>Continued From page 16</p> <p>completed September 8, 2009, revealed Section M "Skin Condition" was inaccurately coded for a Stage 2 ulcer.</p> <p>According to the history and physical signed April 2, 2009, Resident #12's skin was intact.</p> <p>According to nutrition assessments signed April 1, 2009, and June 4, 2009: " Skin condition, No evidence of decubitus present."</p> <p>According to the nursing monthly summary signed June 25, 2009, July 23, 2009, and August 20, 2009, Resident #12's "Condition of skin ...skin intact."</p> <p>A face-to-face interview was conducted with Employee #8 on November 6, 2009 at approximately 10:40 AM. In response to a query regarding Resident #12 skin condition, he/she stated the resident skin was intact. Employee #9 acknowledged that the MDS was coded inaccurately for skin condition. The record was reviewed November 6, 2009.</p> <p>9. Res. #22 Discharge Planning Facility staff failed to accurately code the MDS Discharge Tracking Form for Resident #22</p> <p>A review of resident's closed record revealed MDS Discharge tracking form dated and signed October 11, 2009 that was coded Seven (7) -Discharged-return anticipated.</p> <p>A review of the resident's Discharge Summary Form dated October 11, 2009 indicated that the resident was discharged to his/her responsible parties' home in an out of state location.</p> <p>An interview was conducted with Employee # 9</p>	F 278		

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F 278	<p>Continued From page 17</p> <p>on November 5, 2009 at approximately 4:00 PM. Employee # 9 stated that the MDS was coded in error and that it should have been coded a six (6) indicating that the resident was discharged to home. A corrected MDS tracking form was prepared and placed in the closed record.</p> <p>10. The facility staff failed to accurately coded Resident D1 for modes of locomotion.</p> <p>Review of the significant change MDS completed October 14, 2009 revealed that in Section G5b Modes of locomotion the resident was coded as wheeled self.</p> <p>A review of the Admission Order Sheet and Physician Plan of Care Sheet dated October 24, 2009 revealed in the "Functional Level- section, dependent for bathing, dressing, eating, mobility, continence."</p> <p>A review of the nursing progress note completed October 6, 2009 revealed that "resident requires total care by the staff, turning and repositioning every two (2) hours."</p> <p>On November 9, 2009 at 9:30 AM the resident was observed receiving one-to-one nursing care for turning and repositioning.</p> <p>Review of Resident D1's record revealed that he/she was non-ambulatory and is currently unable to self propel a wheelchair.</p> <p>A face-to-face interview was conducted on November 9, 2009 at 2:50 PM with Employee #7. He/she stated that the resident is non-ambulatory.</p>	F 278		

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F 278	<p>Continued From page 18</p> <p>The record was reviewed on November 9, 2009.</p> <p>11. Facility staff failed to accurately document skin impairment under section M of the quarterly MDS dated September 30, 2009 For resident W1.</p> <p>According to the CMS's RAI Version 2.0 Manual, Chapter 3 MDS Items [M] Page 3-161</p> <p>M2. Type of Ulcer (7-day look back)</p> <p>Definition:</p> <p>a. "Pressure Ulcer - Any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers"</p> <p>b. "Stasis Ulcer - A skin ulcer, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD)."</p> <p>A review of the quarterly MDS completed September 30, 2009, revealed Section M1 was coded for two (2) stage 2[two] and one (1) stage 3 [three], Section M2 "type of ulcer " was coded for 3 pressure ulcers.</p> <p>According to the Annual history and physical signed October 25, 2009, Resident # W1 had " recurrent VAS.. Leg Ulcers ...Multiple leg ulcers c [with] PVD changes "</p> <p>Skin sheets document one (1) Lt [Left] outer leg open blister stage 2; one R [right] heel stage III; and one L [left heel] stage III.</p> <p>Face-to-face interview was held with Employee</p>	F 278		

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F 278	Continued From page 19 #9 on November 5, 2009 who acknowledged the discrepancies between the documentation of pressure ulcers in the clinical record and the coding of the MDS. The record was reviewed November 6, 2009.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 24 sampled records, it was determined facility staff failed to develop a plan of care to address significant weight loss for one (1) resident. Residents #10.	F 279	F 279 – Resident #10 1. The resident was assessed and care plan was updated to address weight loss and nutritional intervention for weight gain. 2. All other residents care plans with weight loss were checked and no discrepancies were found. 3. Resident Care Coordinators and members of the Interdisciplinary Team were provided in-services on Updating Resident Care Plans on 12/1/09. 4. Resident care plans will be monitored monthly through CQI. 5. Complete date 12/24/09.	

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F 279	Continued From page 20 The findings include: A review of the plan of care for Resident #10 lacked problem identification, objectives and approaches to care for significant unplanned weight loss sustained by the resident. According to a dietary progress note dated June 4, 2009, Resident #10 sustained a significant weight loss over the past 90 days. Nutritional interventions were implemented to address the resident ' s weight loss and a dietary progress note dated September 8, 2009 revealed the resident sustained significant weight gain and weight stabilization as of October 5, 2009. A face-to-face interview was conducted with Employee #5 on November 6, 2009 at approximately 3:00 PM. In response to a query regarding the care plan related to the resident ' s weight loss, he/she acknowledged that the problem list lacked evidence of a nutritional care plan. However, Employee #5 requested an opportunity to research further and returned with care plan problem #292 that identified " Resident has hypertension. " Included in this care plan were notations related to the resident ' s weight loss. The clinical record lacked evidence that facility staff developed a plan of care related to the resident ' s weight loss and nutritional needs. The record was reviewed November 6, 2009.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280			

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F 280	<p>Continued From page 21</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:</p> <p>Based on record review and staff interview it was determined that facility staff failed to update care plan status post fall. Resident M1</p> <p>A review of care plan dated August 26, 2008 for potential for injury/fall related to unsteady gait, impaired vision ... and history of falls revealed that the resident fell on January 5, 2009, March 22, 2009, April 1, 2009 and April 26, 2009.</p> <p>Three (3) hand written notations were made under the Interventions column of the care plan. These hand written notations were not dated.</p> <p>(1)-Caregiver to call for assistance when getting resident out of bed (2)-Alarm on wheelchair when out of bed (3) Apply seatbelt to prevent fall. May release Seatbelt</p>	F 280	<p>Resident #M1</p> <ol style="list-style-type: none"> 1. Resident #M1's care plan was updated and reviewed on 11/9/09. 2. All other resident care plans with previous falls were reviewed and no discrepancies were found. 3. Resident Care Coordinators and members of the Interdisciplinary Team were provided in-service on Updating Resident Care Plans on 12/1/09. 4. Resident care plans will be monitored monthly by Resident Care Coordinators and reported through CQI quarterly. 5. Completion date 12/24/09. 	
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F 280	Continued From page 22 A further review of the record and a face to face interview was conducted with Employee #5 and Employee #27 on November 6, 2009 at 10:30 AM. These employees stated: January 1, 2009 fall - the CNA caregiver was educated March 22, 2009 fall- Alarm on wheelchair when out of bed April 26, 2009 fall- Apply seatbelt to prevent fall. May release Seatbelt. In an interview with Employee# 3 on November 6, 2009 about 3:00 PM it was stated " the missing intervention [For the April 1, 2009 Fall] is that we put the resident in a wheelchair " A Nursing Monthly Summary Dated April, 09 and signed April 19, 2009 by LPN and April 22, 2009 by RN States: " Fell on 04/01/09 [April 1, 2009], sustained no injuries. Continue to wander around the unit with close monitor. No hospitalization. On Ativan 0.5mg QD [everyday] for agitation. Denies pain and discomfort. Addendum [no date] Resident gait unsteady, non compliance for sitting on chairs. Due to multiple fall resident [to] use wheelchair for mobility " The record contained no evidence that the Care plan was updated after fall of April 1, 2009,until the fall of April 27, 2009	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 24 sampled residents, it was determined that facility staff failed to follow physician ' s order for Orthopedic Consult and use of a seat belt for one (1) resident, to discontinue wound treatment per physician ' s order for one (1) resident, to follow through on an order for a GI [Gastroenterology] consult for one (1) resident and monitor pain and obtain a physical therapy consult for one (1) resident. Residents #2, 7, 10 and 16. The findings include: 1. A The facility staff failed To follow physician ' s order for Orthopedic Consult and use of a seat belt while out of bed for Resident #2. A. A review of Resident #2 ' s record revealed a physician ' s telephone order dated July 2, 2009 and signed July 5, 2009 which requested Vascular Consult with (MD ' s name) on July 7, at 12:30PM. Further review of the clinical record failed to reveal any documentation depicting the scheduled appointment, result of the consultation or an order cancelling the order for the consultation. A face-to-face interview was conducted with Employee #5 at approximately 11:55AM on November 4, 2009. He/she stated that, " His wife did not want him to have any more tests.	F 309	Residents #2, 7, 10 and 16 Finding #1 – Resident #2 1. There was no orthopedic consult ordered for Resident #2. The Nurse Practitioner discontinued the vascular consult on 12/18/09. The Attending Physician discontinued the order for a seat belt for Resident #2 on 11/4/09. 2. Residents with orders for seat belts are being monitored to ensure that the residents are wearing their seat belts. Residents with orders for physician consults were reviewed to ensure that appointments had been scheduled. 3. In-service was provided for nursing staff on physician consults and monitoring residents with seat belts on 12/17/09, 12/18/09, 12/20/09, 12/22/09. 4. Physician consults and monitoring residents with seat belts will be monitored by Resident Care Coordinators monthly and reported quarterly through CQI. 5. Completion date 12/24/09.	

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F 309	<p>Continued From page 24</p> <p>The doctor called and told us to cancel the appointment with the vascular doctor. When the nurse wrote the order to cancel the appointment she omitted to cancel the Aortogram with Peripheral Run-Off. Those tests were requested by the vascular surgeon and if he/she was not going to see him/her then there was no need to have the tests. " In another face-to-face interview with Employee #5 at approximately 2:30PM, he/she stated, " I spoke to the doctor at 2:00PM and he/she gave me an order to cancel the test. " The record was reviewed on November 3, 2009.</p> <p>B. A review of Resident #2 ' s record revealed a physician ' s telephone order dated August 20, 2009 and signed on September 2, 2009 which directed " Seat belt while out of bed. Release as necessary. "</p> <p>A review of a quarterly Minimum Data Set dated August 27, 2009 revealed that the resident was coded with a (2) in Section P4c indicating that the resident used the seat belt daily.</p> <p>The resident was observed sitting in a wheel chair without a seat belt at 1:30PM on November 3, 2009 and at 9:00AM and 1:30PM on November 4, 2009.</p> <p>A face-to-face interview was conducted with Employee #5 at approximately 1:45PM on November 4, 2009. He/she acknowledged that the resident was not wearing a seat belt while out of bed. The record was reviewed on November 3, 2009.</p> <p>2. Facility staff failed to discontinue wound treatment orders per physician orders for</p>	F 309	<p>Finding #2 – Resident #7</p> <ol style="list-style-type: none"> 1. Physician order for aqua ointment with 4x4 dressing was discontinued on 11/5/09. Resident did not experience any negative outcome. 2. Resident with dressings were assessed and medical records reviewed for valid orders. 3. In-services were provided for charge nurses on accuracy of dressing changes as ordered by the attending physician on 12/17/09, 12/18/09, 12/19/09 and 12/20/09. 4. Residents dressing changes will be monitored by Resident Care Coordinators monthly and reported through CQI quarterly. 5. Completion date 12/24/09. 	

