

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

PRINTED: 01/31/2008
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095022 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/14/2008 |
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| NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | <p>INITIAL COMMENTS</p> <p>An annual recertification survey was conducted on January 7 through 14, 2008. The following deficiencies were based on record review, observations, and interviews with residents and the facility staff. The sample included 30 residents based on a census of 343 residents on the first day of survey and 54 supplemental residents.</p> | F 000 | <p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to provide high quality Resident care</p> | |
| F 157 SS=D | <p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update</p> | F 157 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature] *Administrator* *2/11/08*

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

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| F 157 | <p>Continued From page 1</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 observation, record review and staff interview for three (3) of 30 sampled residents and one (1) supplemental resident, it was determined that the facility staff failed to notify the physician and/or the responsible party of changes in the resident's condition: for one (1) resident with fluctuating weight change, one (1) resident who refused finger sticks for five (5) days, and two (2) residents found in bed together. Residents #14, 20, 21 and F3.</p> <p>The findings include:</p> <p>1. Facility staff failed to notify the physician of fluctuating weights for Resident #14.</p> <p>A review of Resident #14's record revealed that from April through August, 2007 the resident weighed 118 pounds (#). On September 4, 2007 the resident weighed 146# with a re-weight 146#. On October 5, 2007 the resident weighed 135#.</p> <p>According to the dietician's notes (no time included):</p> <p>September 6, 2007, " Diet consult: weight gain. Resident weight has been stable for the past 2 years from 117-118#. However this month's weight is 146#. Needs re-weight. Informed DON today."</p> <p>September 11, 2007: "September 7, 2007 weight 146# consistent with September 4, 2007 weight</p> | F 157 | <p>F 157 483.10(b)(11)</p> <p>1. RESIDENT #14 1. The attending physician of Resident #14 was notified of the resident's fluctuating weights. 2. An audit of all residents weights was conducted to determine if residents with significant fluctuating weights were reported to their attending physicians. 3. Inservice was given to the Nursing staff with emphasis on physician notification of resident's fluctuating weight changes. Monthly monitoring of resident's weights will be conducted to ensure that physicians are notified of any their resident's with significant fluctuating weights. Significant weight loss would be those parameters defined by the MDS. The Clinical Managers will monitor this process to ensure Compliance and report their findings to the DON. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08</p> | <p>1/15/08</p> <p>1/25/08</p> <p>2/10/08</p> <p>2/28/08</p> | |

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| F 157 | <p>Continued From page 2</p> <p>...23% weight increase in one month ...resident appears bigger on the wrist area ..."</p> <p>October 31, 2007: "October 5, 2007 weight 135# indicates 5% weight loss which is significant, and 16% weight increase the past 3 months and 6 months ..."</p> <p>There was no evidence that the physician was informed of the Resident's 20# weight gain or 11# weight loss in two (2) months either in the dietician's notes or the nurses' notes.</p> <p>A face-to-face interview was conducted with Employee #41 on January 9, 2008 at 7:20 AM. He/she acknowledged that the physician was not notified of the resident's changes in weight. The record was reviewed January 9, 2008.</p> <p>2. Facility staff failed to notify the physician of Resident # 20's refusal to have daily finger sticks for 5 (five) days.</p> <p>A physician's order originally written on October 29, 2007 and last signed on December 12, 2007 directed, " Finger stick Blood Sugar (BS) 2 times a day: Give 5 Units Regular Insulin for BS >200 ug/dl."</p> <p>A review of the January 2008 Medication Administration Record (MAR) revealed that the resident refused to have finger sticks done on January 2, 4, 5, 6, and 7, 2008. There was no evidence in the record that the physician was notified of the resident's refusal of finger sticks. The blood sugar was 96 ug/dl on January 1, 102 ug/dl on January 3, 2008 and 96 ug/dl on January 9, 2008.</p> | F 157 | <p>2. RESIDENT #20</p> <p>1. Physician of Resident #20 was notified of his refusal to have daily fingersticks for 5 days. Upon notification, the physician discontinued the order for daily fingersticks.</p> <p>2. An audit of all MAR's on the unit was performed to ensure that all residents refusal to have daily fingersticks were reported to their individual physicians. Orders were changed whenever the physician felt it necessary.</p> <p>3. Nursing staff was inserviced to ensure that proper notification to attending physicians is done when a resident refuse medications, treatment/procedure. Monthly audit of MAR's will be conducted by Clinical Mgr/designee to ensure that refusals of treatments/fingersticks are reported to attending physicians.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | 1/15/08 | 1/25/08 | 2/10/08 | 2/28/08 |

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| F 157 | <p>Continued From page 3</p> <p>A face-to-face interview was conducted with Employee #10 at approximately 1:00 PM on January 10, 2008. He/She acknowledged that the staff failed to notify the physician of the resident's refusal to have finger sticks. The record was reviewed on January 10, 2008. The resident had no untoward effects.</p> <p>3. Facility staff failed to notify the family and/or the responsible party that Resident #21 was found in bed with Resident F3.</p> <p>According to a nurse's note dated December 8, 2007 at 11:00 PM, "Upon conducting my rounds, noted resident [Resident #21] in [Resident F3's] bed. Was told several [on]occasions to go in [his/her] own bed. But [he/she] refused. Supervisor told [Resident #21] to go to [his/her] room and still [he/she] refused. [He/she] then got out of [Resident F3's] bed and they both sit in hallway. [Resident #21] was very agitated. Medication was offered to [him/her]. [He/she] refused ... [Physician notified]." Resident F3's roommate was in his/her bed at the time of this occurrence.</p> <p>A review of Resident #21's nurses' notes and social worker's notes revealed that there was no evidence in the record that the family was notified of this incident.</p> <p>A face-to-face interview was conducted on January 10, 2008 at 8:30 AM with Employee #24. He/she stated, "I didn't do any follow-up because I didn't think this was a behavior issue. The two residents have developed a friendship and I didn't think this was anything unusual."</p> <p>Resident #21's quarterly Minimum Data Set</p> | F 157 | <p>3. RESIDENT #21</p> <ol style="list-style-type: none"> 1. Resident # 21's responsibility party was notified of behavior in question. 2. Medical records of all residents on behavior monitoring were audited for the same deficient practice and corrected as identified. 3. Inservice was given to the Nursing Staff about the importance of family/responsible party notification each time the resident exhibits unusual behavior. Compliance monitoring thru record review will be done by the Clinical Manager/ designee. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/15/08 1/15/08 2/28/08 2/28/08 | |

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| F 157 | <p>Continued From page 4</p> <p>(MDS) assessment, completed October 19, 2007, was reviewed. He/she was coded for long and short-term memory problems and with moderately impaired cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed August 8, 2007 included Dementia.</p> <p>Resident F3's quarterly MDS assessment completed November 20, 2007 coded the resident for long and short term memory problems with modified independence of cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed April 20, 2007 included dementia. The record was reviewed January 9, 2008.</p> <p>4. Facility staff failed to notify Resident F3's family and/or responsible party that Resident #21 was found in his/her bed.</p> <p>A face-to-face interview was conducted on January 10, 2008 at 8:30 AM with Employee #24. He/she stated, "I didn't do any follow-up [with the responsible party or the resident] because I didn't think this was a behavior issue [when Resident #21 was found in bed with Resident F3]. The two(2) residents have developed a friendship and I didn't think this was anything unusual."</p> <p>Resident F3's quarterly MDS assessment completed November 20, 2007 coded the resident for long and short term memory problems with modified independence of cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed April 20, 2007 included dementia.</p> | F 157 | <p>4. RESIDENT #F3</p> <p>1. Resident # 3 responsibility party was notified of behavior in question. 1/15/08</p> <p>2. Medical records of all residents on behavior monitoring were audited for the same deficient practice and corrected as identified. 2/10/08</p> <p>3. Inservice was given to the Nursing Staff about the importance of family/responsible party notification each time the resident exhibits unusual behavior. Compliance monitoring thru record review will be done by the Clinical Managers. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 157 | Continued From page 5 | F 157 | | |
| F 164 SS=D | <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> | F 164 | | |

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| F 164 | <p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview for two (2) of 10 residents observed during medication pass, it was determined that the facility staff failed to ensure the privacy and confidentiality of residents' Medication Administration Records (MARs). Residents JH8 and JH10.</p> <p>The findings include:</p> <p>During the medication pass on January 8, 2008, at approximately 9:45 AM, Employee #20, went into Resident JH8's room to administer medications. At approximately 10:55 AM, he/she went into Resident JH10's room to administer medications. While administering medications to the residents, Employee #20 left the MAR open and exposed on top of the medication cart, located in the hallway of Unit 3 North.</p> <p>The MAR includes the resident's diagnoses, allergies and currently prescribed medications.</p> <p>A face-to-face interview was conducted on January 8, 2008 at approximately 11:00 AM at the completion of the medication pass observation. Employee #20 acknowledged that the MAR was left open on both occasions.</p> | F 164 | <ol style="list-style-type: none"> Inservice was given to the particular charge nurse (employee #20) regarding maintaining privacy and confidentiality of resident's records while administering medications by keeping resident's MARs closed while the nurse is in the resident's room. Clinical Managers/designee will do rounds and observe LPNs during med pass to ensure compliance. Nursing Supervisors on off shifts will do observation of LPNs during rounds to ensure compliance. Deficient practice observed will be corrected as it Occurs. Repeated non-compliance will be cause for discipline per HR policy. Inservice was given to the Nursing Staff about the importance of confidentiality of medical information during med pass. Compliance monitoring will be done by the Clinical Managers. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 2/28/08 | 1/24/08 2/28/08 2/28/08 |
| F 221 SS=D | <p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by:</p> | F 221 | | |

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| F 221 | <p>Continued From page 7</p> <p>Based on observation, staff and resident interviews and record review for two (2) of 49 residents identified by facility staff having restraints, it was determined that facility staff failed to obtain a physician's order for the use of restraints. Residents #3 and 6 .</p> <p>The findings include:</p> <p>1. Facility staff failed to obtain a physician's order for a seat belt for Resident #3.</p> <p>Resident #3 was observed on January 8, 2008 at 10:30 AM and January 9, 2008 at 11:00 AM wearing a padded seat belt. An interview was conducted with the resident at 11:00 AM on January 9, 2007. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head and stated, " No."</p> <p>According to a review of the Rehabilitation Screening dated November 6, 2007, "Patient will require a Velcro seatbelt with alarm for less restrictive device secondary to patient not being able to open current seatbelt upon command. Nursing notified ..."</p> <p>A review of the resident's record revealed that there was no order from the physician to initiate the use of a seat belt.</p> <p>A face-to-face interview with Employee #6 was conducted on January 8, 2008 at 2:30 PM. He/she acknowledged that there was no physician's order. The record was reviewed on January 8, 2008.</p> <p>2. Facility staff failed to obtain a physician's order</p> | F 221 | <p>1. RESIDENT #3</p> <p>1. Physician order was obtained for the seat belt for Resident #3. 1/15/08</p> <p>2. Medical Records of all residents on the unit wearing a seat belt were audited for the presence of a physician order. 2/28/08</p> <p>3. An inservice program reviewing the WNF protocol for Physical Restraints was given to the nursing staff with special emphasis that a physician order must be obtained prior to applying any form of physical restraint on a resident. 2/28/08</p> <p>Monitoring that a physician order is obtained prior to application of a seat belt as a form of physical restraint will be performed by the Restraint Review Committee weekly. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> <p>2. RESIDENT #6</p> <p>1. Physician order was obtained for the seat belt for Resident #6. 1/15/08</p> | | |