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F 309	<p>Continued From page 25 Resident #7.</p> <p>Resident #7 was observed with a white dressing wrapped around his/her lower right leg. White colored stockings covered the dressing. During an interview with Resident #7 he/she stated that the "nurse" applied the dressing to his/her leg.</p> <p>Review of the interim order form dated August 19, 2009 directed " (1) bilateral lower extremity arterial venous doppler studies Diagnosis: swelling/wound (2) cleanse open area Right leg with Normal Saline (NS) apply Aquaphor ointment then 4X4/tape daily until resolved (3) Apply Aquaphor ointment to lower extremity daily for dryness. "</p> <p>A review of the Physician ' s Order Sheet signed October 30, 2009 directed. "cleanse right leg open area with NS, apply Aquaphor ointment daily then 4x4/tape daily until healed.</p> <p>According to the facility's "Skin Assessment Sheet " dated September 11, 2009, Resident #7's right leg open area was resolved.</p> <p>A review of the September 2009 Treatment Administration Record (TAR) revealed that Aquaphor ointment then 4X4/tape was initialed as being administered from September 12 through September 30, 2009.</p> <p>A review of the October 2009 TAR revealed that on October 5, 2009 the aforementioned order was discontinued/resolved.</p> <p>The November 2009 TAR indicated that the site: "® [right] leg cleanse open area with NS [Normal Saline], apply Aquaphor ointment daily then</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>4x4/tape daily until healed as DC ' d (discontinued)/resolved. "</p> <p>Although the order was discontinued as of October 5, 2009, Resident #7 was observed on November 5, 2009 with a white dressing on his/her right lower leg.</p> <p>A face-to-face interview was conducted with Employee #22 at the time of the observation. He/she stated, " The wound is completely healed. "</p> <p>A face-to-face interview was conducted at the time of the observation with Employee #7. He/she also indicated that the wound of Resident #7 is completely healed and identified a photo in the wound treatment book showing the wound completely healed. The record was reviewed on November 5, 2009.</p> <p>3. A review of the clinical record for Resident #10 revealed facility staff failed to act on a Nurse Practitioner ' s order for a gastroenterology (GI) consultation for a period greater than 2 months.</p> <p>An interim order signed by the nurse practitioner on August 21, 2009 directed " please make GI appointment with [doctor ' s name] due to weight loss. "</p> <p>The record lacked evidence of a GI consultation.</p> <p>A face-to-face interview was conducted with Employee #5 on November 6, 2009 at approximately 3:00 PM. He/she acknowledged that the GI consultation was not done and stated that it would be scheduled. The record was reviewed November 6, 2009.</p>	F 309	<p>Finding #3 – Resident #10</p> <ol style="list-style-type: none"> 1. Resident's GI consult was discontinued on 12/18/09 by the nurse practitioner based on resident's condition and per request of resident and responsible party. 2. Other residents with orders for physician consult were reviewed and all resident consults had scheduled appointments. 3. Charge nurses were provided in-service on 12/17, 12/18, 12/19, 12/20, 12/22/09 on physician consult. 4. Physician consults will be monitored monthly and reported through CQI quarterly. 5. Completion date 12/24/09. 	

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F 309	<p>Continued From page 27</p> <p>4. The facility staff failed to follow the physician ' s order to monitor pain and obtain a Physical Therapy Consult for Resident #16.</p> <p>A review of the physician ' s order signed by the physician on October 20, 2009 to " Monitor for pain every shift Y = Yes N = No. If pain is new, worsening or if pain [medication] med. was adjusted, changed - document on the pain assessment form. " A review of another physician ' s order dated September 18, 2009 revealed an order for " Acetaminophen 500mg caplet. Give one caplet by mouth three (3) times a day by mouth for pain. " Another physician ' s order dated October 26, 2009 was also noted. This order documented the following, " Oxycodone 5mg at 8PM every [q] day. "</p> <p>A review of the Medication Administration Record (MAR) revealed that the resident received Acetaminophen Caplets 500mg at 10:00AM, 2:00PM and 6:00PM daily on November 1, 2, 3, 4, 5, 6, 7 and 8 at 10AM on November 9, 2009. The MAR also revealed that the resident received Oxycodone daily at 8:00PM on November 1, 2, 3, 4, 5, 6, 7 and 8, 2009.</p> <p>Further review of the MAR failed to reveal any documentation that the resident was monitored for pain as ordered by the physician.</p> <p>During a face-to-face interview conducted with Employee #8 at approximately 12:30PM on November 9, 2009 he/she acknowledged that there was no evidence that the resident ' s pain was monitored when the pain medication was administered. The record was reviewed on November 9, 2009.</p>	F 309	<p>Finding #4 – Resident #16</p> <ol style="list-style-type: none"> 1. Subsequent pain monitoring documentation for Resident #16 is being done. Resident did not experience any negative outcome. 2. All other residents on pain medication MARs were reviewed to ensure that the residents were being monitored for pain and appropriate documentation existed. 3. Charge nurses received in-service on Pain Management/Monitoring and Documentation on 12/17/09, 12/18/09, 12/19, and 12/20/09. 4. Resident MARs will be reviewed for pain management assessment documentation monthly and reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 309	Continued From page 28 B. A review of the clinical record revealed that Resident #16 suffered a fall and sustained a fracture on September 13. According to documentation in the record, an X-ray report revealed a fractured right hip on September 14, 2009 and the resident was hospitalized at an area hospital later that evening. The resident returned to the facility on September 18, 2009. A physician's order dated September 18, 2009 documented " PT [Physical Therapy] eval. [evaluation] " Further review of the clinical record failed to reveal documentation of an evaluation from the physical therapist. A face-to-face interview was conducted with Employee #11 at approximately 11:30PM on November 9, 2009. He/she acknowledged that the PT Eval. was not done and added, " The Rehab. [Rehabilitation] department did not know he/she needed a PT [Physical Therapy] Eval. I did not receive a consult. " Another face-to-face interview was conducted with Employee #8 at approximately 1:30PM on November 9, 2009. He/she acknowledged that the request for the PT Eval was never sent to the Rehab. Department. The record was reviewed on November 9, 2009.	F 309	Finding B, Resident #16 1. The resident's physical therapy consult was ordered on 9/18/09, and completed on 11/16/09. 2. Other resident with decline in mobility and history of falls were reviewed to ensure that all physical therapy consults were completed. 3. All rehab consults will be tracked and monitored in log book. In-service was provided to Nursing and Rehab team on 12/17, 12/18, 12/19, 12/20/09. 4. Physical Therapy consult will be monitored monthly and reported through CQI quarterly. 5. Completion date 12/24/09.	
F 310 SS=D	483.25(a)(1) ACTIVITIES OF DAILY LIVING Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.	F 310		

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F 310	<p>Continued From page 29</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interview, for one (1) of 24 residents reviewed and one (1) supplemental resident, it was determined that facility staff failed to implement measures to address a decline in activities of daily living (ADL) for Residents #14 and M1.</p> <p>The findings include:</p> <p>1. A review of the clinical record for Resident #14 revealed facility staff failed to implement appropriate treatment and services to maximize the resident 's functional abilities when it was determined Resident #14 sustained a decline in activities of daily living (ADL).</p> <p>A review of the Resident Assessment Instruments (RAI) revealed Resident #14 sustained a decline in the abilities to transfer, walk, eat and dress during the period of April 2009 through the time of this review, October 2009.</p> <p>According to the RAI, Quarterly Minimum Data Set (MDS) completed April 14, 2009, Resident #14 was coded in Section G, "Physical Functioning and Structural Problems" as requiring supervision for transfer, ambulation, eating and dressing.</p> <p>The subsequent RAI assessment, Significant Change MDS completed July 14, 2009 revealed the resident had declined and required limited assistance for transfer and ambulation; extensive assistance for dressing and his/her eating skills were consistent as in the prior assessment</p>	F 310	<p>Resident MI</p> <ol style="list-style-type: none"> 1. Resident was assessed on 11/10/09 and due to cognitive decline, the resident was not appropriate for therapy. 2. All other residents with decline in ADLs were screened by Rehab for possible initiation of service. 3. Nursing staff were provided in-services for decline in ADL for initiation of services by the Rehabilitation Services on 12/18 and 12/19/09 4. Residents with decline in ADL will be monitored for initiation of service monthly and reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 310	<p>Continued From page 30 requiring supervision.</p> <p>The most recent Significant Change MDS assessment completed September 22, 2009 revealed the resident's ADL skills continued to decline wherein he/she was coded as being totally dependent for transfer, ambulation, eating and dressing.</p> <p>Additionally, the record revealed the resident sustained a fracture to the Olecranon process on September 5, 2009 after striking his/her elbow against a sink during ADL care according to a nurse's progress note dated September 5, 2009.</p> <p>The resident was observed during the survey period sitting in a high back wheelchair in the day room of his/her residential unit. During dining observations, the resident was observed being fed by staff. A soft splint was noted positioned on the resident ' s right arm.</p> <p>A review of rehabilitative (rehab) evaluations during the period that the resident sustained a decline in ADL ' s lacked evidence of the initiation of services and/or efforts to ensure that the resident ' s functional abilities were maximized.</p> <p>The rehabilitation evaluations, documented on the facility ' s form entitled " Physical Therapy Screen Form" and "Occupational Therapy Screen Form" revealed the following:</p> <p>Physical Therapy (PT) Screens: April 12, 2009, "No new change in function PT evaluation not indicated" May 5, 2009, "At baseline function, PT evaluation not indicated" July 12, 2009, "At baseline function uses</p>	F 310	<p>Resident #14</p> <ol style="list-style-type: none"> 1. Resident 14 was screened by Rehab and started on occupational therapy on 12/14/09. 2. All other residents with decline in ADLs were screened by Rehab for possible initiation of service. 3. Nursing staff were provided in-services for decline in ADL for initiation of services by the Rehabilitation Services on 12/18 and 12/19/09 4. Residents with decline in ADL will be monitored for initiation of service monthly and reported to CQI quarterly. 5. Completion date 12/24/09. 		

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F 310	<p>Continued From page 31</p> <p>wheelchair, PT evaluation not indicated" October 6, 2009, "At baseline function, uses Gerichair, confused, requires extensive assistance in transfers and bed mobility, right arm in cast (status post fracture), PT evaluation not indicated."</p> <p>Occupational Therapy (OT) Screens: April 14, 2009, "OT therapy evaluation not indicated" October 6, 2009 " Continues in right arm hard cast with no significant change in functional status, OT evaluation not indicated. "</p> <p>The record revealed that a self care deficit plan of care was developed for Resident #14 and most recently updated October 13, 2009. However, there was no evidence that interventions and approaches had been revised to address the ADL decline sustained by the resident.</p> <p>A face-to-face interview was conducted with Employee #11 on November 6, 2009 at approximately 4:00 PM. In response to a query regarding methods that had been implemented to address Resident #14 ' s ADL decline, he/she responded that the resident was cognitively not a candidate for rehabilitative services. The surveyor ' s query regarding the rehab screens that revealed no change in function documented after the resident sustained an ADL decline; Employee #11 did not have a response.</p> <p>The clinical record lacked evidence that facility staff implemented measures to maximize the resident ' s functional abilities when he/she sustained an ADL decline. The record was reviewed November 5, 2009.</p>	F 310			

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F 310	<p>Continued From page 32</p> <p>2. Facility staff failed to implement interventions to address resident 's decline in mobility.</p> <p>A review of care plan dated August 26, 2008 for potential for injury/fall related to unsteady gait, impaired vision ... and history of falls revealed that the resident fell on January 5, 2009, March 22, 2009, April 1, 2009 and April 26, 2009.</p> <p>Three (3) hand written notations were made under the Interventions column of the care plan. These hand written notations were not dated.</p> <p>(1)-Caregiver to call for assistance when getting resident out of bed (2)-Alarm on wheelchair when out of bed (3) Apply seatbelt to prevent fall. May release Seatbelt</p> <p>A further review of the record and a face to face interview was conducted with Employee #5 and Employee #27 on November 6, 2009 at 10:30 AM. These employees stated: January 1, 2009 fall - the CNA caregiver was educated March 22, 2009 fall- Alarm on wheelchair when out of bed April 26, 2009fall- Apply seatbelt to prevent fall. May release Seatbelt.</p> <p>The record contained no evidence that the Care plan was updated after the fall of April 1, 2009</p> <p>In an interview with Employee# 3 on November 6, 2009 about 3:00 PM it was stated that the resident was formerly ambulatory with a cane but due to repeated falls "we put the resident in a wheelchair." The wheelchair for mobility was the care plan intervention implemented after the fall</p>	F 310		

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F 310	<p>Continued From page 33 sustained April 1, 2009.</p> <p>A Nursing Monthly Summary Dated April, 09 and signed April 19, 2009 by LPN and April 22, 2009 by RN revealed: " Fell on 04/01/09 [April 1, 2009], sustained no injuries." Continue to wander around the unit with close monitor. No hospitalization. On Ativan 0.5mg QD [everyday] for agitation. Denies pain and discomfort. Addendum [no date] Resident gait unsteady, non compliance for sitting on chairs. Due to multiple fall resident [to] use wheelchair for mobility "</p> <p>The record lacked evidence of a physician's order for the implementation of a wheelchair and there was no evidence of a Physical Therapy assessment related to the appropriateness of the use of a wheelchair for mobility.</p> <p>The resident was screened by Physical Therapy (PT) after each fall. PT Screen dated January 6, 2009 " [Resident] will benefit from contact guard with ambulation and use of a gait belt.(Restorative nursing gait belt on unit) " PT Screen dated March 24, 2009 " Pt.[patient] c [with] no new [symbol for change] in function. PT Screen dated April 3, 2009 " Pt.[patient] c [with] no new [symbol for change] in function. PT Screen Dated April 27, 2009 " Pt.[patient] c [with] no new [symbol for change] in function.</p> <p>The record documents interventions to keep the resident from falling, but lacks evidence that Facility staff implemented interventions to maintain the resident ' s ability to ambulate with a cane.</p>	F 310			
F 314 SS=G	483.25(c) PRESSURE SORES	F 314			

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F 314	<p>Continued From page 34</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of nine (9) supplemental residents, it was determined that facility staff failed to ensure that a resident that enters the facility without pressure sores does not develop pressure sores. Resident D1.</p> <p>The findings include:</p> <p>Resident D1 is a 97 year old admitted with a primary diagnosis of Dementia and a secondary diagnosis of Latent Neurosyphillis and Hypertension.</p> <p>According to the significant change MDS completed September 17, 2009, " Section B Cognitive Patterns B2: Memory coded Resident D1 as having short-term and long-term memory problems; B4: Cognitive Skills for Daily Decision-Making was coded as moderately impaired; Section G Physical Functioning and Structural Problems G1a: bed mobility as (4) total dependent and (2) one person physical assist; G1i: Toilet Use (4) total dependent and (2) one person physical assist; G1j: Personal Hygiene coded as (4) total dependent and (2) one person</p>	F 314	<p>Resident #D1</p> <ol style="list-style-type: none"> 1. The Nurse Practitioner and attending physician were notified and orders were received for treatment on 10/07/09. 2. All other residents were assessed using the Braden Scale to make sure, preventive measures are in place and treatment orders obtained if necessary. 3. Nursing staff were provided in-service on Prevention of Pressure Ulcers and Wound Care Management on 12/17/09, 12/18/09, 12/19/09 and 12/20/09. 4. Resident skin integrity /pressure ulcers will be monitored weekly by Resident Care Coordinators and reported through CQI quarterly. 5. Completion date 12/24/09. 	

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F 314	<p>Continued From page 35</p> <p>physical assist; Section H Contenance in Last 14 Days H1a: Bowel coded as (4) incontinent; Bladder coded as (4) incontinent; Section M Skin Condition M1b: number of stage 2 ulcers as one (1); M2a Type of Ulcer as zero (0) pressure ulcer, stasis ulcer coded as zero (0). M3 History of Resolved Ulcers in last 90 days as no.</p> <p>According to the Plan of Care: original date September 3, 2009 (no time indicated) with problem/strengths indicates: " August 29, 2009 Blister Left arm resolved; October 7, 2009 sacral skin breakdown, October 8, 2009 left arm breakdown. "</p> <p>The progress notes revealed the following:</p> <p>A nurse practitioner progress note dated and signed October 7, 2009 at 2:00 PM indicated, " Skin warm, dry, un-stageable wound noted to the sacral area, measures about 2x2; circular; redness around wound, no drainage noted area warm to touch. "</p> <p>A nursing progress note dated and signed October 7, 2009 at 4:30 PM revealed, " Sacrum, stage 2 open area measures 5X5 cm. Order given for Accuzyme after cleaning with Normal Saline (NS) daily until resolved. "</p> <p>According to the "Skin Assessment Sheet" dated October 7, 2009 (no time indicated) revealed, "Sacrum, pressure, 5X5 cm length and width, gray/black in character, no drainage, treatment for Accuzyme, turn every 2 hours, out of bed in chair, air mattress/with pump, heel elbow protectors for pressure relieving devices."</p> <p>A physician's progress note dated October 8,</p>	F 314		
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F 314	<p>Continued From page 36</p> <p>2009 dated 11:15 AM documented, "96 year old resident with sacral decubitus ulcer. Patient has history of UTI on Zosyn via PICC line. Sacral 4x4 soft eschar, edges intact, no drainage, non-tender stage 3. Stage 3 or 4 sacral ulcer with necrotic skin, soft, questionable ischemic fat/subcutaneous, hypoalbuminemia, poor candidate for healing."</p> <p>Nursing progress note dated October 8, 2009 12:35 PM..."Abnormal lab results read to nurse practitioner, [WBC][White Blood Cells] 19.3, [RBC][Red Blood Cells] 3.68, hemoglobin 11.4, hct [hemaocrit] 34.7, sodium 160, potassium 3.4, glucose 159 mg/dl...</p> <p>According to the nurse practitioner noted dated October 30, 2009 at 10:00 AM, revealed "...Anemia of chronic disease, Labs H/H [hemoglobin/hemaocrit] 8.0/24.0, started on FeS04 [Ferrous Sulfate], will monitor...</p> <p>2. low albumin-ALB 1.5, due to compromised nutritional status..."</p> <p>The record lacked evidence that the residents sacral wound was identified prior to October 7, 2009 when it was identified as un-stageable by the nurse practitioner.</p> <p>A face-to-face interview was conducted with Employee #7 on November 6, 2009 at 2:30 PM. He/she acknowledged that there were no notes concerning skin breakdown of the sacral area in the record prior to the discovery of an ulcer on October 7, 2009.</p>	F 314			
F 323 SS=G	<p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview for three (3) of 24 sampled residents, it was determined that facility staff failed to safely transfer the residents to prevent accidents and/or injuries. Residents #16, 19 and 20.</p> <p>The findings include:</p> <p>A.1. Facility staff failed to transfer Resident #16 safely to prevent accidents.</p> <p>A review of Resident #16's record lacked evidence that the resident was safe for a two (2) person transfer versus the use of an assistive device e.g. Hoyer Lift. During the process of a bed to chair transfer by two (2) Certified Nursing Assistants (CNAs) on September 13, 2009; the resident who was identified as dependent in transfer, subsequently was lowered to the floor and sustained a fracture of the right hip.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated July 21, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and two (2) for B4 which indicated a problem with Cognitive Skills for Daily Decision Making. A score of four (4) for Transfer and for Ambulation indicated that the resident was totally dependent on staff for both activities (transfer and ambulation). A score of</p>	F 323	<p>Resident #16 and #19</p> <ol style="list-style-type: none"> Residents were reassessed for alternative safe transfer method on 11/16/09 and care plans were updated on 11/16/09. All other residents requiring assistance with transfer were assessed for alternative safe methods of transfer and care plans updated where needed. Nursing staff were provided in-service on Alternative Safe Methods of Transfer on 12/17/09, 12/18/09, 12/19/09, and 12/20/09. Residents will be monitored monthly for safe transfers by Resident Care Coordinators and reported to CQI quarterly. Completion date 12/24/09. 	