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| F 221 | Continued From page 8 for the use of a seat belt for Resident #6. Resident #6 was observed on January 9, 2008 at approximately 11:55 AM seated in a wheel chair wearing a padded seat belt. A face-to-face interview was conducted with Employee #36 and the resident at 11:55 AM. Employee #36 and the resident were asked if the resident was able to open the seat belt. The resident responded verbally " No" after two (2) failed attempts to open the seat belt. Employee #36 responded " The resident will fall if the seat belt is released. It's for safety." A review of the clinical record for Resident #6 revealed a Physician's Order Form (POF) signed and dated December 12, 2007. There was no physician's order to initiate the use of a seat belt. A face-to-face interview was conducted on January 9, 2008 at approximately 12:45 PM with Employees #29 and #40. They both acknowledged that there was no physician's order for the use of the seat belt. The record was reviewed on January 9, 2008. | F 221 | 2. RESIDENT #6 (continued from page 8) 2. Medical Records of all residents on the unit wearing a seat belt were audited for the presence of a physician order. 3. An inservice program reviewing the WNF protocol for Physical Restraints was given to the nursing staff with special emphasis that a physician order must be obtained prior to applying any form of physical restraint on a resident. Monitoring that a physician order is obtained prior to application of a seat belt as a form of physical restraint will be performed by the Restraint Review committee weekly. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/15/08 2/28/08 2/28/08 | |
| F 241 SS=D | 483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 54 supplemental residents, it was determined that facility staff failed to promote care in a manner and in an environment that | F 241 | | | |

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| F 241 | Continued From page 9 maintains or enhances dignity. Resident A2. The findings include: Resident A2 was observed on January 10, 2008 at approximately 8:30 AM in bed. The hallway and the resident's room emitted a urine odor. The urinal was attached by the handle to the resident's bed rail and appeared to be one-quarter filled. While the surveyor was conducting an interview with Employee # 33 regarding the urine odor, Employee #17 came in with the resident's breakfast, set the tray on the beside table, removed the cover from the food, opened a carton of milk and uncovered a glass of juice. The urinal was not emptied prior to setting up the resident's breakfast. A review of the Interdisciplinary summary dated November 14, 2007 revealed: " The resident continued to require assistance with Activities of Daily Living (ADL) including bathing and grooming." A face-to-face interview was conducted with Employees #10 and #17 on January 10, 2008 at approximately 8:45 AM. They both acknowledged that the resident should not have been served breakfast in a room with urine odor and urine in the urinal hanging on the resident's side rail. The record was reviewed on January 10, 2008 | F 241 | RESIDENT #A2 1. The resident was moved to the day room where he was fed breakfast. The room was cleaned by housekeeping. The urinal was emptied by the nursing staff. The involved CNA was counseled by the Clinical Manager about Dignity in Dining practice. 2. The Clinical Manager/designee made rounds on the unit to ensue that the same deficient practice did not reoccur with any other resident. 3. Nursing staff was given an inservice about Dignity in Dining Practice. Rounds are to be made by the Clinical Manager/designee during meal times to ensure that meal service is a dignified experience for the residents. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/11/08 1/11/08 2/10/08 2/28/08 |
| F 247 SS=D | 483.15(e)(2) NOTICE BEFORE ROOM CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. | F 247 | | |

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| F 247 | <p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to notify the resident and/or responsible party prior to a room change. Residents #10 and 11.</p> <p>The findings include:</p> <p>1. Facility staff failed to notify the family and/or responsible party prior to a room change for Resident #10.</p> <p>A review of Resident #10's record revealed a "Notice of Discharge or Transfer from this facility or Relocation within the facility" form dated October 2, 2007. Under (2), "The specific reason for this action is as follows: Resident was relocated from [room number] to [room number] because you were attempting to feed your roommate."</p> <p>On the second page under, "Resident's Legal Representative: notified by nursing" and was dated "10/2/07."</p> <p>According to a social worker's note dated October 4, 2007, "Resident is being relocated from [room number] to [room number] because he/she was attempting to feed his/her roommatenursing staff has notified the R.P."</p> <p>According to a quarterly Minimum Data Set assessment completed September 6, 2007, the resident was coded in Section B (Cognitive Pattern) for long and short term memory loss.</p> | F 247 | <p>RESIDENT #10</p> <p>1. The resident is her own Responsible Party and was notified prior to her move. Interviewing the resident, she recalls the request by nursing and also recalls giving her permission prior to the move.</p> <p>2. The documentation of all residents who recently had their room relocated was audited and corrections were made when necessary.</p> <p>3. Inservice was given by the Director of Social Work to the Social Workers and Charge Nurses regarding the notification of responsible parties prior to the relocation of a resident.</p> <p>4. The Director of Social Work will monitor all room change documentation to ensure compliance and will report his findings to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | <p>10/2/07</p> <p>2/10/08</p> <p>2/28/08</p> <p>2/28/08</p> |

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| F 247 | <p>Continued From page 11</p> <p>There was no evidence in the nurses' notes from October 1 through October 20, 2007 that the responsible party was notified of the resident's room change. The record was reviewed January 10, 2008.</p> <p>2. Facility staff failed to notify the family and/or responsible party prior to a room change for Resident #11.</p> <p>A review of Resident #11's record revealed a "Notice of Discharge or Transfer from this facility or Relocation within the facility" form dated October 23, 2007. Under (2) "The specific reason for this action is as follows: Resident was relocated from [room number] to [room number] due to administrative purposes. 7 day waiting period waived."</p> <p>On the second page under, "Resident's Legal Representative: notified by SW [social worker]" dated "10/23/07."</p> <p>According to a social worker's note dated October 23, 2007, "Resident is being relocated from [room number] to [room number] secondary to administrative reasons. Writer left message on RP (responsible party) voicemail. PL6-108 (above cited notification form) completed. Original to RP, copy for chart."</p> <p>A face-to-face interview was conducted with Employee #24 on January 14, 2008 at 9:05 AM. He/she stated, "This was an emergency transfer. Another resident was coming in that needed an isolation room later in the day. I left a message on the RP's voice mail to call the facility."</p> <p>According to a nurse's note dated October 24,</p> | F 247 | <p>2. RESIDENT #11</p> <p>1. The return phone call from the Responsible Party Was received soon after the relocation and permission Was received. 10/23/07</p> <p>2. The documentation of all residents who recently had their room relocated was audited and corrections were made when necessary to ensure proper and timely notification. 1/31/058</p> <p>3. Inservice was given by the Director of Social Work to the Social Workers and Charge Nurses regarding the notification of responsible parties prior to the relocation of a resident. 2/28/08</p> <p>4. The Director of Social Work will monitor all room change documentation to ensure compliance and will report his findings to the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 247 | Continued From page 12 2007 at 4:00 PM,"Call place to responsible party [name] concerning room transfer of resident from [room number] to [room number]. Responsible party was made aware." According to the quarterly MDS assessment completed November 29, 2007, the resident was coded in Section B for long and short term memory problems. Employee #24 acknowledged that the relocation of the resident occurred before the RP was notified. The record was reviewed January 14, 2008. | F 247 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled ceiling tiles and floors, odors, and dryers with accumulated lint. The environmental tour was conducted on January 7, 2008 from 8:30 AM to 11:30 AM in the presence of Employees # 3, 4 and 26. Additionally, odors were detected during the survey period. The findings include: | F 253 | | |

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| F 253 | <p>Continued From page 13</p> <p>1. Soiled ceiling tiles in the following areas:</p> <p>First floor- Room 111 bathroom, in one (1) of five (5) rooms observed.</p> <p>Second floor- Rooms 222, 227, 229, 244, 245, 2N and 2S clinical storage areas, and 2N hallway restroom in eight (8) of 17 rooms observed.</p> <p>Third floor-Rooms 331, 356 and the 3N training bathroom in thee (3) of 14 rooms observed.</p> <p>2. Soiled floors were observed behind the washers in the laundry room.</p> <p>During a tour of the laundry on January 18, 2008 at 8:30 AM, it was observed that the floor behind the washers was soiled with accumulated dust and debris. This was observed in the presence of Employee #3, who acknowledged the finding at the time of the observation.</p> <p>3. Urine, fecal, body and/or smoke odors were detected during the survey period in the following areas:</p> <p>First floor urine odors were detected as follows:</p> <p>First floor elevators at 6:55 AM on January 7, 2008</p> <p>Rooms 111 and 118 on January 7, 2008 at approximately 8:15 AM.</p> <p>Resident #2 on January 9, 2008 at 12:45 PM.</p> <p>Resident A2 on January 10, 2008 at 8:30 AM.</p> <p>1N hallway between rooms 118 and 148 on</p> | F 253 | <p>1. Ceiling Tiles</p> <p>1. All ceiling tiles noted as soiled at the time of the survey have been replaced. 1/15/08</p> <p>2. All ceiling tile has been evaluated and replaced where necessary. 1/31/08</p> <p>3. The Maintenance supervisors will closely monitor the condition of the ceiling tiles to ensure compliance. 2/28/08</p> <p>4. The Director of Maintenance will oversee the monitoring efforts and report his findings to the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> <p>2. Soiled floors behind washers</p> <p>1. Floors behind the washers noted as soiled with debris at the time of the survey have been cleaned. 1/11/08</p> <p>2. All floors of the laundry area were evaluated and cleaned to ensure compliance. 1/11/08</p> <p>3. The Environmental Supervisors will conduct frequent monitoring rounds to ensure the cleanliness of the laundry area. 2/28/08</p> <p>4. The Director of Environmental Services will oversee the monitoring efforts and report her findings to the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> <p>3. Odors</p> <p>1. Odors noticed at the time of the survey were dealt With appropriately and eradicated. 1/10/08</p> <p>2. Other areas of the facility were checked for odors And none were present. 1/10/08</p> <p>3. An upgrade of filters for the HVAC systems have Been ordered for the dining rooms to assist in the Elimination of the smoke odors from the 1st floor Smoking patio. Inservices are scheduled regarding The reporting of and the eradicating any odors re- Lated to patient care and services. The Clinical Managers, Supervisors and Department Heads will monitor for the presence of odors on an on-going basis. 2/15/08</p> <p>4. The DON and Maintenance Director will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 253 | <p>Continued From page 14 January 11, 2008 at 10:30 AM.</p> <p>Smoke odors were detected as follows:</p> <p>First floor dining room on January 7, 2008 at 8:30 AM, January 8, 2008 at 9:45 AM and 2:05 PM, January 9, 2008 at 3:40 PM and 6: 24 PM, January 10, 2008 at 10:23 AM and January 11, 2008 at 9:10 AM and 3:05 PM.</p> <p>Second floor urine odors were detected as follows:</p> <p>Rooms 213, 243, 255 and 259 on January 7, 2008 during the initial tour between 8:30 AM and 10:00 AM.</p> <p>Room 204 on January 10, 2008 at 12:25 PM.</p> <p>Room 211 on January 10, 2008 at 7:30 AM, and room 259 on January 7, 2008 at 11:15 AM</p> <p>Third floor- Room 301 on January 8, 2008 at 3:00 PM, and January 10, 2008 at 11:30 AM, room 359 on January 7, 2008 at 9:30 AM, room 355 on January 9, 2008 at 10:00 AM, and the multipurpose room on January 7, 2008 at approximately 2:50 PM</p> <p>4. Two (2) of two (2) dryers in the laundry room were observed with accumulated lint in the lint traps. On January 7, 2008 at 11:30 AM, it was observed that according to the monitoring sheets attached to each dryer, the lint trap in Dryer A was last cleaned on January 3, 2008 at 10:30 PM. The lint trap to Dryer B was last cleaned on January 4, 2008 at 10:00 PM.</p> <p>A face-to-face interview was conducted with</p> | F 253 | <p>4. Lint in the dryers</p> <ol style="list-style-type: none"> 1. Lint in the dryers noted at the time of the survey was removed upon discovery. 2. All dryers were assessed for accumulated lint to ensure safety and compliance. 3. The entire laundry staff was inserviced on the cleaning and recording of cleaning time of the dryers. The supervisors will monitor the lint screens on to ensure compliance. 4. The Director of Environmental Services will ensure that the monitoring of the dryers for lint accumulation is done on an on-going basis and will report her findings to the QA Committee which is chaired by the Administrator. 5. 2/28/08 | <p>1/10/08</p> <p>1/10/08</p> <p>2/28/08</p> <p>2/28/08</p> | |