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F 323	<p>Continued From page 38</p> <p>two (2) in Section G4 indicated a loss of movement in both arms, hands, legs and feet. A weight of 193 pounds was recorded in Section K2 (Weight) of this MDS and a weight of 196 pounds on the significant change MDS dated September 29, 2009.</p> <p>Further review of the record revealed the following documentation which was dated September 13, 2009 at 8:30 AM; " Resident observed on floor in sitting position with his/her back against the wall. [Two] (2) CNAs present in room and reported resident attempted to stand and leaned forward before staff could prevent fall landing with his/her back against the wall in sitting position. "</p> <p>A review of the facility ' s policy #991-004 titled "Lifting and Transferring Residents" revealed documentation which stated, " Mechanical lift procedures are used on any resident who is obese or deemed unsafe for a two person manual transfer." A review of the resident's record failed to reveal an assessment to determine how the resident should be transferred. Under the heading of Procedures in Item #5 of the same document, it is stated, "The designated method of lifting and transferring of a resident is indicated in Resident Plan of Care." A review of the plan of care failed to reveal any documentation regarding the method of lifting or transferring the resident.</p> <p>A face-to-face interview was conducted with Employee #24 at approximately 11:00AM on November 9, 2009. He/she stated, "I went in to assist with transferring [Resident ' s name] from bed to chair. We sat him/her up and attempted to transfer him/her. He/she tried to stand. He/she</p>	F 323	<p>Resident #20</p> <ol style="list-style-type: none"> 1. The attending physician was notified and orders were received for treatment of laceration on 11/3/09. The resident was reassessed for alternative safe transfer method on 11/16/09. 2. All other residents requiring assistance with transfer were assessed for alternative safe methods of transfer and care plans updated where needed. 3. Nursing staff were provided in-service on Assessments and Methods of Transferring Residents on 12/17, 12/18, 12/19, 12/20, and 12/21/09. 4. Residents will be monitored for safe transfer by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 323	<p>Continued From page 39</p> <p>started falling so we lowered him/her to the floor. He/she had a new pillow [cushion] and they wanted to use it [the pillow] to try getting him/her out of bed without the Hoyer lift." The employee acknowledged transferring the resident weighing 193-196 pounds without the use of a Hoyer Lift or a Gait Belt.</p> <p>A face-to-face interview was conducted with Employee # 11 at approximately 11:45AM on November 9, 2009. He/she acknowledged that the Rehabilitation Department had provided a wedge cushion for the resident's chair after a prior fall on August 13, 2009. Employee #11 stated, "I taught the staff to transfer the resident without a Hoyer Lift. I demonstrated transferring the resident with the use of a Gait Belt." Employee #11 also acknowledged telling the staff that the resident could be transferred without the Hoyer Lift. He/she added, "It can be done. I have done it." In a telephone interview conducted at approximately 2:30PM on November 23, 2009 Employee #8 was asked whether there was any documentation to inform staff of the procedure to be followed when transferring the resident and whether in-services had been provided to train staff about the procedures. Employee #8 responded that there was no documentation and added, "Everyone knows how to transfer. There is nothing different about how to transfer this resident. The in-services are held annually. The last in-service would have been this Summer."</p> <p>During a telephone interview at approximately 2:30 PM on November 23, 2009 Employees #3 and #8 acknowledged that the mode of transfer for any resident can change on any shift. "Sometimes we do not have enough Hoyer lifts." Both employees also stated that the CNA has</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>his/her own report sheet and that the mode of transfer for each resident is usually documented on the report sheet. A blank report sheet was received by this regulatory agency. When asked about the documentation on the report sheet, Employee #8 acknowledged that there was no documentation. He/she stated, "We do not keep the sheets. They are discarded at the end of each shift. "</p> <p>A telephone interview was also conducted with Employee #11 at approximately 2:30PM on November 23, 2009. The employee stated, "There was no reason for me to be involved in the transfer of this resident. They [staff] do a two (2) person transfer with him/her. A two (2) person transfer is a nursing transfer." He/she added, "However, they [staff] can use any transfer that they want or a Hoyer Lift. " Employee #11 acknowledged demonstrating a bed to wheel chair transfer to the staff with the use of a gait belt, and that she had no supportive documentation to verify the content of his/her instructions and/or the list of participants.</p> <p>The facility failed to provide documentation that the resident was ever assessed to determine an appropriate mode of transfer for him/her or that the staff was adequately trained to transfer the resident safely to prevent accidents and/or injuries. The resident sustained a fractured hip while being transferred from his/her bed to a wheel chair by two CNAs. The record was reviewed on November 9, 2009.</p> <p>A.2. Facility staff failed to safely transfer Resident #19 who subsequently fell during a transfer.</p> <p>A review of the quarterly MDS completed March</p>	F 323		

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F 323	<p>Continued From page 41</p> <p>31, 2009 revealed, "In Section G [Physical Functioning and Structural Problems] the resident was coded as total dependence for bathing and transfer and requiring two person physical assistance. Section J Health Conditions: J4 Accidents was coded as Resident #19 having no falls in last 31-180 days."</p> <p>A nursing progress note dated January 15, 2009 at 2:00 PM revealed, "At 1:30 PM it was report to staff that Resident was observed in a sitting position on the floor in his/his room. CNA stated 'He/she was trying to transfer [the resident by] him/her self from the wheel chair to bed when the [resident's] leg gave out and [the resident] fell.' Upon assessment [of the resident] Range of Motion (ROM) in both upper/lower."</p> <p>A Plan of Care related to falls last updated June 9, 2009 revealed, "...January 15, 2009, Status Post (S/P) fall due to staff poor judgment." The care plan "Interventions Section" revealed, "Two person assistance with baths, transfers ...Transfers with mechanical lift ..." Interventions dated January 15, 2009, "Encourage staff to call for assistance."</p> <p>Facility staff failed to transfer the resident in accordance with the plan of care. Subsequently, the resident fell. No injury was observed and/or noted.</p> <p>A face-to-face interview was conducted with Employee #8 on November 6, 2009 at 4:40 PM. He/she acknowledged that staff used "poor judgment during transfer". The record was reviewed on November 6, 2009.</p> <p>A.3. Facility staff failed to transfer Resident #20</p>	F 323			

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F 323	<p>Continued From page 42 safely to prevent accidents.</p> <p>A review of Resident #20's record revealed that on November 3, 2009 the resident sustained a 2 centimeter (cm) by 0.5cm laceration to his/her right shin while he/she was being transferred from a geri-chair to bed by two (2) Certified Nursing Assistants (CNAs).</p> <p>A review of the admission Minimum Data Set (MDS) dated September 24, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and a three (3) for Section B4 which indicated severe impairment with Cognitive Skills for Daily Decision Making. A score of (0) for E1 and E4 indicated the resident had no problems with mood and/or psychosocial behavior. A score of 4/3 for Bed Mobility indicated that the resident was totally dependent on two (2) persons when being moved in or out of bed (transfer). A score of four (4) for Ga and b indicated total dependence for Ambulation on/off the unit. A score of (0) for G4 indicated no limitation in any extremity.</p> <p>A review of the documentation in the Facility Occurrence Report dated November 3, 2009 at 2:45PM documented that, "Resident dropped her right @ foot and it got caught in between the geri-chair where he/she sustained the cut." Further review of the facility's Occurrence Report revealed recommendation from a supervisor which stated, " CNA [Certified Nursing Assistant] to be more careful with transporting residents and check position of limbs frequently."</p> <p>A face-to-face interview was conducted with Employee #5 at approximately 12:30PM on November 6, 2009. He/she stated, "They (the</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>staff) demonstrated to me how it occurred. While they were transferring the resident into the bed from the geri-chair he/she [the resident] started tossing his/her legs around. The right leg got caught between the chair and the leg rest and the resident sustained a small cut on his/her shin. "</p> <p>A face-to-face interview was conducted with Employee #23 at approximately 2:30PM. on November 6, 2009. He/she stated that he/she was assisting another CNA to transfer Resident #20 from a geri-chair to bed and just as they were about to pick the resident up he/she tossed his/her right leg and it got lodged between the seat and the leg rest. The leg started bleeding right away and we reported it to the charge nurse.</p> <p>The facility staff failed to transfer the resident safely to prevent accidents and/or injuries and the resident sustained a laceration on his/her shin. The record was reviewed on November6, 2009.</p> <p>B. The facility staff failed to ensure that the residents' environment remained as free of accident hazards as is possible by failing to secure five (5) full oxygen tanks and eight (8) empty tanks.</p> <p>On November 5, 2009 at 9:40 AM five (5) full oxygen tanks were observed unsecured in the oxygen tank storage room in the basement of the facility. Eight (8) of eight (8) empty oxygen tanks were also found unsecured at that time. These findings were acknowledged by Employee #25 at the time of observation.</p>	F 323	<p>F 323 – finding B:</p> <ol style="list-style-type: none"> Five (5) full oxygen tanks and eight (8) empty oxygen tanks were secured properly on 11/05/09. All medical and other equipment in the facility was checked for safe storage. Nursing staff and other employees were provided in-service on Safe Storage of Equipment and Accident Prevention on 12/17, 12/18, 12/19, and 12/20. Safe storage of equipment will be monitored monthly through CQI. Completion date 12/24/09. <p>F 371 - #1</p> <ol style="list-style-type: none"> Identified soiled muffin pans were removed from service immediately on 11/9/09. All other muffin pans were checked for grease and washed if needed. Staff were provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment. The Dietary Director/designee will conduct period check of cleaning assignment and inspect muffin pans. Observations will be reported to CQI quarterly. Completion date 11/16/09. 		
F 371	<p>483.35(i) SANITARY CONDITIONS</p> <p>The facility must -</p>	F 371			

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F 371	<p>Continued From page 44</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations that were made during a tour of the dietary services on November 3 and 4, 2009 it was determined that the dietary staff failed to store, prepare or serve food under sanitary conditions as evidenced by: 10 of 10 soiled muffin pans, four (4) of four stained frying pans, 16 of 64 damaged serving trays, and soiled stove burners and a convection oven.</p> <p>These observations were made in the presence of Employee #10 who acknowledged these findings at the time of the observations.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 10 of 10 muffin trays were observed to be soiled with grease. Four (4) of four (4) frying pans were observed to be covered with dark stains and needed to be cleaned or replaced. 16 of 64 serving trays were observed to be damaged One (1) of two (2) convection ovens and six (6) of six (6) stove burners were soiled with 	F 371	<p><u>Finding #2</u></p> <ol style="list-style-type: none"> The identified soiled frying pan was immediately removed and discarded. New frying pans were purchased. All other frying pans were inspected. There were no other soiled pans. Staff were provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment. Dietary management team will spot check daily to make sure all cooking equipment is clean and in good working order. Completion date 11/16/09 <p><u>Finding #3</u></p> <ol style="list-style-type: none"> Identified serving trays were immediately removed and discarded on 11/6/09. All other trays were checked for damage and discarded if damaged. New trays were purchased. All staff were provided in-service on removing damaged equipment from service 11/16/09. The management team will spot check equipment used for residents periodically and reported to CQI quarterly. Completion date 11/16/09 <p><u>Finding #4</u></p> <ol style="list-style-type: none"> The oven and stove were immediately cleaned on 11/6/09. There were no other ovens to be cleaned. Staff were provided an in-service on 11/16/09 regarding proper cleaning procedures and the importance of keeping clean equipment The management team will spot check equipment and report to CQI quarterly. Completion date 11/16/09. 		