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| F 253 | Continued From page 15 Employee #3, present during the observation. Employee #3 stated, "The lint traps should be cleaned every two hours everyday." The above findings were acknowledged by Employees # 3, 4 and 26 at the time of the observations. | F 253 | | |
| 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 | F 278 | | |

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| F 278 | <p>Continued From page 16</p> <p>by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to sign the Minimum Data Set (MDS) for one (1) resident in Section R and code one (1) resident for falls. Residents #2 and 7.</p> <p>The findings include:</p> <p>1. The registered nurse (RN) failed to sign at R2 for the admission MDS dated May 15, 2007.</p> <p>A review of Resident #2's admission MDS for May 15, 2007 was observed without a signature at Section R, "Assessment Information" for R2b "Signature of the person coordinating the assessment."</p> <p>According to the "MDS 2.0 User's Manual," page 3-212, "Federal regulation requires the RN Assessment Coordinator to sign and certify that the assessment is complete."</p> <p>On January 7, 2008 at approximately 11:30 AM, a face-to-face interview was conducted with Employee #7 who acknowledged the lack of a signature. The record was reviewed on January 1, 2008.</p> <p>2. Facility staff failed to code Resident #7 for falls.</p> <p>A review of the resident's quarterly MDS completed December 11, 2007 coded Section J4 "Accidents" as none of above [indicating no falls] in the last 30 days and/or last 31-180 days."</p> <p>A review of the nurses' progress notes revealed: " September 14, 2008 at 4:00 PM ...CNA</p> | F 278 | <p>1. RESIDENT #2</p> <p>1. MDS of resident #2 was signed by the RN upon discovery. 1/11/08</p> <p>2. An audit of all MDSs was conducted by the MDS Coordinator to ensure that all of the MDSs were complete with an RN signature at section R2b. 1/15/08</p> <p>3. MDS staff were inserviced to ensure that RN Signatures are present prior to putting MDS documents in the resident's medical record. Monthly audit will be conducted by the MDS Coordinator to monitor for completion with RN signatures. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> <p>2. RESIDENT #7</p> <p>1. Correction modification was done on the MDS of Resident #7. 1/15/08</p> <p>2. An audit of all residents MDS who had falls were reviewed to ensure that falls were coded appropriately in section J4. 1/31/08</p> <p>3. MDS staff were inserviced regarding coding of falls in the appropriate section of the MDS – J4 Accidents. MDS Coordinator will conduct monthly audits of all falls to ensure that they are appropriately coded in the resident's MDS 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 278 | Continued From page 17 [certified nurse aide] stated that resident fell on the floor, and bumped his/her head, writer assessed resident ' s right side of forehead swollen ... " " September 30, 2008 at 1:30 PM, Resident was observed walking from his/her chair in the hallway. He/she was then observed sliding to the floor by said writer. The occurrence was observed; he/she did not hit his/her head ... " A face-to-face interview was conducted with Employee #23 on January 9, 2008 at 10:12 AM. He/she acknowledged that the quarterly MDS failed to reflect the resident's falls. The record was reviewed January 9, 2008. | 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). | F 279 | | |

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| F 279 | <p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for three (3) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to initiate a care plan with approaches and goals for: one (1) resident with incontinence, one (1) resident who developed eschar, one (1) resident for the use of psychotropic medication and one (1) resident for smoking. Residents # 6, 10, 18, and S4.</p> <p>The findings include:</p> <p>1. Facility staff failed to initiate an incontinence care plan with goals and approaches for Resident #6.</p> <p>A review of Resident #6's record revealed an admission Minimum Data Set (MDS) completed May 10, 2007, significant change August 17, 2007 and a quarterly November 5, 2007. In Section H "Continence" the resident was coded for incontinence of bladder and and bowel.</p> <p>A review of the Interdisciplinary summary of May 17, August 23 and November 29, 2007 revealed that the team failed to address the resident's incontinence. A review of the resident's care plan / problem list failed to include the resident's incontinence. There was no care plan that included goals and approaches for the resident's incontinence.</p> <p>A face-to-face interview was conducted on January 9, 2008 at approximately 11: 35 AM with Employee #29. He/She acknowledged that a</p> | F 279 | <p>1. Resident #6</p> <p>1. An incontinence care plan was initiated with goals and approaches for Resident #6. 1/25/08</p> <p>2. An audit was conducted on the medical records of all residents on the unit to determine if all residents who are incontinent have a incontinence care plan with individualized goals and approaches. 1/31/08</p> <p>3. An inservice will be given to the nursing staff addressing Developing Incontinence Care Plans on residents assessed and documented to be incontinent. The Incontinent Care Plan will have individualized goals and approaches. Monitoring of residents care plans that are determined to be incontinent will be conducted by the IDT for compliance. Deficient practices will be corrected as identified. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | | |

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| F 279 | <p>Continued From page 19</p> <p>care plan for incontinence was not initiated. He/She said; " I will add it now" . The record was reviewed on January 9, 2008.</p> <p>2. Facility staff failed to initiate a care plan for Resident #10's pressure sore prior to the development of eschar on the right heel.</p> <p>A review of the Resident #10's record revealed a nurse's note dated September 23, 2007 at 2:45 PM, "Resident returned to the unit and stated that [he/she] fell outside...[physician] was called and an order for x-ray of right leg and hip to rule out any internal injury or fracture..."</p> <p>X-ray results from September 23, 2007, indicated a fracture of the right Fibula.</p> <p>On September 24, 2007, the orthopedic physician applied a splint (soft cast) to the right lower extremity to include the heel and plantar area of foot.</p> <p>A care plan initiated on September 24, 2007, identified the problem, " Resident has cast to (R) [right] Leg " Approaches listed on the care plan included: " Check cast/circulation daily ...Report any abnormal findings to MD " .</p> <p>A review of Resident #10's significant change Minimum Data Set Assessment (MDS), completed October 3, 2007, revealed that the resident was coded as totally dependent for bed mobility in Section G ("Physical Function and Structural Problems").</p> <p>The Resident Assessment Protocol Summary completed October 3, 2007, triggered for approaches to prevent the development of</p> | F 279 | <p>2. RESIDENT #10</p> <p>1. The care plan of Resident #10 was updated to include goals and approaches to prevent further skin breakdown and pressure ulcers. 1/15/08</p> <p>2. Head to toe skin assessments was done on all residents on all units. Medical Records of all residents on the unit assessment and documented to be totally dependent for bed mobility were audited to ensure that the care plan included goals and approaches to prevent skin break down and pressure ulcers. 2/5/08</p> <p>3. An inservice on daily skin assessments by CNAs and weekly skin assessments during wound rounds by LPNs was given by the Wound Nurse Consultant and ADON. Skin assessment monitoring reports will be submitted to the Charge Nurse daily by the CNAs using the daily skin report sheet 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 279 | <p>Continued From page 20 pressure ulcers.</p> <p>There was no evidence in the record that facility staff assessed the resident's skin from October 3 through October 20, 2007.</p> <p>According to a nurse's note dated October 20, 2007 at 3:00 PM, "Eschar noted on Resident 's RT [Right] Heel " .</p> <p>There was no evidence that facility staff initiated a care plan with goals and approaches to prevent the development of pressure ulcers until October 20, 2007 when a pressure wound on the right heel was first identified as a 3 cm (centimeter) X 3.5 cm area of eschar.</p> <p>A face-to-face interview with Employees # 6 and 15 was conducted on January 9, 2008 at 3:00 PM. After reviewing the record, Employees #6 and 15 acknowledged that facility staff failed to initiate a care plan to prevent pressure ulcer for Resident #10. The record was reviewed January 9, 2008.</p> <p>3. Facility staff failed to initiate a care plan with goals and approaches for Resident #18 who was on medications for depression and sleep.</p> <p>A review of the resident's record revealed the following: " Initial Psychiatric Evaluation dated November 29, 2007: [increase] Zoloft 100 mg P.O.[By Mouth] daily X [for] six (6) weeks then 50 mg P.O. daily for Depression/pain. Ambien 6.25 mg P.O. QHS [every night] X 2 weeks" , and an " Interim Order Form" dated November 29, 2007: [increase] Zoloft 100 mg P.O.[By Mouth] daily X six (6) weeks then 50 mg P.O. daily for Depression / pain. Ambien 6.25 mg P.O. QHS X</p> | F 279 | <p>3. RESIDENT# 18</p> <p>1. The care plan of resident #18 was updated to include goals and approaches addressing medications for depression and sleep. 1/15/08</p> <p>2. Medical records of residents receiving medications for depression and sleep were audited for care plans addressing these aspects of care. 1/31/08</p> <p>3. Inservice was given to the nursing staff regarding developing care plans with goals and approaches for residents receiving medications for depression and sleep. Monitoring of residents care plans who are receiving medications for depression and sleep will be monitored to ensure that they have goals and approaches addressing these medications 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/0/</p> <p>5. 2/28/08</p> | | |

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| F 279 | <p>Continued From page 21 2 weeks"</p> <p>A review of the resident's November and December 2007 Medication Administration Record revealed that the resident received Zolofl daily.</p> <p>A review of the resident's record revealed a social work note dated November 21, 2007: "IDT [Interdisciplinary Team] Conference Quarterly Note: ...Resident receives Sertraline [Zoloff] for Depression ...".</p> <p>A review of the resident's care plan problem list revealed that facility staff failed to include goals and approaches for the resident's use of Zoloff and Ambien.</p> <p>A face-to-face interview was conducted on January 8, 2008 at approximately 10: 50 AM with Employee #10. He/She acknowledged that a care plan for the use of the medications was not initiated. The record was reviewed on January 8, 2008.</p> <p>3. Facility staff failed to initiate a care plan for Resident S4 with appropriate goals and approaches for smoking.</p> <p>A review of Resident S4's record revealed a social worker's note dated March 4, 2007, documenting, "Resident was found with cigarettes in [his/her] possession...the resident is aware that [he/she] should not have cigarettes in [his/her] possession and agreed to follow the facility's smoking policy."</p> <p>Facility staff generated a list of smokers residing on unit 2 South. Resident S4's name appeared on</p> | F 279 | <p>3. RESIDENT #S4</p> <p>1. The care plan for Resident S4 was updated to include goals and approaches for smoking. 1/15/08</p> <p>2. Care plans of all residents identified to have smoking behavior were audited to ensure that they have goals and approaches for smoking. Care plans were updated as the need was identified. 1/31/08</p> <p>3. An inservice to the nursing staff was given to ensure that residents with identified smoking behaviors will have corresponding care plans with goals and approaches for smoking. Care plans will be reviewed for compliance during the IDT meeting. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> | | |

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| F 279 | Continued From page 22 the smoker's list. A review of the resident's record revealed that facility staff failed to initiate a care plan with appropriate goals and approaches for smoking. A face-to-face interview with Employee #7 was conducted on January 10, 2008 at 11:30 AM. He/she acknowledged that a smoking care plan should have been initiated. The record was reviewed January 11, 2008. | F 279 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review for | F 280 | | |

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| F 280 | <p>Continued From page 23</p> <p>three (3) of 30 sampled residents and two (2) supplemental residents, it was determined that facility staff failed to update the care plan for five (5) residents with multiple falls and for one (1) resident with a cigarette burn. Residents # 2, 10, 30, A1 and S1.</p> <p>The findings include:</p> <p>1. Facility staff failed to update a care plan for Resident #2 who had multiple falls.</p> <p>A review of the care plan for Resident #2 last updated on November 7, 2007 revealed that the resident fell on May 20, 2007, June 23, 2007, and August 4, 14, and 27, 2007. All of the falls were without injury. However, the interdisciplinary care plan was not updated to include new approaches to prevent further falls.</p> <p>On January 8, 2007 at approximately 10:30 AM, a face-to-face interview was conducted with Employee #15 who acknowledged that the care plan was not updated for falls. The record was reviewed on January 7, 2008.</p> <p>2. Facility staff failed to update a care plan for Resident #10 who had multiple falls.</p> <p>A review of the " Falls " care plan for Resident #10 revealed, " August 14, 2007 fall- with no injury, August 31, 2007- fall with no injury, September 23, 2007- fall which resulted in injury.</p> <p>An additional care plan for falls was added on September 24, 2007. On November 12, 2007 - fall no injury and November 21, 2007- Resident found beside the bed - no injury.</p> <p>The aforementioned care plan lacked evidence</p> | F 280 | <p>1. RESIDENT #2</p> <p>1. This resident has not fallen since August 27, 2007. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 1/15/08</p> <p>2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 1/31/08</p> <p>3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> <p>2. RESIDENT #10</p> <p>1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 1/15/08</p> <p>2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 1/31/08</p> <p>3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee Meeting 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/28</p> | |

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| F 280 | <p>Continued From page 24</p> <p>that new goals and approaches were implemented to address the resident's falls.</p> <p>On January 9, 2007 at approximately 3:00 PM, a face-to-face interview was conducted with Employee # 6 and 15 who acknowledged that the " Falls " care plan was not updated with new goals and approaches to address the resident's falls. The record was reviewed on January 9, 2008.</p> <p>3. Facility staff failed to update Resident #30's care plan after multiple falls.</p> <p>A review of the interdisciplinary care plan for Resident #30 (closed record) initiated May 25, 200 and last reviewed September 5, 2007 revealed that the resident fell on June 6 and 18, and August 24, 2007. The interdisciplinary care plan was not updated to include new approaches after each fall. The record was reviewed on January 8, 2008.</p> <p>4. Facility staff failed to update the care plan for Resident A1 who had multiple falls.</p> <p>Resident was observed on January 10, 2008 at about 9:00 AM with unsteady gait exiting the bathroom without assistance.</p> <p>A review of the resident's record revealed an annual Minimum Data Set (MDS) completed November 30, 2007. Section G3 " Test for Balance" , coded the resident: " Unsteady balance while standing" .</p> <p>A review of the entry on the Interdisciplinary Care Plan for Falls dated December 31, 2007 revealed a chair alarm as one of the approaches identified</p> | F 280 | <p>3. RESIDENT #30</p> <p>1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 1/15/08r</p> <p>2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 1/31/08</p> <p>3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/28</p> <p>4. RESIDENT # A1</p> <p>1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 1/15/08</p> <p>2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 1/31/08</p> <p>3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/28</p> | |

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| F 280 | <p>Continued From page 25 by facility staff.</p> <p>A review of Resident A1's record revealed the following nurse's notes: February 14, 2007 at 10:30 AM, " Resident was observed lying on the floor ... Responsible Party and physician made aware." March 26, 2007 at 10:00 PM, " ...Resident was observed ... in [own] room sitting on the floor ..." May 14, 2007, at 5:00 AM " Resident was observed on the floor during routine visual room round ..." June 24, 2007 at 3:30 PM, " ...Resident was observed lying on the floor ...no injuries. Resident stated I am ok, my leg gave up on me when I was trying to get up from chair. PMD [Primary Medical Doctor] notified ..." July 5, 2007 at 10:00 PM " ...found sitting on the floor ...no visible injury ..." October 9, 2007 at 3:00 PM " Resident was observed by a nurse sitting on the floor in the bathroom ..." October 11, 2007 at 6:00 PM, " Resident was observed on the floor in own room ...MD on the unit ...denies any pain ..." October 14, 2007, at 3:00 PM, " Resident was observed in the floor in [] room beside his bed. No injury noted. Resident complained of pain ...MD notified ..." November 3, 2007 at 4:00 PM, " ...upon round making Resident observed on the floor lying on left side. He was assessed ...noted abrasion on (R) [right] 2nd finger ...pain on (L) [left] hip ... MD. And Supervisor aware ...Resident to ER [emergency room] for evaluation of left hip pain ..." November 12, 2007 at 1:15 PM " resident was observed on the floor ...Resident stated I want to use the bathroom ...denied pain ..."</p> | F 280 | | |
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| F 280 | <p>Continued From page 26</p> <p>November 27, 2007, at 11:00 AM Resident was observed on the floor by one of the Rehab tech ...Denies pain. MD notified ..."</p> <p>November 29, 2007 at 3:10 PM, " resident was observed on the floor lying on [] back, close to [] bed ...MD notified.</p> <p>December 19, 2007 at 3:00 PM, " Resident was observed sitting ...floor and back resting against bed ...Resident stated, I slipped and fell..."</p> <p>December 31, 2007 at 11:00 AM, " Resident was observed by a nurse sitting on the floor beside bed in [] room. MD notified..."</p> <p>A face-to-face interview was conducted with Employee #7 on January 10, 2008 at approximately 9:30 AM. He/she acknowledged that the care plan was not updated, evaluated and revised to reflect additional goals and approaches in response to the above cited falls. He /she said,"I understand now that the bed/chair alarm was not an effective approach in preventing the resident from falling. They are not effective monitoring tools for this resident. We never hear them go off when the resident falls. I did not know that the resident could take the alarm off before getting out of bed" The record was reviewed on January 10, 2008.</p> <p>5. Facility staff failed to update the care plan for Resident S1 who had multiple falls.</p> <p>A review of Resident S1's record revealed the following nurses' notes: December 21, 2007 at 11:00 PM: " Resident found sitting on the floor beside [his/her] bed at 8 pmresident said [he/she] was trying to walk to the toilet, lost [his/her] balance and fell on [his/her] buttock ...Neurochecks initiated and within normal limits ..."</p> | F 280 | <p>5. RESIDENT #S1</p> <p>1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 1/15/08</p> <p>2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 1/31/08</p> <p>3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/28</p> | |

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| F 280 | <p>Continued From page 27</p> <p>January 7, 2008 at 8:30 AM: Resident found sitting upright in front of [his/her] wheelchair. No injury ..."</p> <p>January 9, 2008 at 12:30 PM: " Resident was observed on the floor in the shower at 9:20 AM in the shower room. Complained of pain. Was transferred to his room and fell again. PMD (private medical doctor) made aware ...x-rays ordered ..."</p> <p>January 9, 2008 at 11:00 PM: " ...X-ray results received with positive for fracture of 7th posterior left rib ..."</p> <p>According to the " Rehabilitation Screening" dated January 8, 2008, " Pt. (patient) currently functioning at baseline. Rec (recommend) self release seat belt. Therapist tightened both breaks. No skilled PT ordered at this time."</p> <p>A physician's telephone order dated January 8, 2008 at 4:00 PM directed, "Patient screened from physical therapy. Therapist adjusted left and right brakes on w/c; rec [recommend] self release seat belt." The record was audited by a licensed practical nurse.</p> <p>A face-to-face interview was conducted with Employee #13 on January 10, 2008 at 1:30 PM. He/she stated, " I found [Resident S1] in the shower room on Wednesday (January 9, 2008). There was no seat belt in the wheelchair. Another nurse and I assessed [him/her]. There was no complaint of pain. We took [Resident S1] back to the room and I wasn't even at the nursing station when [he/she] fell again."</p> <p>A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 2:00 PM regarding the physician's order regarding the</p> | F 280 | | |
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| F 281 | Continued From page 29 1.5 cm with no slough or necrosis. According to the Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guidelines, pressure ulcers are staged as follows: "Stage 2: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. Stage 3: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue." A face-to-face interview was conducted with Employee #6 on January 8, 2008 at 10:00 AM. He/she acknowledged that the descriptions of the resident's wound incorrectly identified the stage of the wound. The record was reviewed January 8, 2008. | F 281 | | |
| F 309 SS=E | 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review for five (5) of 30 sampled residents and two (2) of 54 supplemental residents, it was determined that facility staff failed to: correctly transcribe a physician's order for psychotropic | F 309 | | |

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| F 309 | <p>Continued From page 30</p> <p>medications for two (2) residents, obtain an order for an assistive device for one (1) resident, elevate the feet and obtain laboratory studies per physician order for one (1) resident, use a bed alarm for one (1) resident with multiple falls, check the expiration date before administering a medication for one (1) resident and clarify an order to leave the facility for one (1) resident. Residents #1, 7, 14, 17, 18, JH9 and S2.</p> <p>The findings include:</p> <p>1. Facility staff failed to transcribe an order for Remeron for Resident #1.</p> <p>A review of Resident # 1's record revealed the following physician's order dated March 1, 2007: "Remeron 15mg P.O. QHS [every night] [to increase appetite ...", and a Psychiatrist's Treatment Plan dated November 29, 2007: "...continue with Remeron as Rx [order]." There was no current order for Remeron.</p> <p>A review of the resident's March 2007 Medication Administration Record (MAR) revealed that Remeron 15mg was administered March 1 and 2, 2007. Review of subsequent days and months revealed that the Remeron was not administered.</p> <p>A face-to-face interview was conducted with Employee #9 on January 11, 2008 at approximately 10:00 AM. He/she acknowledged that facility staff failed to administer Remeron as per the physician's order. He/she said, " The nurse dropped Remeron accidentally from the resident's order when the resident returned from the hospital in March 2007 and again when the order was transcribed on November 29, 2007 ..." The record was reviewed on January 11, 2008.</p> | F 309 | <p>1. RESIDENT #1</p> <p>1. An Occurrence Report was completed, physician notified and orders carried out. Pharmacy and RP was also notified and the resident was assessed for adverse effect from the missed doses of Remeron. None was noted. The involved nurse received counseling and inservice for failing to follow facility procedure in transcription of orders.</p> <p>2. A chart audit was conducted by the nursing staff on all medical records to ensure compliance.</p> <p>3. Inservice review of the facility protocol for physician order transcription focusing on the transcription of medication orders on resident readmission was given to all licensed nursing staff to prevent future occurrence of transcription errors. Performance monitoring of chart audits will be conducted by the Clinical Managers/designee to ensure compliance on an on-going basis. Identified errors will be included in the employee's performance appraisal.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | <p>1/11/08</p> <p>1/31/08</p> <p>2/28/08</p> <p>2/28/08</p> |

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| F 309 | Continued From page 31 2. Facility staff failed to obtain an order for Resident #7 to be placed in a merry walker. On January 9, 2008 at 8:45 AM a merry walker was observed in Resident #7's room. A face-to-face interview was conducted with Employee #8 on January 9, 2008 at 10:40 AM. He/she stated, " He/she is in the merry walker everyday. When he/she gets out of bed he/she is placed in the merry walker." Employee #8 then acknowledged that there was no order for the resident to be placed in a merry walker. A review of the physician's orders lacked evidence that an order was written for Resident #7 to be placed in a merry walker. The record was reviewed January 9, 2008. 3. Facility staff failed to elevate Resident #14's feet and obtain laboratory studies as per physician's orders. A. Review of the resident's record revealed a physician's order dated November 20, 2007 that directed, " Elevate feet at night. Mild pitting edema pedal area - provide extra pillow for resident's feet at night." The resident was observed in bed on January 9, 2008 at 7:20 AM. The resident was positioned on his/her left side with feet not elevated. No extra pillow was observed under the resident's feet. A face-to-face interview was conducted with Employee #27 on January 9, 2007 at 7:25 AM, who had cared for Resident #14 from 11:00 PM the previous night. Employee #27 stated that | F 309 | 2. Resident #7 1. A physician's order for a merry walker was obtained for Resident #7. 2. Medical records of residents using a Merry Walker were audited to ensure the presence of a physician's order for its use. 3. An inservice was given to all staff with a special focus on the requirement that assistive devices are not to be used on residents without a physician's order. Compliance monitoring will be reviewed by the Clinical Managers of each unit. 4. The DON will report on the performance monitoring and any action plans for improvement to the Administrator 5. 2/28/08 3A. RESIDENT #14 1. Resident #14 feet were evaluated for the presence of edema by the Clinical Manager of the unit. Attending physician was notified and the order to elevate the feet at night was discontinued. The nurse involved was counseled for signing without checking that the resident's feet were elevated at night as ordered at the time. 2. A 100% chart audit was done to ensure that all physician orders were transcribed accurately and being carried out by the nursing staff. Corrections were made whenever necessary. 3. An inservice regarding the nurse's responsibility in carrying out physician orders and corresponding outcomes for non-compliance was discussed with all nursing staff. Clinical Managers/designee will monitor on an on-going basis to ensure compliance. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 5. 2/28/08 | 2/1/08 2/1/08 2/28/08 2/28/08 1/15/08 1/31/08 2/28/08 2/28/08 |