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<p>F 371</p> <p>F 386</p> <p>SS=D</p>	<p>Continued From page 45 leftover food residue.</p> <p>483.40(b) PHYSICIAN VISITS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 24 records revealed, it was determined that the medical team failed to review the total plan of care as evidenced by failure to follow through on a request for a gastroenterology consultation for one (1) resident and failure to clarify the type of cardiac device when he/she reviewed the resident's total plan of care for one (1) resident. Residents #10 and 18.</p> <p>The findings include:</p> <p>1. A review of the clinical record for Resident #10 revealed the medical team failed to follow through on a request for a gastroenterology consultation.</p> <p>The nurse practitioner wrote the following interim order on August 21, 2009: "Please make GI appointment with [doctor 's name] due to weight loss. "</p> <p>A monthly note dated August 24, 2009 documented by the nurse practitioner included "</p>	<p>F 371</p> <p>F 386</p>	<p>Finding #1 – Resident #10</p> <ol style="list-style-type: none"> 1 The nurse practitioner discontinued GI consults on 12/8/09. Resident did not experience any negative outcome. 2. All other residents with orders for consults were reviewed. All appointments have been scheduled. 3. Medical Director provided in-service for attending physician on writing orders and close review of hospital discharge summaries 12/21/09. 4. Monthly monitoring of medical consultation and validation of appointments will be conducted and reported to CQI quarterly. 5. Completion date 12/24/09 	

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F 386	<p>Continued From page 46</p> <p>...weight loss continues ...will follow up with gastroenterology and recommendations ...responsible party agrees with plan of care to have GI consult "</p> <p>The record lacked evidence that the GI consultation was performed and there was no evidence that the request for the GI consultation had been cancelled. The record lacked evidence that the medical team followed up on the request for the resident to undergo GI consultation. The record was reviewed November 6, 2009.</p> <p>2. The physician failed to clarify the type of cardiac device when he/she reviewed the resident's total plan of care for Resident #18.</p> <p>The history and physical examination signed April 11, 2009 revealed, "Past historys/p permanent pacemaker insertion, chest...permanent pacemaker, medical assessment and/or diagnoses: 89 year old AA male/female s/p CVA with R sided hemiparesis, chronic atrial fibrillation with decrease L.V. [left ventricular] function and permanent pacemaker. "</p> <p>According to [Pharmacy] Admission Order Sheet and Physician Plan of Care signed April 4, 2009 and every month thereafter revealed, " Monthly pacemaker checks q [every] 6 months. "</p> <p>According to [radiology company] pacemaker info [information] sheet signed September 29, 2009, " Resident #18 has defibrillator ...implanted May 12, 2003. "</p> <p>A review of the clinical record for Resident #18 revealed " progress [nursing] note dated October 1, 2009 at 1:20 PM [Radiology Company]</p>	F 386	<p>Finding #2 – Resident #18</p> <ol style="list-style-type: none"> 1. Resident #18's medical records were reviewed by Medical Director on 12/21/09. There was no negative outcome to the resident. 2. There were no other residents in the facility with an Internal Atrial Defibrillator. 3. Medical Director provided in-service for attending physicians on writing orders and close review of hospital discharge summaries every six months on 12/21/09. 4. Monitoring of defibrillator checks will be reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 386	<p>Continued From page 47</p> <p>called and stated resident has an ICD and is to be checked in physician's office, pacemaker check not needed. [Physician] to be informed. "</p> <p>The attending note dated October 24, 2009 revealed, "Patient remains in atrial fibrillation with controlled ventricular response ... "</p> <p>The attending's note lacks documented evidence of clarification and/or a review of the Resident #18's type of cardiac device.</p> <p>A face-to-face interview was conducted with Employee #5 on November 6, 2009 at approximately 2:00 PM. In response to a query regarding Resident #18's implanted cardiac device, he/she stated the resident has a defibrillator. Employee #5 acknowledged that the physician failed to clarify the type of cardiac device in his/her review of the resident's total program of care. The record was reviewed November 6, 2009.</p>	F 386		
F 387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for one (1) of 24 sampled residents, it was</p>	F 387		

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F 387	<p>Continued From page 48</p> <p>determined that the physician failed to make a visit at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for Resident #3.</p> <p>The findings include:</p> <p>The physician failed to make a visit at least once every 30 days for the first 90 days after admission, and at least once every 60 days for Resident #3.</p> <p>A. review of the admission Minimum Data Set completed January 20, 2009 Section AB and AC Demographic Information coded Resident #3 's date of entry as January 13, 2009.</p> <p>A review of the attending physician's notes revealed that the physician reviewed the resident 's plan of care on January 15, 2009.</p> <p>The next documented review of the resident 's plan of care by the attending physician was dated May 5, 2009.</p> <p>The clinical record lacked documented evidence that the physician reviewed the resident 's plan of care between January 15, 2009 and May 5, 2009.</p> <p>A face-to-face interview was conducted with Employee #8 on November 3, 2009 at approximately 11:00 AM. He/she acknowledged that the record lacked documented evidence that the physician reviewed the resident 's plan of care between January 15, 2009 and May 5, 2009. The record was reviewed on November 3, 2009.</p>	F 387	<p>Resident #3</p> <ol style="list-style-type: none"> 1. The Medical Director reviewed Resident #3's medical record on 12/23/09. The resident did not experience any negative outcome. 2. All other residents assigned to identified attending physician were checked and assessed for required medical documentation. 3. The Medical Director provided in-service to the medical staff regarding required frequency of visits and documentation 12/21/09. 4. Medical visits and documentation will be monitored monthly and reported to CQI quarterly. 5. Completion date 12/24/09. 		
F 425 SS=D	<p>483.60(a),(b) PHARMACY SERVICES</p> <p>The facility must provide routine and emergency</p>	F 425			

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F 425	<p>Continued From page 49</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ol style="list-style-type: none"> Based on observation, in the presence of facility staff, it was determined staff failed to remove expired medications found in the facility's Interim Box. <p>On November 5, 2009, at approximately 2: 00 PM during the inspection of the facility's Interim Box, the following expired medications were found:</p> <ol style="list-style-type: none"> Four of four (4) ampules of Cogentin 1mg/1cc, expiration date September 2009 One of ten (10) vials Heparin 5,000units, expiration date October 2009 Two of four (4) Tobramycin 80mg/2cc, expiration date October 2009 Ten of ten (10) Dicloxicillin 250mg capsule, expiration date September 30, 2009 	F 425	<ol style="list-style-type: none"> The Interim Box was replaced via STAT delivery on 11/5/09. There were no negative outcomes. There are no other Interim boxes in the facility. The Interim Box will be replaced twice a week by contract Pharmacy. Interim Box will be audited by the pharmacist on a monthly basis and reported to CQI quarterly. Completion date 11/5/09. 	

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F 425	<p>Continued From page 50</p> <p>5. Ten of ten (10) Docusate 100mg capsules, expiration date September 2009</p> <p>2. Based on record review, it was determined that facility staff failed to either sign out controlled substances on the Controlled Substance Record or to record the administration of controlled substances on the Medication Administration Record (MAR) for two (2) of seven (7) residents. JKG1 and JKG2</p> <p>The findings include:</p> <p>A. On November 6, 2009, at approximately 2:00 PM, a review of the Resident 's (JKG1) record revealed a physician' s order, dated September 4, 2009, that directed, "Fentanyl 25mcg/hr patch, apply 1 patch to skin and change every 72 hours for pain for 60 days. "</p> <p>The November 2009 MAR was reviewed and indicated that Fentanyl 25mcg/hr patch was documented as being administered on November 5, 2009. The " Resident Controlled Substance Record " failed to show that a patch was signed out on that date.</p> <p>B. On November 6, 2009, at approximately 2:30 PM, during a review of Resident' s (JKG2) record revealed a physician' s order, dated October 31, 2009, that directed, " Percocet 5/325mg, 2 tabs by mouth every 6 hours as needed for pain for 60 days. "</p> <p>The November 2009 MAR was reviewed and indicated that there was no documentation That two (2) tablets of Percocet 5/325 were</p>	F 425	<p>Finding JKG1 and JKG2</p> <ol style="list-style-type: none"> 1. Documentation on Controlled Substance Record and the Medication Administration Record could not be changed or updated. Records of JKG1 and JKG2 were reviewed on 11/8/09; there were no negative outcomes noted on these residents. 2. All controlled substances records were reviewed and validated with MARs. No other findings were noted. 3. In-service was provided for licensed staff on Controlled Substance Medication/Documentation on 12/18, 12/19 and 12/20/09. 4. Controlled Substance and Medication Administration Documentation will be monitored by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 425	Continued From page 51 administered on November 1, 2009. The " Resident Controlled Substance Record " did indicate that two (2) tablets were signed out on that date.	F 425		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	Residents JKG3, JKG4 an JKG5 1. Controlled substance medications for above residents were disposed of and witnessed by (2) licensed nurses with signatures on 11/4/09. 2. All other records were reviewed for discontinued controlled substance. There was no other discontinued controlled substance found. 3. Licensed nurses were provided in-service on Documentation of Controlled Medications and Disposal of Controlled Medications on 12/18/09, 12/19/09, and 12/21/09. 4. Controlled Substance Medications will be monitored by Resident Care Coordinators monthly and reported through CQI quarterly. 5. Completion date 12/24/09	

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F.431	<p>Continued From page 52</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of records, it was determined that for three (3) of seven (7) " Individual Resident ' s Controlled Substances Records " discontinued controlled substance medications were not disposed of (or witnessed by) by two (2) licensed health care providers.</p> <p>On November 5, 2009 destruction of Discontinued Controlled Substances records were reviewed. The following discontinued controlled substances lacked a witness as evidenced by the lack of a second signature:</p> <ol style="list-style-type: none"> 1. Resident JKG3: Lorazepam 1mg, 27 tablets, disposition date September 1, 2009. 2. Resident JKG4: Oxycodone/APAP 7.5/325mg, 10 tablets, disposition date November 1, 2009. 3. Resident JKG5: Lorazepam 0.5mg, 13 tablets, disposition date October 1, 2009 <p>Based on observations made during the environmental tour on November 4, 2009, it was determined that facility staff failed to discard medications and biologicals after the expiration date.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. One (1) of one (1) box of Mesalt Natrii Choridum, expired on September 2008. 2. 12 packs of a 50-pack box of Kendall, Xeroform dressing expired May 2008. 	F 431	<ol style="list-style-type: none"> 1. All expired medications and biological agents were disposed of by 2 licensed nurses on 11/4/09. There were no negative outcomes. 2. All nursing units were checked for other expired medications and biological agents, but none were found. 3. Licensed nurses were provided in-service on Disposal of Expired Medications and Biological agents on 12/17/09, 12/18/09, 12/19/09 and 12/20/09. 4. Expired Medications and Biological Agents will be monitored monthly by Resident Care Coordinators and reported quarterly through CQI. 5. Completion date 12/20/09. 	
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F 431	Continued From page 53 3. Two (2) bottles of Operand Iodine Solution expired May 2008. 4. 20 packs of Surgical Lube expired February 2009. 5. One (1) box of Providone Iodine swabsticks expired April 2008. 6. A bottle of eyewash solution was observed open in the 3rd floor soiled utility room. According to the manufacturer's recommendation, once open, the solution must be discarded. These observations were made in the presence of Employee # 25 who acknowledged the findings at the time of the observations.	F 431		
F 441	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on the following observations made during an environmental survey conducted on November 4, 2009, it was determined that the facility staff failed to store infectious waste boxes	F 441		

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F 441	<p>Continued From page 54</p> <p>under sanitary conditions. Additionally, during a dining observation for Resident #14 on November 5, 2009 at the lunchtime meal, it was determined that facility staff failed to ensure proper food handling practices while feeding a resident.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Four (4) of six (6) infectious waste boxes were stored upside down in the infectious waste storage room located in the basement. Facility staff failed to ensure proper food handling practices while assisting Resident #14 with nutritional intake. <p>The Food and Drug Administration's (FDA) Employee Health and Personal Hygiene Handbook 2006 stipulates, "The 2005 FDA Food Code discourages bare hand contact with ready to eat food and requires the use of suitable utensils such as scoops, spoons, forks, spatulas, tongs, deli tissue, single-use gloves or dispensing equipment when handling these food items."</p> <p>During a dining observation on November 5, 2009 at approximately 12:35 PM Employee #26 was observed feeding Resident #14 with bare hands. The employee was observed placing potato tots and a submarine style sandwich into the resident 's mouth with bare hands.</p> <p>A face-to-face interview was conducted with Employee #8 on November 5, 2009 at approximately 12:50 PM. In response to a query regarding the facility 's protocol for handling food for residents that required feeding assistance, he/she stated that utensils should be utilized. If</p>	F 441	<p>Medical Wastes:</p> <ol style="list-style-type: none"> The infectious waste boxes were immediately turned right side up on 11/09/09. There were no other improperly stored medical waste boxes. EMS director provided in-service to EMS staff 12/16/09. EMS director/designee will make daily rounds to check proper storage of infectious medical waste in closet. EMS will monitor storage of infectious waste and report to CQI quarterly. Completion date 12/16/09. <p>Res. #14:</p> <ol style="list-style-type: none"> Employee received counseling immediately regarding protocol for handling food for residents that required feeding assistance. There was no negative outcome noted on resident #14. All other staff assisting with mealtimes were observed for compliance with protocol for food handling while assisting during mealtimes. There were no similar instances observed. 	

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F 441	Continued From page 55 finger foods were administered, gloves should be worn.	F 441		
F 468	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations that were made during an environmental inspection of the facility conducted on November 3 and November 4, 2009 between 2:20 pm and 4:30 pm it was determined that the facility failed to secure handrails in resident areas. The findings include: It was observed that handrails in the hallways were loose in the following areas: 1. Two (2) of two (2) between rooms 204 and 206. 2. Two (2) of two (2) Between rooms 130 and 131. 3. Five (5) of nine (9) located on unit one of the first floor. 4. Three (3) of three (3) located near the central supply room and the shower room. These observations were made in the presence of Employee #25 who acknowledged the findings at the time of the observations.	F 468	3. Staff was provided in-service on proper food handling while assisting residents during mealtimes on 11/16/09. 4. Mealtime observation will be conducted and reported to CQI quarterly. 5. Completion date: Dec 24, 2009 F468 1. Loose handrails indicated in this report have been corrected. 2. All corridor handrails were checked throughout the Units to ensure that they were firmly secured. 3. Maintenance staff were provided training on how to inspect handrails on 11/16/09. Maintenance will conduct routine inspections of corridor handrails to ensure they are safe and secure. 4. Compliance to keeping corridor handrails firm and secure will be monitored monthly and reported at quarterly CQI. 5. Correction action was complete 11/9/2009.	
F 490 SS=D	483.75 ADMINISTRATION	F 490		

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F 490	<p>Continued From page 56</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:</p> <p>Based on record review and staff interview for one (1) of 24 sampled residents and one (1) of nine (9) supplemental residents, it was determined that the facility staff failed to maintain the highest practicable physical, mental, and psychosocial well-being of one (1) resident who entered the facility without pressure sores from developing pressure sores and one resident who sustained an injury during transfer by facility staff. Resident #16 and D1.</p> <p>The findings include:</p> <p>CFR 483.25 (c) F 314 Pressure Sores</p> <p>Resident D1 is a 97 year old admitted with a primary diagnosis of Dementia and secondary diagnosis Latent Neurosyphilis.</p> <p>According to the significant change MDS completed September 17, 2009, " Section B Cognitive Patterns B2: Memory coded Resident D1 as having short-term and long-term memory problems; B4: Cognitive Skills for Daily Decision-Making was coded as moderately impaired; Section G Physical Functioning and Structural Problems G1a: bed mobility as (4) total dependent and (2) one person physical assist; G1i: Toilet Use (4) total dependence and (2) one person physical assist; G1j: Personal Hygiene</p>	F 490	<p>Resident #D1</p> <ol style="list-style-type: none"> 1. The Nurse Practitioner and attending physician were notified and orders were received for treatment of wound on 10/07/09. 2. All other residents were assessed using the Braden Scale to make sure, preventive measures are in place, and treatment orders obtained if necessary. 3. Policy on Skin Assessment was reviewed and amended. Nursing staff were provided in-service on Prevention of Pressure Ulcers and Wound Care Management on 12/18/09, 12/19/09 and 12/20/09. Nursing staff was provided in-service of revisions to policy on 12/23/09. The Administrator or designee and the Director of Nursing will continue to monitor and enforce compliance. 4. Resident skin integrity /pressure ulcers will be monitored weekly by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09. 		

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F 490	<p>Continued From page 57</p> <p>coded as (4) total dependent and (2) one person physical assist; Section H Continence in Last 14 Days H1a: Bowel coded as (4) incontinent; Bladder coded as (4) incontinent; Section M Skin Condition M1b: number of stage 2 ulcers as two (2); M2a Type of Ulcer as zero (0) pressure ulcer, stasis ulcer coded as zero (0). M3 History of Resolved Ulcers in last 90 days as no.</p> <p>The progress notes revealed the following:</p> <p>October 8, 2009 12:35 PM..."Abnormal lab results read to nurse practitioner, [WBC] 19.3, [RBC] 3.68, hemoglobin 11.4, hct [hemacrit] 34.7, sodium 160, potassium 3.4, glucose 159 mg/dl...</p> <p>A progress note dated and signed October 7, 2009 at 4:30 PM revealed, " Sacrum, stage 2 open area measures 5X5 cm. Order given for Accuzyme after cleaning with Normal Saline (NS) daily until resolved. "</p> <p>The nurse practitioner progress note dated and signed October 7, 2009 at 2:00 PM indicated, " Skin warm, dry, un-stageable wound noted to the sacral area, measures about 2x2; circular; redness around wound, no drainage noted area warm to touch. "</p> <p>According to the "Skin Assessment Sheet" dated October 7, 2009 (no time indicated) revealed, "Sacrum, pressure, 5X5 cm length and width, gray/black in character, no drainage, treatment for Accuzyme, turn every 2 hours, out of bed in chair, air mattress/with pump, heel elbow protectors for pressure relieving devices."</p> <p>A physician's progress note dated October 8, 2009 dated 11:15 AM documented, "96 year old</p>	F 490	<p>Resident #16</p> <ol style="list-style-type: none"> 1. The resident physical therapy consult was ordered on 9/18/09, and completed on 10/09/09. 2. Other resident with decline in mobility and history of falls were reviewed to ensure that all physical therapy consults were completed. 3. Process of referring residents for rehab was reviewed and amended. A log book was instituted to track and monitor all referrals. In-service on the new process was provided to Nursing and Rehab team on 12/17, 12/18, 12/19, 12/20/09. 4. Physical Therapy consult will be monitored monthly through CQI. 5. Completion date 12/24/09. 	
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F 490	<p>Continued From page 58</p> <p>resident with sacral decubitus ulcer. Patient has history of UTI on Zosyn via PICC line. Sacral 4x4 soft eschar, edges intact, no drainage, non-tender stage 3. Stage 3 or 4 sacral ulcer with necrotic skin, soft, questionable ischemic fat/subcutaneous, hypoalbuminemia, poor candidate for healing."</p> <p>According to the nurse practitioner dated October 30, 2009 at 10:00 AM, revealed "...Anemia-of chronic disease, Labs h/h [hemoglobin/hemaocrit] 8.0/24.0, started on FeS04, will monitor... 2. low albumin-ALB 1.5, due to compromised nutritional status..."</p> <p>According to the Plan of Care: original date September 3, 2009 (no time indicated) with problem/strengths indicates: " August 29, 2009 Blister Left arm resolved; October 7, 2009 sacral skin breakdown, October 8, 2009 left arm breakdown. "</p> <p>According to Policy number 99P-014 Pressure Ulcer, section (3) Physical Care of Residents at High Risk for Developing Decubiti: "(b) full body inspection daily during skin care."</p> <p>The record lacked evidence that the residents sacral wound was identified prior to October 7, 2009 when it was identified as un-stageable by the nurse practitioner.</p> <p>A face-to-face interview was conducted with Employee #7 on November 6, 2009 at 2:30 PM. He/she acknowledged that there were no notes concerning skin breakdown of the sacral area in the record prior to the discovery of an ulcer on October 7, 2009.</p>	F 490			

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F 490	<p>Continued From page 59</p> <p>CFR 483.25(h) F 323 Accidents and Supervision</p> <p>The findings include:</p> <p>A.1. Facility staff failed to transfer Resident #16 safely to prevent accidents.</p> <p>A review of Resident #16's record lacked evidence that the resident was safe for a two (2) person transfer versus the use of an assistive device e.g. Hoyer Lift. During the process of a bed to chair transfer by two (2) Certified Nursing Assistants (CNAs) on September 13, 2009; the resident who was identified as dependent in transfer, subsequently was lowered to the floor and sustained a fracture of the right hip.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated July 21, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and two (2) for B4 which indicated a problem with Cognitive Skills for Daily Decision Making. A score of four (4) for Transfer and for Ambulation indicated that the resident was totally dependent on staff for both activities (transfer and ambulation). A score of two (2) in Section G4 indicated a loss of movement in both arms, hands, legs and feet. A weight of 193 pounds was recorded in Section K2 (Weight) of this MDS and a weight of 196 pounds on the significant change MDS dated September 29, 2009.</p> <p>Further review of the record revealed the</p>	F 490			

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F 490	<p>Continued From page 60</p> <p>following documentation which was dated September 13, 2009 at 8:30 AM; " Resident observed on floor in sitting position with her back against the wall. (2) CNAs present in room and reported resident attempted to stand and leaned forward before staff could prevent fall landing with her back against the wall in sitting position. "</p> <p>A review of the facility ' s policy #991-004 and Titled Lifting and Transferring Residents revealed documentation which stated, " Mechanical lift procedures are used on any resident who is obese or deemed unsafe for a two person manual transfer." A review of the resident's record failed to reveal an assessment to determine how the resident should be transferred. Under the heading of Procedures in Item #5 of the same document, it is stated, "The designated method of lifting and transferring of a resident is indicated in Resident Plan of Care." A review of the plan of care failed to reveal any documentation regarding the method of lifting or transferring the resident.</p> <p>A face-to-face interview was conducted with Employee #24 at approximately 11:00AM on November 9, 2009. He/she stated, "I went in to assist with transferring [Resident ' s name] from bed to chair. We sat him/her up and attempted to transfer him/her. He/she tried to stand. He/she started falling so we lowered him/her to the floor. He/she had a new pillow [cushion] and they wanted to use it [the pillow] to try getting him/her out of bed without the Hoyer lift." The employee acknowledged transferring the resident weighing 193-196 pounds without the use of a Hoyer Lift or a Gait Belt.</p> <p>A face-to-face interview was conducted with</p>	F 490		