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| F 309 | <p>Continued From page 32</p> <p>he/she was unaware that the resident's feet should have been elevated.</p> <p>According to the January 2008 Medication Administration Record, Employee #27 initialed that the resident's feet were elevated throughout the night. He/she stated that it was a mistake and confirmed that the resident's feet were not elevated throughout the night.</p> <p>B. A review of Resident #14's record revealed a physician's telephone order dated November 20, 2007 that directed, " UA/CS (urinalysis/culture and sensitivity)</p> <p>There were no results in the record for a UA/CS for the above order.</p> <p>A face-to-face interview was conducted with Employee #29 on January 9, 2008 at 10:30 AM. After reviewing the record, he/she acknowledged that the UA/CS was not done. The record was reviewed January 9, 2008.</p> <p>4. Facility staff failed to apply a bed alarm for Resident #17 as per physician's orders.</p> <p>A physician's telephone order written on December 2, 2007 directed, " Bed alarm - resident to have bed alarm while in bed -safety ..."</p> <p>Resident #17 was observed on January 8, 2007 at 6:45 AM in bed. There was no bed alarm observed.</p> <p>A face-to-face interview was conducted in the resident's room with Employee #28 at the time of the observation, who had cared for Resident #17 throughout the previous night. He/she confirmed</p> | F 309 | <p>3B. RESIDENT #14</p> <p>1. The physician was notified immediately that the order for the UA/CS was not carried out. The nurse involved was counseled and an inservice was given specifically to this unit. 2/5/08</p> <p>2. A 100% chart audit was done to ensure that all physician orders were transcribed accurately and being carried out by the nursing staff. The Lab book was included in the audit. Corrections were made whenever necessary. 2/28/08</p> <p>3. An inservice regarding the nurse's responsibility in carrying out physician orders and corresponding outcomes for non-compliance was discussed with all nursing staff. Clinical Managers/designee will monitor on an on-going basis to ensure compliance. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> <p>4. RESIDENT #17</p> <p>1. The bed alarm was put in place for this specific resident. The nurse involved was counseled and an inservice was given to this specific unit regarding legal aspects of documentation. 1/15/08</p> <p>2. A 100% chart audit was done to ensure that all physician orders were transcribed accurately and being carried out by the nursing staff. Rounds were made to ensure that devices signed for are truly with the resident. Corrections were made whenever necessary. 1/31/08</p> <p>3. An inservice regarding the nurse's responsibility in carrying out physician orders and corresponding outcomes for non-compliance was discussed with all nursing staff. Clinical Managers/designee will monitor on an on-going basis to ensure compliance. 2/28/08</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08</p> <p>5. 2/28/08</p> | | |

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| F 309 | <p>Continued From page 33 that no bed alarm had been in use for the night.</p> <p>A review of the January 2008 Treatment Administration Record revealed that Employee #28 had signed that the bed alarm had been in place throughout the night. Employee #28 stated that he/she must have made a mistake. The record was reviewed January 8, 2008.</p> <p>5. Facility staff failed to administer Ambien as per physician's order for Resident #18.</p> <p>A review of Resident # 18's record revealed the followings: "Initial Psychiatric Evaluation dated November 29, 2007: ...Ambien CR 6.25mg P.O. QHS [By mouth every night] x 2 weeks for sleep then PRN [As Needed]."</p> <p>A physician's order dated November 29, 2007 directed : "Ambien CR 6.25mg P.O. QHS [By mouth every night] x 2 weeks for sleep then PRN [As Needed]."</p> <p>According to the December 2007 MAR, the order was transcribed as follows: "Ambien CR 6.25mg po q HS x 2 wks for sleep." The December 2007 MAR revealed that Ambien 6.25mg was signed as administered on December 1 through December 21, 2007. There was no PRN order transcribed onto the December 2007 MAR.</p> <p>A face-to-face interview was conducted with Employee #10 on January 8, 2008 at approximately 10:50 AM. He/she acknowledged that facility staff failed to correctly transcribe the physician's order and administer the Ambien as per the physician's order. The record was reviewed on January 8, 2008.</p> | F 309 | <p>5. RESIDENT #18</p> <ol style="list-style-type: none"> 1. Occurrence report was completed and the physician and resident were notified. It was determined that no harm occurred to the resident. 2. An audit was performed to ensure that orders from the Physician's Order Sheet were transcribed accurately. Corrections were made whenever necessary. 3. An inservice was given to the nursing staff which focused upon the accuracy of order transcription and prevention of medication errors of omission. Highlight and reinforcement given to the night staff who perform the daily 24 hour audits. The Clinical Managers/designee will monitor the MARs for accuracy and completeness to ensure on-going compliance. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | <p>1/15/08</p> <p>1/31/08</p> <p>2/28/08</p> <p>2/28/08</p> |
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| F 309 | <p>Continued From page 34</p> <p>6. Facility staff failed to ensure that an expired medication was discarded and not administered to Resident JH9.</p> <p>On January 8, 2008, approximately 9:14 AM, during the medication pass, Employee #19 administered Alupent Metered Dose Inhaler to Resident JH9. The medication was expired " December 2007 " as indicated on the medication packaging.</p> <p>A face-to-face interview was conducted on January 8, 2008 at approximately 9:20 AM with Employee #19. He/she acknowledged that the inhaler was expired.</p> <p>7. Facility staff failed to clarify an order for Resident S2 to leave the facility. The resident was identified as an elopement risk.</p> <p>Resident S2 was admitted to the facility on October 3, 2007. According to an " Elopement Risk Assessment" completed on October 4 and 16, 2007 by the social worker, the resident was identified as an elopement risk.</p> <p>The " Initial Social Work Initial History and Assessment" completed October 4, 2007 documented, " The resident is currently being processed to receive a legal guardian ..."</p> <p>The admission Minimum Data Set assessment completed October 11, 2007 coded the resident for long and short term memory problems with independent cognitive skills for daily decision-making (Section B).</p> <p>A physician's telephone order dated October 5, 2007 at 10:00 PM directed, " Hourly monitoring</p> | F 309 | <p>6. RESIDENT JH9</p> <ol style="list-style-type: none"> 1. Resident was assessed for any adverse effects of this drug which had been expired for 9 days. A literature review showed that the medication's shelf life is stable for 52 months after the expiration date on the package. An occurrence report was completed. The physician and responsible party were notified. The nurse involved was counseled regarding the need to review the labeling of each medication prior to administration. 2. All medications in the refrigerator and in the medication carts were checked for expiration dates both on the medication containers and packages. No other expired medications were found. 3. Inservices were given to the licensed nursing staff administering medications to make sure to check both package and containers of medications for expiration dates prior to administering meds. Daily checks of medications on the medication cart and in the refrigerators will be done by the Charge Nurses and monitored by the Clinical Managers. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 <p>7. RESIDENT # S2</p> <ol style="list-style-type: none"> 1. Resident's physician and responsible party were both notified. Order was clarified that Resident S2 is an elopement risk and is now not allowed to go out on pass except if with a responsible party. Update: Resident is now his own RP, cleared by Psychiatrist to be not an elopement risk anymore and may go out on pass. 2. Medical records of residents allowed to go out on pass were reviewed for the same deficient practice. 3. An inservice was given reviewing the Facility Elopement Risk Protocol. Compliance monitoring will be done by Clinical Mgr./designee to ensure on-going Compliance. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | <p>1/15/08</p> <p>1/15/08</p> <p>2/28/08</p> <p>2/28/01</p> <p>1/8/08</p> <p>2/6/08</p> <p>1/18/08</p> <p>2/28/08</p> <p>2/28/08</p> |
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| F 309 | <p>Continued From page 35</p> <p>for elopement risk. Wanderguard bracelet monitoring every shift for placement. Wanderguard bracelet to be checked every day by night supervisor."</p> <p>A physician's telephone order dated October 9, 2007 at 4:30 PM, " D/c'd (discontinue) wanderguard bracelet monitoring secondary to non-compliance. D/C (discontinue) Wanderguard bracelet to be checked by nurse."</p> <p>An initial psychiatric evaluation for capacity to make decision was completed on October 18, 2007. According to the psychiatrist, " Patient seems to understand the benefits and the risks of having a court appointed guardian to make decisions on his behalf. The court will make a final decision regarding his/her competence/capacity issue."</p> <p>A hand written letter from the responsible party dated December 10, 2007 directed, "[Resident S2] may go to the [grocery] store once a week in the day light hours by [him/herself]."</p> <p>A second hand written entry from the responsible party on the same piece of paper directed, "[Resident S2] may go to the [grocery] store twice a week in the day light hours by [him/herself]. [He/she] is not to buy sweets or candy."</p> <p>A physician's telephone order dated December 20, 2007 at 2:10 PM directed, " Psych consult to eval (evaluate) need of Aricept and dx (diagnosis) of dementia secondary to resident and R/P (responsible party) request." The physician signed the order on January 2, 2008.</p> <p>There was no evidence that the psychiatrist</p> | F 309 | | |

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| F 309 | Continued From page 36 evaluated the resident for the use of Aricept and to allow the resident to leave the facility. A telephone order dated December 21, 2007 at 1:00 PM, which was not signed by the physician directed, "Resident may go to the store twice a week." There was no evidence in the record that facility staff notified the physician of the above order for the resident to go to the store while being identified as an elopement risk. A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 10:00 AM. He/she acknowledged that the order for the resident to leave the facility should have been discussed with the physician and the interdisciplinary care team. The record was reviewed January 10, 2008. | F 309 | | |
| F 314 SS=G | 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review for three (3) of 30 sampled residents, it was determined that facility staff failed to assess one (1) resident for a pressure wound first | F 314 | | |

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| F 314 | <p>Continued From page 37</p> <p>identified with eschar, and for two (2) of five (5) wound treatment observations, the facility failed to utilize a barrier under the pressure wounds. Residents #10, 13 and 18.</p> <p>The findings include:</p> <p>1. Facility staff failed to monitor and assess Resident 10's skin prior to the development of a pressure wound on the right heel first identified as a 3 cm X 3.5 cm area of eschar.</p> <p>A review of Resident #10's record revealed the following:</p> <p>According to a nurse's note dated September 23, 2007, Resident # 10 fell and sustained a right leg/ankle fracture.</p> <p>X-ray results from September 23, 2007, indicated a fracture of the right Fibula.</p> <p>On September 24, 2007, the orthopedic physician applied a splint (soft cast) to the right lower extremity to include the heel and plantar area of foot.</p> <p>A care plan initiated on September 24, 2007, identified the problem, " Resident has cast to (R) [right] Leg " Approaches listed on the care plan included: " Check cast/circulation daily ...Report any abnormal findings to MD " .</p> <p>There was no evidence that facility staff initiated goals and approaches to assess the resident's skin after the splint was applied.</p> <p>According to the Significant Change Minimum Data Set Assessment (MDS), completed October</p> | F 314 | <p>1. RESIDENT #10</p> <p>1. Nursing staff of this unit were inserviced on how to do a skin assessment from head to toe by the Clinical Manager and the ADON. The resident's care plan was reviewed and updated where necessary.</p> <p>2. All of the residents on all of the nursing units were given a head to toe skin assessment by the nursing staff. A report of the findings were given to the Administrator and DON. Physicians and responsible parties were notified whenever necessary for a change in or addition to the current treatment regime. Head to toe assessment are done weekly on those Residents with existing pressure ulcers. Head to Toe assessments are done on all residents with each Shower. Documentation is forwarded to the Charge nurses and sent to the DON.</p> <p>3. An inservice on Skin Assessments was given to all nursing staff to ensure continuous staff competency regarding this aspect of resident care and documentation. Weekly monitoring for staff compliance will be done by the ADON.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | <p>1/15/08</p> <p>2/5/08</p> <p>2/28/08</p> <p>2/28/08</p> | |

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| F 314 | <p>Continued From page 38</p> <p>3, 2007, the resident was coded as totally dependent for bed mobility in Section G (Physical Function and Structural Problems).</p> <p>The Resident Assessment Protocol Summary and approaches to prevent the development of pressure ulcers.</p> <p>No evidence was found in the medical record that the resident ' s skin was assessed from October 3, 2007 - October 20, 2007.</p> <p>Nursing notes dated October 20, 2007 at 3:00 PM: " Eschar noted on Resident ' s RT [Right] Heel " .</p> <p>A physician progress note dated October 22, 2007, " (R) heel has developed an eschar 2 [secondary] to resting in the splint " .</p> <p>Nursing note dated October 26, 2007 at 5:00 PM " Rt. heel eschar on Rt. heel [secondary] to resting on splint " .</p> <p>There is no evidence in the medical record from September 24, 2007 through October 20, 2007 that facility staff monitored changes in Resident #10's skin, specifically the right heel after placement of a right leg splint which enclosed the right heel.</p> <p>A face to face interview with Employees # 6 and #15 was conducted on January 9, 2008 at 3:00 PM. After reviewing the record, Employees #6 and #15 acknowledged that there was assessment of the right heel prior to the development of eschar. The record was reviewed January 9, 2008.</p> | F 314 | | |

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| F 314 | <p>Continued From page 39</p> <p>2. Facility staff failed to place a barrier under Resident #13's left heel during a wound treatment observation.</p> <p>A wound treatment was observed on January 8, 2008 at 11:35 AM. Resident #13 was seated in a chair with the sock and dressing removed from the left foot. Employee #13 failed to place a barrier under Resident #13's left heel. Employee #13 cleansed the left heel pressure ulcer. The resident placed the cleansed left heel on the floor. Employee #13 re-cleansed the wound and while he/she was reaching for the clean dressing, the resident placed his/her left foot on the floor. Employee #13 did not cleanse the wound before applying the treatment and dressing. Additionally, after the dressing was placed on the resident's left foot, Employee #13 wrote his/her initials and date on the dressing. A review of the wound assessment sheets revealed that the wound was healing. The record was reviewed January 8, 2008.</p> <p>3. Facility staff failed to place a barrier under Resident #18's left foot during a wound treatment observation.</p> <p>A wound treatment was observed on January 8, 2008 at approximately 11:15 AM. Resident #18 was in bed. Employee #18 removed the prior dressing from the left foot and placed the resident's left foot on a pillow without a barrier. Some drainage from the wound was observed on the pillow. Employee #18 applied a new dressing to the cleansed left foot pressure ulcer. On completion of the wound treatment, Employee #18 exited the resident's room with the newly dressed left foot on the contaminated soiled pillow.</p> | F 314 | <p>2. RESIDENT #13</p> <ol style="list-style-type: none"> The particular licensed staff with the responsibility of performing wound treatments to this resident were given and 1:1 inservice by the Clinical Managers and the Staff Development/Infection Control Coordinator. Clinical Managers/designee and nursing supervisors will conduct daily and random wound treatment observations to ensure on-going compliance. Repeated non-compliant employees will be subject to the facility's disciplinary protocols. Inservice was given to the staff of the facility's procedure on performing wound treatment with special emphasis on placing a barrier to prevent re-contamination of the newly dressed wound during the treatment procedure. Clinical Managers will monitor wound care on their units and report their findings to the DON. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08 <p>3. RESIDENT #18</p> <ol style="list-style-type: none"> The particular licensed staff with the responsibility of performing wound treatments to this resident were given and 1:1 inservice by the Clinical Managers and the Staff Development/Infection Control Coordinator. Clinical Managers/designee and nursing supervisors will conduct daily and random wound treatment observations to ensure on-going compliance. Repeated non-compliant employees will be subject to the facility's disciplinary protocols. Inservice was given to the staff of the facility's procedure on performing wound treatment with special emphasis on placing a barrier to prevent re-contamination of the newly dressed wound treatment procedure. Clinical Managers will monitor wound care on their units and report their findings to the DON. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 2/28/08 | <p>1/9/08</p> <p>1/15/08</p> <p>2/28/08</p> <p>2/28/08</p> <p>1/8/08</p> <p>1/15/08</p> <p>2/28/08</p> <p>2/28/08</p> |

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| F 314 | Continued From page 40 A review of the wound assessment sheets revealed that the wound was responding to treatment. A face-to-face interview was conducted with Employee #18. He/she acknowledged that he/she failed to place a barrier under Resident #18's foot during the wound treatment observation. He/she acknowledged that the resident's newly dressed left foot was returned to the contaminated soiled pillow. The record was reviewed on January 8, 2008. | F 314 | | |
| F 323 SS=G | 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review for three (3) of 30 sampled residents and 28 supplemental residents, it was determined that facility staff failed to provide adequate supervision for two (2) residents who had multiple falls with subsequent injury, one (1) resident who sustained a burn, one (1) resident observed with burning pants, one (1) resident who was found in an electrical closet and in another resident's bed, 13 of 44 smokers found with smoking paraphernalia and nine (9) of 35 residents identified as elopement risks without pictures at the front door. Facility | F 323 | | |

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| F 323 | <p>Continued From page 41</p> <p>staff also failed to maintain a hazard free environment as evidenced by: missing eye guards from television antennas, oxygen tanks unsecured, and extension cords observed in residents rooms.</p> <p>Residents #10, S1, H1, 24, 21, C1, C2, C3, C4, C5, C6, C7, C8, C9, C10, C11, C12, C13, E1, E2, E3, E4, E5, E6, E7, E8, and E9.</p> <p>The findings include:</p> <p>1. Facility staff failed to provide adequate supervision for Resident #10 who had multiple falls with subsequent fracture of the right fibula.</p> <p>A review of the nurses' notes in Resident #10's medical record indicates:</p> <p>August 14, 2007 at 11:39 PM: "Resident was observed in [on] patio sitting on her buttocks next to wheel chair. No injury; Consult for therapy." August 31, 2007 at 2:30 PM: "Resident was observed in a sitting position [on floor] in the bathroom; No injury" September 23, 2007 at 5:00 PM: "Resident fell outside on patio; X-ray reveals fracture Right Fibula; Resident Hospitalized; No consult for therapy." November 12, 2007 at 11:00 PM: "Resident was observed sitting on floor ...in her bathroom. No injury; Consult for therapy." November 21, 2007 at 6:00 PM: "Resident observed on floor No injury; No consult for therapy."</p> <p>"Risk Management: Fall: Interdisciplinary Care Plan," initiated 5/30/2006; Dates of falls indicated on care plan but no new interventions were added</p> | F 323 | <p>1. RESIDENT #10</p> <p>1. The care plan of Resident #10 was updated to include new goals and approaches to prevent future falls.</p> <p>2. Medical records of all residents with multiple falls were audited to ensure that appropriate and updated goals and approaches to prevent future falls were present.</p> <p>3. An inservice was given to the nursing staff addressing the importance of initiating new goals and approaches after each fall on the care plan of residents identified with multiple falls in an effort to ensure compliance. Focus was placed on a physical therapy involvement after each fall and the enhancement of communication between nursing and physical therapy to ensure the continuity of care. Monitoring will be done by the Clinical Managers who will report their findings to the DON and the Falls Review Committee.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | <p>1/15/08</p> <p>1/31/08</p> <p>2/28/08</p> <p>2/28/08</p> |

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| F 323 | <p>Continued From page 42</p> <p>to care plan after multiple falls until September 24, 2007. Care plan #5: Resident at risk for falls initiated 9/24/2007 updated 11/12/07 and 11/21/07"</p> <p>There were no new interventions added after falls on November 12 and November 21, 2007. The care plan was last reviewed January 4, 2008.</p> <p>A review of the Physical Therapy (PT) Notes in Resident # 10's medical record indicated: August 14, 2007: "Nursing to ensure seat belt is applied at all times." August 31, 2007: "R resident educated to call for assistance." September 23, 2007: "No consult for therapy." November 16, 2007: "Pt. will require Velcro seat belt alarm ...nursing notified. " November 23, 2007: "Recommended for Pt. to use call light and wait for assist with transfer."</p> <p>Facility staff failed to obtain a physician's order for the use of a wheel chair alarm as recommended by Physical Therapy staff on November 16, 2007.</p> <p>A face-to-face interview with Employees #6 and #15 was conducted on January 9, 2008 at 3:00 PM. After reviewing the record, Employees #6 and #15 acknowledged that facility staff failed to initiate new interventions for Resident # 10 after multiple falls. The record was reviewed January 9, 2008.</p> <p>2. Facility staff failed to provide adequate supervision for Resident S1 who had multiple falls with subsequent injury.</p> <p>A review of Resident S1's record revealed the following nurses' notes:</p> | F 323 | <p>2. RESIDENT #S1</p> <p>1. The care plan of Resident #10 was updated to include new interdisciplinary goals and approaches to prevent future falls 2. Medical records of all residents with multiple falls were audited to ensure that appropriate and updated goals and approaches to prevent future falls were present. 3. An inservice was given to the nursing staff addressing the importance of initiating new nursing goals and approaches after each fall on the care plan of residents identified with multiple falls in an effort to ensure compliance. Focus was placed on clear and concise communication with physical therapy involvement</p> | 1/15/08 1/15/08 2/28/08 | |

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| F 323 | <p>Continued From page 43</p> <p>December 21, 2007 at 11:00 PM: " Resident found sitting on the floor beside [his/her] bed at 8 pmresident said [he/she] was trying to walk to the toilet, lost [his/her] balance and fell on [his/her] buttock ...Neurochecks initiated and within normal limits ..."</p> <p>January 7, 2008 at 8:30 AM: Resident found sitting upright in front of [his/her] wheelchair. No injury ..."</p> <p>January 9, 2008 at 12:30 PM: " Resident was observed on the floor in the shower at 9:20 AM in the shower room. Complained of pain. Was transferred to his room and fell again. PMD (private medical doctor) made aware ...x-rays ordered ..."</p> <p>January 9, 2008 at 11:00 PM: " ...X-ray results received with positive for fracture of 7th posterior left rib ..."</p> <p>According to the " Rehabilitation Screening" dated January 8, 2008, " Pt. (patient) currently functioning at baseline. Rec (recommend) self release seat belt. Therapist tightened both breaks. No skilled PT ordered at this time."</p> <p>A physician's telephone order was dated January 8, 2008 at 4:00 PM and directed, " Patient screened from physical therapy. Therapist adjusted left and right brakes on w/c; rec self release seat belt."</p> <p>A face-to-face interview was conducted with Employee #13 on January 10, 2008 at 1:30 PM. He/she stated, " I found [Resident S1] in the shower room on Wednesday (January 9, 2008). There was no seat belt in the wheelchair. Another nurse and I assessed [him/her]. There was no complaint of pain. We took [Resident S1] back to the room and I wasn't even at the nursing</p> | F 323 | <p>2. RESIDENT #S1 (continued from page 43) after each fall and the enhancement of communication between nursing and physical therapy to ensure the continuity of care. Monitoring will be done by the Clinical Managers who will report their findings to the DON and the Falls Review Committee.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | 2/28/08 | |