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F 490	<p>Continued From page 61</p> <p>Employee # 11 at approximately 11:45AM on November 9, 2009. He/she acknowledged that the Rehabilitation Department had provided a wedge cushion for the resident's chair after a prior fall on August 13, 2009. Employee #11 stated, "I taught the staff to transfer the resident without a Hoyer Lift. I demonstrated transferring the resident with the use of a Gait Belt." Employee #11 also acknowledged telling the staff that the resident could be transferred without the Hoyer Lift. He/she added, "It can be done. I have done it." In a telephone interview conducted at approximately 2:30PM on November 23, 2009 Employee #8 was asked whether there was any documentation to inform staff of the procedure to be followed when transferring the resident and whether in-services had been provided to train staff about the procedures. Employee #8 responded that there was no documentation and added, "Everyone knows how to transfer. There is nothing different about how to transfer this resident. The in-services are held annually. The last in-service would have been this Summer."</p> <p>During a telephone interview at approximately 2:30 PM on November 23, 2009 Employees #3 and #8 acknowledged that the mode of transfer for any resident can change on any shift. "Sometimes we do not have enough Hoyer lifts." Both employees also stated that the CNA has his/her own report sheet and that the mode of transfer for each resident is usually documented on the report sheet. A blank report sheet was received by this regulatory agency. When asked about the documentation on the report sheet, Employee #8 acknowledged that there was no documentation. He/she stated, "We do not keep the sheets. They are discarded at the end of each shift."</p>	F 490		

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F 490	Continued From page 62 A telephone interview was also conducted with Employee #11 at approximately 2:30PM on November 23, 2009. The employee stated, "There was no reason for me to be involved in the transfer of this resident. They [staff] do a two (2) person transfer with him/her. A two (2) person transfer is a nursing transfer." He/she added, "However, they [staff] can use any transfer that they want or a Hoyer Lift." Employee #11 acknowledged demonstrating a bed to wheel chair transfer to the staff with the use of a gait belt, and that she had no supportive documentation to verify the content of his/her instructions and/or the list of participants. The facility failed to provide documentation that the resident was ever assessed to determine an appropriate mode of transfer for him/her or that the staff was adequately trained to transfer the resident safely to prevent accidents and/or injuries. The resident sustained a fractured hip while being transferred from his/her bed to a wheel chair by two CNAs. The record was reviewed on November 9, 2009.	F 490	F492 1. Criminal background checks on the two identified contract employees without a background check were requested and received in Human Resource Department on 11/16/09. 2. All other contract employee's personnel files were checked for availability of Criminal Background Check. There were no other contract staff members without a criminal background check. 3. Human Resource will conduct bi-weekly conference with contract services to ensure new hires meet facility requirements. 4. Information will be compiled and reported to CQI quarterly. 5. Completion Date: 12/21/09.	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Abased on record review and staff interview it was determined that a company providing	F 492		

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NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010
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F 492	<p>Continued From page 63</p> <p>contracted services failed to obtain criminal background checks for two (2) employees who worked in the facility.</p> <p>The findings include: Chapter 47 Health-Care Facility Unlicensed Personnel Criminal Back Ground Checks 22 DCMR 4703.4 " Each facility shall maintain, in the personnel record of each employee covered by these rules the following: ...(d) Official documentation of criminal background checks;..."</p> <p>A random review of personnel files was conducted on November 5-6, 2009. This review identified employee files for two (2) contracted employees that did not contain evidence that a criminal background check had been performed.</p> <p>An interview was conducted with employee #10 on November 6, 2009 at approximately 4:00 PM. Employee #10 was unable to produce documentation that background checks had been performed on these employees.</p> <p>B. Based on review of the occurrence reports and staff interview for 12 of 13 occurrences, it was determined that facility staff failed to consistently report the occurrences to the state agency.</p> <p>The findings include: Title 22 District of Columbia Municipal Regulations 3232.4 stipulates, "Each incident shall be documented in the resident ' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident</p>	F 492	<ol style="list-style-type: none"> 1. Identified occurrence report of 11/6/09 was re-faxed to the Department of Health on 12/24/09. 2. All other occurrence reports were reviewed to ensure that all appropriate occurrence reports were faxed to the Department of Health with confirmation fax sheet. 3. The Operations Coordinator will be responsible effective 12/23/09 for sending, tracking and validating distribution reports to the Department of Health. A log will be maintained in Administration. Nursing leadership provided training on revised process on 12/22/09. 4. Occurrence Reporting will be monitored monthly through CQI. 5. Completion date 12/24/09 	
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F 492	Continued From page 64 shall be reported to the licensing agency within eight (8) hours of occurrence." The "September 2009 Occurrence Report" line listing revealed 13 occurrences. At the time of the review, facility staff presented one (1) occurrence report with verification that the occurrence was sent to the state agency. A face-to-face interview was conducted with Employee #3 on November 6, 2009 at 3:00 PM. He/she acknowledged that of the all of the occurrences had been reported but was only able to produce documentation that one (1) was reported to the state agency.	F 492		
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 24 sampled residents and one (1) of nine (9) supplemental residents, it was determined that the governing body failed to ensure that facility staff implemented policies to prevent a resident that entered the facility without pressure sores from developing pressure sores and to ensure that facility staff safely	F 493		

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F 493	<p>Continued From page 65</p> <p>transfer residents to prevent accidents and/or injuries. Resident #16 and D1.</p> <p>The findings include:</p> <p>CFR 483.25 (c) F 314 Pressure Sores</p> <p>Resident D1 is a 97 year old admitted with a primary diagnosis of Dementia and secondary diagnosis Latent Neurosyphilis.</p> <p>According to the significant change MDS completed September 17, 2009, " Section B Cognitive Patterns B2: Memory coded Resident D1 as having short-term and long-term memory problems; B4: Cognitive Skills for Daily Decision-Making was coded as moderately impaired; Section G Physical Functioning and Structural Problems G1a: bed mobility as (4) total dependent and (2) one person physical assist; G1i: Toilet Use (4) total dependence and (2) one person physical assist; G1j: Personal Hygiene coded as (4) total dependent and (2) one person physical assist; Section H Continence in Last 14 Days H1a: Bowel coded as (4) incontinent; Bladder coded as (4) incontinent; Section M Skin Condition M1b: number of stage 2 ulcers as two (2); M2a Type of Ulcer as zero (0) pressure ulcer, stasis ulcer coded as zero (0). M3 History of Resolved Ulcers in last 90 days as no.</p> <p>The progress notes revealed the following:</p> <p>October 8, 2009 12:35 PM..."Abnormal lab results read to nurse practitioner, [WBC] 19.3, [RBC] 3.68, hemoglobin 11.4, hct [hemacrit] 34.7, sodium 160, potassium 3.4, glucose 159 mg/dl...</p> <p>A progress note dated and signed October 7,</p>	F 493	<p>F 493</p> <p>Resident #D1</p> <ol style="list-style-type: none"> 1. The Nurse Practitioner and attending physician were notified and orders were received for treatment on 10/07/09. 2. All other residents were assessed using the Braden Scale to make sure, preventive measures are in place, and treatment orders obtained if necessary. 3. Policy on Skin Assessment was reviewed and amended. Nursing staff were provided in-service on Prevention of Pressure Ulcers and Wound Care Management on 12/18/09, 12/19/09 and 12/20/09. Nursing staff was provided in-service of revisions to policy on 12/23/09. The Administrator or designee and the Director of Nursing will continue to monitor and enforce compliance. 4. Resident skin integrity /pressure ulcers will be monitored weekly by Resident Care Coordinators and reported to CQI quarterly. 5. Completion date 12/24/09. 	

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F 493	<p>Continued From page 66</p> <p>2009 at 4:30 PM revealed, " Sacrum, stage 2 open area measures 5X5 cm. Order given for Accuzyme after cleaning with Normal Saline (NS) daily until resolved. "</p> <p>The nurse practitioner progress note dated and signed October 7, 2009 at 2:00 PM indicated, " Skin warm, dry, un-stageable wound noted to the sacral area, measures about 2x2; circular; redness around wound, no drainage noted area warm to touch. "</p> <p>According to the "Skin Assessment Sheet" dated October 7, 2009 (no time indicated) revealed, "Sacrum, pressure, 5X5 cm length and width, gray/black in character, no drainage, treatment for Accuzyme, turn every 2 hours, out of bed in chair, air mattress/with pump, heel elbow protectors for pressure relieving devices."</p> <p>A physician's progress note dated October 8, 2009 at 11:15 AM documented, "96 year old resident with sacral decubitus ulcer. Patient has history of UTI on Zosyn via PICC line. Sacral [ulcer] 4x4 soft eschar, edges intact, no drainage, non-tender stage 3. Stage 3 or 4 sacral ulcer with necrotic skin, soft, questionable ischemic fat/subcutaneous, hypoalbuminemia, poor candidate for healing."</p> <p>According to the nurse practitioner dated October 30, 2009 at 10:00 AM, revealed "...Anemia-of chronic disease, Labs h/h [hemoglobin/hemaocrit] 8.0/24.0, started on FeS04, will monitor... 2. low albumin-ALB 1.5, due to compromised nutritional status..."</p> <p>According to the Plan of Care: original date September 3, 2009 (no time indicated) with</p>	F 493		

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F 493	<p>Continued From page 67</p> <p>problem/strengths indicated: " August 29, 2009 Blister Left arm resolved; October 7, 2009 sacral skin breakdown, October 8, 2009 left arm breakdown. "</p> <p>According to Policy number 99P-014 Pressure Ulcer, section (3) Physical Care of Residents at High Risk for Developing Decubiti: "(b) full body inspection daily during skin care."</p> <p>The record lacked evidence that the residents sacral wound was identified prior to October 7, 2009 when it was identified as un-stageable by the nurse practitioner.</p> <p>A face-to-face interview was conducted with Employee #7 on November 6, 2009 at 2:30 PM. He/she acknowledged that there were no notes concerning skin breakdown of the sacral area in the record prior to the discovery of an ulcer on October 7, 2009.</p> <p>CFR 483.25(h) F 323 Accidents and Supervision</p> <p>The findings include:</p> <p>A.1. Facility staff failed to transfer Resident #16 safely to prevent accidents.</p> <p>A review of Resident #16's record lacked evidence that the resident was safe for a two (2) person transfer versus the use of an assistive device e.g. Hoyer Lift. During the process of a bed to chair transfer by two (2) Certified Nursing</p>	F 493	<p>Resident #16</p> <ol style="list-style-type: none"> 1. The resident's physical therapy consult was ordered on 9/18/09, and completed on 11/16/09. 2. Other resident with decline in mobility and history of falls were reviewed to ensure that all physical therapy consults were completed. 3. Process of referring residents for rehab was reviewed and amended. A log book was instituted to track and monitor all referrals. In-service on the new process was provided to Nursing and Rehab team on 12/17, 12/18, 12/19, 12/20/09. 4. Rehabilitation Therapy consults will be monitored by Resident Care Coordinators monthly through CQI. 5. Completion date 12/24/09. 		