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| F 323 | <p>Continued From page 44 station when [he/she] fell again."</p> <p>There was no evidence in the record that facility staff implemented additional monitoring of Resident S1 until the seat belt was applied.</p> <p>A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 2:00 PM about the physician 's order regarding the implementation of a seat belt. Employee #5 stated, " The seat belt comes from the Rehab department or Central Supply. It should have been put on when it was ordered." The record was reviewed January 10, 2008.</p> <p>3. Facility staff failed to adequately supervise Resident H1 who sustained burns to the back after the use of a heating pad.</p> <p>The review of the resident 's diagnoses at Section I, " Disease Diagnoses," on the admission (Minimum Data Set) MDS dated April 23, 2007 included Hypertension, Paraplegia, Depression, and Anemia.</p> <p>A nurse 's note dated October 16, 2007 at 3:00 PM indicated, " Resident alert and oriented x 3 and verbally responsive. No distress noted. Resident was noted with multiple blisters (burns) on Lumbar (back). Resident stated, ' heating pad was given to him/her by his/her [family member] and the care giver put it on his/her back in the morning' Writer called unit manager to the resident's room. MD (medical doctor) notified and ordered to transfer resident to the nearest hospital for evaluation. Resident was transferred to the hospital."</p> <p>Nurse's note October 17, 2007. 10:20 AM, Late</p> | F 323 | <p>3. RESIDENT #H1</p> <p>1. This resident was discharged from the facility to her own apartment in November 2007 with no lasting effects from this incident.</p> <p>2. Nursing staff on all units checked each resident room to ensure that no unauthorized appliances were present. Family members and residents were educated about the use of appliances such as a heating pad without a physician's order and/or the facility's approval.</p> <p>3. Inservice was given to all nursing staff about the use of such appliances at this facility. Emphasis was placed on the CNA's role in working with residents who produce such an appliance and the need to report it immediately to the charge nurse. All staff will monitor the resident rooms on an on-going basis to ensure compliance. Acknowledgement of this policy will begin through the admissions process.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator.</p> <p>5. 2/28/08</p> | 11/30/07 | 1/31/08 | 2/28/08 | 2/28/08 |

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| F 323 | <p>Continued From page 45</p> <p>entry for October 16, 2007, " Writer was notified and requested to come to resident's room. Writer assessed resident secondary to burns/blister to lower back from heating pad. Writer questioned resident about use of heating pad. Resident stated I asked [name] to put it on. CNA [name] stated complied with request. CNA stated that he/she did not turn the heating pad on. Resident sustained a large burn blister along with smaller multiple blisters surrounding the large blister. All blisters were intact. Cold cloth applied to reduce heat. Resident was later transferred to nearest ER for evaluation."</p> <p>Nurse's note October 16, 2007 11:30 PM, " ER called at 11:15 PM, charge nurse at ER stated that the resident was on his/her way back to the facility and that no treatment order was given as regards to the burn on the back. MD made aware of incident ... "</p> <p>Nurse's note October 17, 2007 11:00 PM, " Was unsuccessful in getting the heating pad. Pt. (patient) stated that it was his/her personal property ..."</p> <p>On October 20, 2007 the resident was seen by the primary physician who indicated, " Recent events described in nursing notes. Have blister to lower back from her heating pad ... Skin burns are granulating, no evidence of infection."</p> <p>October 27, 2007 physician's note indicated, " Granulating well, no necrotic tissue; Continue Silvadene ..."</p> <p>November 5, 2007, physician's note indicated, " Pt. will be referred to plastic for evaluation of possible skin graft ..."</p> | F 323 | | |

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| F 323 | <p>Continued From page 46</p> <p>November 12, 2007 physician's noted indicated," Pt. alert and comfortable ...Skin 1-2nd degree burns healing very well. No need for skin graft as per plastic surgery. Pt. ready for discharge Friday. Prescription written. Need to get a primary a physician."</p> <p>On January 10, 2007 at approximately 7:50 AM a face-to-face interview was conducted with Employee #23. He/she stated, " I was assigned to the resident and he/she asked me to pass her the heating pad The heating pad was at his/her bedside on the stand and I gave it to him/her. It was already plugged in the electrical outlet; he/she turned it on and put it on his/her shoulder. I went back to change him/her; I turned him/her and saw blisters on his/her back; I went to get the charge nurse. He/she had the heating pad before he/she came to this unit.</p> <p>On January 11, 2007 at approximately 3:25 PM a face-to-face interview was conducted with Employee #5 who indicated, " The heating pad was not known to me until it was bought to my attention. Staff came to change him/her and that is when the blisters were noted."</p> <p>On January 14, 2007 at approximately 8:00 AM a face- to- face interview was conducted with Employee #4 who indicated, " all electrical appliances brought into the facility are to be checked by customer service, tagged and sent to maintenance for observation for safety and pest control. I was not aware of the resident's heating pad."</p> <p>Resident sustained burns to his/her back due to the use of a heating pad that was not cleared by</p> | F 323 | | | |

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| F 323 | <p>Continued From page 47</p> <p>facility staff for use and/or supervised by facility staff. The record was reviewed on January 9, 2007</p> <p>4. Facility staff failed to adequately supervise Resident #24 who was previously observed by facility staff with burning clothing from a cigarette.</p> <p>At approximately 10:15 AM on January 11, 2008 one (1) cigarette butt was observed on the floor of Resident #24's room by the head of Bed A. Five (5) cigarettes were observed in a pack in the drawer of the resident's bedside table and one (1) cigarette lighter was observed in the right pocket of the resident's pant. Employee #10 was present during these observations.</p> <p>A review of the record revealed a nurse's note dated November 18, 2007 at 3:00 PM which stated, " While resident was wheeling his/her wheel chair up the hallway toward the Nurses' Station small amount of smoke was noted coming from his/her lap... Cigarette was sitting on his/her lap burning his/her pants."</p> <p>A review of the care plan revealed an entry dated November 18, 2007 which stated " All smoking materials to be kept by customer service. Inspect resident's skin, or clothing as well as furniture for signs of cigarette burns, an indication of unsafe smoking. Smoking apron to be applied by customer service when on the patio." The care plan was reviewed on January 11, 2008.</p> <p>A face-to-face interview was conducted with Employee # 10 at approximately 10:00 AM on January 11, 2008. He/she stated that Resident # 24 was not permitted to have any smoking materials in his/her room. He/she added " His/her</p> | F 323 | <p>4. RESIDENT #24</p> <p>1. Inservice was given to the nursing staff about the Facility's smoking policy emphasizing the need to Supervise smokers while they smoke on the smoking patio.</p> <p>2. The facility's Smoking Policy has been revised to Distinguish between dependent and independent smokers and their ability to smoke safely. Each Resident who smokes will be assessed for smoking safety upon admission and at least quarterly. No Resident is allowed to maintain matches on their Person however those who are deemed to be independent smokers will be allowed to keep their tobacco products. A contract will be signed by Each resident deemed to be an independent and safe Smoker so to impose consequences for infractions of the policy.</p> <p>3. Inservices will be given to all staff with the implementation of the new smoking policy. Clinical Managers, Customer Service Representatives, Charge Nurses and CNAs will monitor the residents for safe smoking practices.</p> <p>4. The DON and Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | <p>2/8/08</p> <p>2/28/08</p> <p>2/28/08</p> <p>2/28/08</p> | |

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| F 323 | <p>Continued From page 48</p> <p>cigarettes and lighter are kept by customer service. They give him/her cigarettes and light them for him/her on the patio."</p> <p>5. Facility staff failed to supervise Resident #21 who wandered into an electrical closet and was found in bed with Resident F3.</p> <p>A. Facility staff failed to supervise Resident #21 who wandered into an unlocked electrical closet on another floor and was found in bed with another resident.</p> <p>Review of Resident #21's record revealed the following nurse's note dated November 26, 2007 at 8:00 AM, "Resident observed sleeping in [his/her] room at 6 AM. At 6:30 AM resident observed sitting in the chair by... the nursing station. Resident was seen in the hallway (2 South) at 7 AM. When resident was not seen returning back to the unit, writer and CNA went in search for resident. Resident was found at 8 AM on 3rd floor in stable condition, was brought back to the unit and had [his/her] breakfast."</p> <p>A notation on the resident's care plan, "Elopement Risk" documented, "11/26/07 Wandered and found in elec equip room."</p> <p>A face-to-face interview was conducted with Employee #44 on January 9, 2008 at 1:00 PM. He/she stated. "We found the resident in the electrical closet at about 8:00 AM."</p> <p>A face-to-face interview was conducted with Employee #4 on January 9, 2008 at approximately 1:10 PM. He/she stated, " That room [electrical closet] should always be locked. I can't explain why it was unlocked that morning."</p> | F 323 | <p>5A. RESIDENT #21</p> <p>1. This resident was found sitting on a chair with his legs propped up sleeping in a closet that housed stored items and an electrical transformer. Once he was returned to his unit, the door to that closet was locked so to avoid any future occurrence of the same sort. The resident was on a Q 15 minute monitoring schedule for elopement which was change to a 1:1 monitoring because of his propensity to wander. The nurse in charge of his care was counseled regarding adherence to the facility monitoring policy</p> <p>2. All residents who were on a monitoring schedule for elopement were checked to ensure that their whereabouts were known and that the documentation on the monitoring sheets was accurate and up-to-date.</p> <p>3. Inservices were given to all facility staff about the policy on Missing Residents with the emphasis that if the resident is not able to be found in 10 minutes then the policy is to be activated. Elopement and behavior monitoring sheets will be reviewed for completeness of assessment and signatures every shift by Charge Nurses, Clinical managers and House Supervisors to ensure compliance. The sheets are now reviewed daily at the nurse managers' 8:00 am stand-up meeting by the DON and the ADON for accurate, timely, and appropriate documentation.</p> <p>4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator.</p> <p>5. 2/28/08</p> | 11/26/07 11/26/07 2/9/08 2/28/08 | |

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| F 323 | Continued From page 49 The resident was concurrently being monitored every 15 minutes as a result of facility staff identifying him/her as an elopement risk. The elopement monitoring sheets for November 26, 2007 for 7:00 AM, 7:15 AM, and 7:30 AM were signed with the notation of "eating breakfast" and initialed. The three (3) entries were lined through. The entry for 7:45 AM had no location or initials. There was a line drawn through the entry slot for 7:45 AM. B. According to a nurse's note dated December 8, 2007 at 11:00 PM, "Upon conducting my rounds, noted resident [Resident #21] in [Resident F3's] bed. Was told several occasions to go in [his/her] own bed. But [he/she] refused. Supervisor told [Resident #21] to go to [his/her] room and still [he/she] refused. [He/she] then got out of [Resident F3's] bed and they both sat in hallway. [Resident #21] was very agitated. Medication was offered to [him/her]. [He/she] refused ... [Physician notified]." Resident F3's roommate was in his/her bed at the time of this occurrence. Resident #21's quarterly Minimum Data Set (MDS) assessment, completed October 19, 2007, was reviewed. He/she was coded for long and short-term memory problems and with moderately impaired cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed August 8, 2007 included Dementia. Telephone interviews were conducted with the CNAs assigned to be with Resident #21 with one-on-one monitoring. Both Employee #31 and Employee #40 stated that they did not recall the incident. The record was reviewed January 9, | F 323 | 5B. RESIDENT #21 1. Resident #21 and Resident #F3 have developed a Close friendship since their admission to the facility. Although they are not married, they have the same Last names and they treat each other as their husband or wife. Resident #21 was lying next to Resident #F3 fully clothed and not engaged in any unusual or aberrant behavior. Resident #21 is closely monitored and has 1:1 supervision because of his propensity to wander. However, nurse in charge of his care was counseled regarding adherence to the facility monitoring policy 2. All residents who were on a monitoring schedule for elopement were checked to ensure that their whereabouts were known and that the documentation on the monitoring sheets was accurate and up-to-date. 3. Inservices were given to all facility staff about the policy on Missing Residents with the emphasis that if the resident is not able to be found in 10 minutes then the policy is be activated. Elopement and behavior monitoring sheets will be reviewed for completeness of assessment and signatures every shift by Charge Nurses, Clinical managers and House Supervisors to ensure compliance. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 | 11/26/07 2/9/08 2/28/08 |