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F 493	<p>Continued From page 68</p> <p>Assistants (CNAs) on September 13, 2009; the resident who was identified as dependent in transfer, subsequently was lowered to the floor and sustained a fracture of the right hip.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated July 21, 2009 revealed a one (1) for Section B2a and b which indicated a problem with Short and Long Term Memory and two (2) for B4 which indicated a problem with Cognitive Skills for Daily Decision Making. A score of four (4) for Transfer and for Ambulation indicated that the resident was totally dependent on staff for both activities (transfer and ambulation). A score of two (2) in Section G4 indicated a loss of movement in both arms, hands, legs and feet. A weight of 193 pounds was recorded in Section K2 (Weight) of this MDS and a weight of 196 pounds on the significant change MDS dated September 29, 2009.</p> <p>Further review of the record revealed the following documentation which was dated September 13, 2009 at 8:30 AM; " Resident observed on floor in sitting position with her back against the wall. (2) CNAs present in room and reported resident attempted to stand and leaned forward before staff could prevent fall landing with her back against the wall in sitting position. "</p> <p>A review of the facility ' s policy #99I-004 and Titled Lifting and Transferring Residents revealed documentation which stated, " Mechanical lift procedures are used on any resident who is obese or deemed unsafe for a two person manual transfer." A review of the resident's record failed to reveal an assessment to determine how the resident should be transferred. Under the heading of Procedures in Item #5 of the same</p>	F 493		

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F 493	<p>Continued From page 69</p> <p>document, it is stated, "The designated method of lifting and transferring of a resident is indicated in Resident Plan of Care." A review of the plan of care failed to reveal any documentation regarding the method of lifting or transferring the resident. "</p> <p>A face-to-face interview was conducted with Employee #24 at approximately 11:00AM on November 9, 2009. He/she stated, "I went in to assist with transferring [Resident ' s name] from bed to chair. We sat him/her up and attempted to transfer him/her. He/she tried to stand. He/she started falling so we lowered him/her to the floor. He/she had a new pillow [cushion] and they wanted to use it [the pillow] to try getting him/her out of bed without the Hoyer lift." The employee acknowledged transferring the resident weighing 193-196 pounds without the use of a Hoyer Lift or a Gait Belt.</p> <p>A face-to-face interview was conducted with Employee # 11 at approximately 11:45AM on November 9, 2009. He/she acknowledged that the Rehabilitation Department had provided a wedge cushion for the resident's chair after a prior fall on August 13, 2009. Employee #11 stated, "I taught the staff to transfer the resident without a Hoyer Lift. I demonstrated transferring the resident with the use of a Gait Belt." Employee #11 also acknowledged telling the staff that the resident could be transferred without the Hoyer Lift. He/she added, "It can be done. I have done it." In a telephone interview conducted at approximately 2:30PM on November 23, 2009 Employee #8 was asked whether there was any documentation to inform staff of the procedure to be followed when transferring the resident and whether in-services had been provided to train</p>	F 493			

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F 493	<p>Continued From page 70</p> <p>staff about the procedures. Employee #8 responded that there was no documentation and added, "Everyone knows how to transfer. There is nothing different about how to transfer this resident. The in-services are held annually. The last in-service would have been this Summer."</p> <p>During a telephone interview at approximately 2:30 PM on November 23, 2009 Employees #3 and #8 acknowledged that the mode of transfer for any resident can change on any shift. "Sometimes we do not have enough Hoyer lifts." Both employees also stated that the CNA has his/her own report sheet and that the mode of transfer for each resident is usually documented on the report sheet. A blank report sheet was received by this regulatory agency. When asked about the documentation on the report sheet, Employee #8 acknowledged that there was no documentation. He/she stated, "We do not keep the sheets. They are discarded at the end of each shift. "</p> <p>A telephone interview was also conducted with Employee #11 at approximately 2:30PM on November 23, 2009. The employee stated, "There was no reason for me to be involved in the transfer of this resident. They [staff] do a two (2) person transfer with him/her. A two (2) person transfer is a nursing transfer." He/she added, "However, they [staff] can use any transfer that they want or a Hoyer Lift. " Employee #11 acknowledged demonstrating a bed to wheel chair transfer to the staff with the use of a gait belt, and that she had no supportive documentation to verify the content of his/her instructions and/or the list of participants.</p> <p>The facility failed to provide documentation that</p>	F 493		

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F 493	Continued From page 71 the resident was ever assessed to determine an appropriate mode of transfer for him/her or that the staff was adequately trained to transfer the resident safely to prevent accidents and/or injuries. The resident sustained a fractured hip while being transferred from his/her bed to a wheel chair by two CNAs. The record was reviewed on November 9, 2009.	F 493	<u>Resident #12</u> 1. The attending physician was notified on 6/6/09 regarding resident's skin integrity and orders were received on 6/6/09. 2. All other residents with high risk for impaired skin integrity were assessed by the licensed staff and physician notified if necessary. 3. Existing policy on skin integrity was amended to reflect standing order treatment for care of stage 1 skin integrity concern. Licensed staff were provided in-service on Resident Skin Integrity and Change in Assessment on 12/17/09, 12/18/09, 12/19/09, 12/20/09. 4. Resident Skin Integrity will be monitored weekly by Resident Care Coordinators and through CQI quarterly. 5. Completion date 12/24/09.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 24 sampled residents, it was determined that facility staff failed to accurately document the resident's skin integrity for one(1) resident, to transcribe a physician's order to monitor pain for one (1) resident and facility staff failed to accurately document in the clinical record regarding the resident's mental status for one (1) resident. Residents #12, 15 and 16. The findings include: 1. Facility staff failed to accurately document the	F 514	<u>Resident #16</u> 1. The resident physical therapy consult was ordered on 9/18/09, and completed on 10/09/09. 2. Other resident with decline in mobility and history of falls were reviewed to ensure that all physical therapy consults were completed. 3. All rehab consults will be tracked	

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F 514	<p>Continued From page 72</p> <p>resident ' s skin integrity for Resident #12.</p> <p>A review of the clinical record for Resident #12 revealed facility staff failed to accurately document the resident ' s skin integrity.</p> <p>A review of the admission note dated March 31, 2009 at 8:15 PM revealed " Resident is incontinent of bowel and bladder, skin intact, warm to touch, has peripheral line on the right lower arm, old scar on the left upper hand (old burn scar), sacrum ulcer which is healing. "</p> <p>A review of the admission note/resident assessment-data collection form signed March 31, 2009 at 8:15 PM, revealed " posterior anatomical diagram Stage II sacrum ulcer " .</p> <p>A review of the Nursing monthly summary signed April 20, 2009, revealed " SkinCondition of Skin ...has sacrum ulcer which healed. "</p> <p>According to the history and physical examination signed and dated April 2, 2009, physician documented skin intact.</p> <p>According to Nutrition assessment signed April 1, 2009, revealed " Skin condition, no evidence of decubitus present, other skin breakdownno evidence. "</p> <p>A face-to-face interview was conducted with Employee# 8 on November 6, 2009, approximately 10:30AM. In response to a query regarding Resident #12 skin integrity assessment, he/she stated the resident sacrum ulcer was healed; he/she had no sacrum ulcer when he/she was admitted. Additionally, Employee #8 acknowledged that the staff failed to accurately</p>	F 514	<p>and monitored in log book. In-service was provided to Nursing and Rehab team on 12/17, 12/18, 12/19, 12/20/09.</p> <p>4. Rehab Therapy consult will be monitored monthly through CQI.</p> <p>5. Completion date 12/24/09.</p> <p>Resident #15</p> <p>1. PASSAR form reviewed and updated to reflect mental retardation. Level 2 evaluation requested on 12/23/09.</p> <p>2. All other residents with diagnosis of mental retardation were reviewed for accuracy of PASSAR and updated information if needed.</p> <p>3. Nursing and Admissions staff were provided an in-service on accuracy of PASSAR. 12/21/09</p> <p>4. All admissions will be monitored monthly for accuracy of PASSR and reported to CQI quarterly.</p> <p>5. Completion Date: 12/24/09.</p>	

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F 514	<p>Continued From page 73</p> <p>document the resident ' s skin integrity. The record was reviewed November 6, 2009.</p> <p>2. Facility staff failed to clarify and accurately document the residents MI/MR status for Resident #15.</p> <p>The nursing admitting progress note dated May 26, 2006 at 1:00 PM identifies resident as having a diagnosis of Mental Retardation.</p> <p>A review of the Physician's Admitting Evaluation Sheet dated and signed May 27, 2006, identifies Mental Retardation as number (4) on a list of "Medical Assessment and/or Diagnoses section".</p> <p>The Government of the District of Columbia Pre-Admission Screen/Resident Review for "Mental Illness and/or Mental Retardation" form dated and signed May 25, 2006, Part B identifies the resident as not having a mental retardation.</p> <p>Review of the Psychiatric consultation dated signed June 9, 2006 (no date included) reveals, "...Diagnoses: Schizophrenia, chronic (in remission); diagnosis II Deferred ...Plan (2) no indication of MR or treatment."</p> <p>According the Nurse Practitioners note signed May 22, 2009 (no date included) indicated" Resident has a past medical/surgical history of under psychiatric: Schizophrenia, Dementia, Mental Retardation."</p> <p>A face-to-face interview was conducted with Employee #7 on November 5, 2009 at approximately 11:30 AM. He/she indicated that the resident has a mental illness of Schizophrenia.</p>	F 514			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/09/2009
NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
(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 514	<p>Continued From page 74</p> <p>A face-to-face interview was conducted with Employee #20 on November 5, 2009 at approximately 11:45 AM. He/she indicated that [he/she] is aware of the resident having a diagnosis of mental retardation and that he/she does not play a role in the in the MI/MR screen process and/or the Level 2 evaluation, but that the Admission Office addresses this area.</p> <p>The medical record lack evidence of accurate documentation in the clinical record regarding the resident ' s mental status.</p> <p>3. Facility staff failed to transcribe the physician's order to monitor pain every shift on to the Medication Administration Record (MAR) for Resident #16.</p> <p>A review of the clinical record revealed that the facility staff failed to transcribe the physician's order to monitor pain every shift on to the Medication Administration Record (MAR) for November 2009.</p> <p>A review of the physician ' s order dated September 18, 2009 revealed the following order, "Monitor for pain every shift and document (Y=Yes N=No.) If pain is new, worsening or if pain med was adjusted, changed - document on the assessment form." A review of the MAR for November, 2009 revealed that the order to monitor pain was not transcribed on to the MAR.</p> <p>Further review of the MAR revealed that the resident received pain medication on the following days: November 1, 2, 3, 4, 5, 6, 7, 8 and 9, 2009.</p>	F 514	<p>Finding #3</p> <p>Resident #16</p> <ol style="list-style-type: none"> 1. Subsequent pain monitoring documentation for Resident #16 is being done. Resident did not experience any negative outcome. 2. All other residents on pain medication MARs were reviewed to ensure that the residents were being monitored for pain and appropriate documentation existed. 3. Charge nurses received in-service on Pain Management/Monitoring and Documentation on 12/17/09, 12/18/09, 12/19, and 12/20/09. 4. Resident MARs will be reviewed for pain management assessment documentation monthly and reported to CQI quarterly. 5. Completion date 12/24/09. 		

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NAME OF PROVIDER OR SUPPLIER STODDARD BAPTIST NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1818 NEWTON ST. NW WASHINGTON, DC 20010		
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F 514	Continued From page 75 A face-to-face interview was conducted with Employee #8 at approximately 4:00 PM on November 6, 2009. He/she acknowledged that the order to monitor pain was not transcribed on to the MAR for November, 2009. The record was reviewed on November 6, 2009.	F 514			