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| F 323 | <p>Continued From page 50 2008.</p> <p>6. Facility staff failed to ensure that residents did not have smoking paraphernalia in their possession.</p> <p>A face-to-face interview was conducted on January 14, 2008 at 10:30 AM with Employee #11. He/she was asked if residents were allowed to carry smoking paraphernalia. Employee #11 stated, " No resident should have an incendiary device (matched or lighter). However, if a competent resident has carried their own cigarettes for 30 years we are not going to take them away."</p> <p>Employee #11 was asked if there was a list identifying the residents allowed to carry their own cigarettes. He/she stated no.</p> <p>Employee #25 compiled a list of residents who had incidents with smoking issues, including residents smoking in undesignated places, or found with cigarettes on their person.</p> <p>A face-to-face interview was conducted with Employee #38 on January 10, 2007 at 8:15 AM and Employee #39 on January 11, 2008 at 3:15 PM. Both employees monitor residents who smoke. Both employees were asked if there was a list of smokers allowed to keep their cigarettes and matches or lighter. Both employees stated that they had no list identifying residents allowed to keep their smoking items.</p> <p>The above cited interviews initiated observations of all residents identified by facility staff as smokers. The observations were conducted on January 11, 2007 between 9:30 AM and 11:00</p> | F 323 | <p>6. RESIDENTS #24, #C1, #C2, #C3, #C4, #C5, #C6, #C7, #C8, #C9, #C10, #C11, #C12, #C13</p> <p>1. All residents cited at the time of the survey as Having tobacco products and matches/lighters have Been evaluated using the new smoking policy. See Attached. Inappropriate storage of tobacco products and Matches/lighters have been addressed. Inservice was given to the nursing staff about the Facility's smoking policy emphasizing the need to Supervise smokers while they smoke on the smoking patio.</p> <p>2. The facility's Smoking Policy has been revised to Distinguish between dependent and independent smokers and their ability to smoke safely. Each Resident who smokes will be assessed for smoking safety upon admission and at least quarterly. No Resident is allowed to maintain matches on their Person however those who are deemed to be independent smokers will be allowed to keep their tobacco products. A contract will be signed by Each resident deemed to be an independent and safe Smoker so to impose consequences for infractions of the policy. A meeting was held with the residents who smoke and the administrator to explain the new policy and practice. A packet of information was sent out to the Responsible Parties asking for their Acknowledgement of the policy and their assistance With their resident to maintain compliance. The Ambassadors (managers, social workers, rec Therapists assigned to certain rooms to field complaints and help with adjustment to new environment for new residents) are asked to review the Bedside stands of smokers every other day to look For the presence of lighters and matches.</p> <p>3. Inservices will be given to all staff with the implementation of the new smoking policy. Clinical Managers, Customer Service Representatives, Charge Nurses and CNAs will monitor the residents for safe smoking practices.</p> <p>4. The DON and Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator</p> <p>5. 2/28/08</p> | <p>2/28/08</p> <p>2/28/08</p> <p>2/28/08</p> <p>2/28/08</p> | |

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| F 323 | <p>Continued From page 51</p> <p>AM in the presence of Employees # 5, 6, 7, 8, 9 and 10. The following observations were made:</p> <p>Resident #24 -observed with a pack containing 5 cigarettes in bedside drawer, a butt on floor in the resident 's room and 1 lighter on person. According to the annual Minimum Data Set (MDS) assessment, the resident was coded in Section I, "Disease Diagnoses" for Dementia.</p> <p>Resident C1- 14 lighters and 24 books of matches were observed in the resident's room. According to the annual MDS completed July 6, 2007, the resident was coded for Seizure Disorder Section I.</p> <p>Resident C2 - 1 package of cigarettes and 1 lighter were observed on the resident. According to the annual MDS completed June 8, 2007, the resident was coded for Cerebrovascular Accident (CVA) and cataracts in Section I.</p> <p>Resident C3- 1 lighter was observed on the resident. According to the annual MDS completed March 21, 2007 in Section I, the resident was coded for Dementia.</p> <p>Resident C4 - 1 lighter observed on the resident. According to the admission MDS completed August 30, 3007, the resident was coded for Dementia in Section I.</p> <p>Resident C5- 1 lighter was observed on the resident. According to the significant change MDS completed April 18, 2007, the resident was coded for a CVA in Section I.</p> <p>Resident C6- 1 package of cigarettes was observed in the resident's drawer. According to</p> | F 323 | | | |

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| F 323 | <p>Continued From page 52</p> <p>the significant change MDS completed September 7, 2007 coded the resident in Section I for Seizure Disorders.</p> <p>Resident C7 - 1 package of cigarettes was observed on the resident 's bedside tray. According to the annual MDS completed August 7, 2007, coded the resident in Section I for Manic-Depression.</p> <p>Resident C8 -1 lighter and a package of cigarettes were observed on resident's bedside table. According to the admission MDS completed April 10, 2007, the resident was coded in Section I for Schizophrenia.</p> <p>Resident C9- 1 lighter and a package of cigarettes were observed on the resident. According to the annual MDS completed April 7, 2007, the resident was coded in Section I for Schizophrenia.</p> <p>Resident C10- 1 lighter was observed in the resident's drawer with an empty package of cigarettes. According to the significant change MDS completed June 26, 2007, the resident was coded in Section I for CVA with hemiplegia/hemiparesis and Seizure Disorder.</p> <p>Resident C11- admitted to having lighter and cigarettes on person but refused to show them. According to the admission MDS completed May 11, 2007 the resident was coded in Section I for alcohol abuse.</p> <p>Resident C12- Observed with 1 lighter on person. According to the annual MDS completed April 6, 2007 the resident was coded in Section I for Schizophrenia.</p> | F 323 | | |

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| F 323 | <p>Continued From page 53</p> <p>Resident C13 - Observed with 1 lighter and cigarettes on person. According to the significant change MDS completed November 5, 2007, the resident was coded in Section I for Depression.</p> <p>Facility staff failed to adequately supervise residents who smoked. These observations led to an investigation of the facility's monitoring program for elopement risk residents.</p> <p>According to the "Elopement and Behavior Monitoring List" updated January 5, 2008, the facility identified 35 residents at risk for elopement. A prior intervention initiated by the facility was to place the resident's photograph at the points of exit.</p> <p>Additionally, the facility's policy, "Elopement Risk," Policy #1401023A.000, page 2, under item #4,"d. Photographs posted at the points of exit."</p> <p>The photographs for nine (9) of 35 residents identified as "at risk for elopement" were not placed at the front door. Six (6) photographs were in the binder but stacked upon each other and not immediately visible.</p> <p>The residents' photographs that were placed in a binder at the front door were reviewed and compared to the "Elopement and Behavior Monitoring List" dated January 5, 2008. Photographs for the following residents were not in the binder at the front door: E1, E2, E3, E4, E5, E6, E7, E8, and E9.</p> <p>The photograph binder was observed to be locked in the Customer Service Representative's (CSR) top desk drawer on January 11, 2008 at</p> | F 323 | <ol style="list-style-type: none"> 1. Photographs of the residents found at the time Of the survey not to have their pictures in the binder at the front desk have had their pictures taken and have been added to the binder. Each picture has its own slot and is easily visible. The desk use for Customer Service has no lock on any of the drawers. 2. An audit of all resident listed on the Elopement And Behavior Monitoring List was done and any Missing pictures were replaced if needed. 3. The Assistant Administrator and overseer of Customer Service will receive an updated Elopement And Behavior Monitoring List each week from Nursing to ensure all pictures are in place . 4. The Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/31/08 1/31/08 2/28/08 |

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| F 323 | Continued From page 54 8:55 AM. A face-to-face interview was conducted with the CSR at the front door on January 11, 2008 at 9:00 AM. He/she stated that the photograph binder was kept in the top drawer and that the top drawer was always locked. A face-to-face interview was conducted with Employee#11 on January 11, 2008 at 10:00 AM. He/she confirmed that all residents who were identified as an elopement risk had a picture at the front door. 7. Eye guards were observed missing off of television antennas in three (3) of 12 rooms on the third floor rooms- 319, 355 and 356 8. Oxygen tanks unsecured in the following areas: First floor- 1 North, one (1) of seven (7) oxygen tanks and the door was unlocked Second floor-2 North, two (2) of nine (9) oxygen tanks and the door unlocked 9. Extension cords were observed in rooms 222 and 245 in two (2) of 37 rooms observed. 10. Parallel bars in the Occupational Therapy room were observed unsecured to the base and moved back and forth when pushed. This observation was made on January 7, 2008 at 1:45 PM in the presence of Employee #35, who acknowledged the findings at the time of the observation. 11. It was observed that the cover of an electrical box located behind the steamer was not secure and electrical wires were exposed. this observation was made in the presence of | F 323 | 7. Eye Guards 1. Eye guards were replaced immediately upon discovery. 2. All T.V.s with antennae were inspected for appropriate eye guards and changes were made where necessary. 3. The facility has changed from the use of "rabbit ear" telescoping type antennae to a wire antenna which connected directly to the antennae or cable hook-up. This is done at the expense of the facility to ensure compliance with providing a safe environment for residents. The Maintenance staff will continuously monitor antenna and other electrical equipment for safety. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 8. Oxygen Tanks 1. Any oxygen tanks found not to be properly secured at the time of the survey were secured immediately. 2. All oxygen tanks were evaluated to ensure that they were properly secured. 3. Maintenance Supervisors staff will continuously Monitor the safe storage of oxygen tanks during their Daily rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 9. Extension Cords 1. Domestic extension cords found at the time of the Survey were removed immediately. 2. An audit was done on all resident rooms for the Presence of like extension cords to ensure their Removal. 3. Maintenance Supervisors staff will continuously Monitor the safe storage of oxygen tanks during their Daily rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 | 1/11/08 1/11/08 2/28/08 2/28/08 1/11/08 1/11/08 2/28/08 2/28/08 1/11/08 1/15/08 2/28/08 2/28/08 | |

10. Parallel Bars

1. The parallel bars cited at the time of the survey Have been removed from use. 1/14/08
2. New parallel bars have been ordered and Are expected to be delivered shortly. 1/14/08
3. Maintenance supervisor will check the safety of Therapy equipment during their preventative maintenance rounds.
4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 2/28/08
5. 2/28/08

11. Electrical Box

1. The covered was secured immediately upon Discovery. 1/11/08
2. All other electrical box covers were reviewed to Ensure their covers were secured. 1/11/08
3. Maintenance Supervisors staff will continuously Monitor the proper functioning and repair of the electrical Boxes in the kitchen during their daily rounds and Their monthly preventative maintenance rounds. 2/28/08
4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 2/28/08
5. 2/28/08

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| F 323 | Continued From page 55 Employee #2 who acknowledged the findings at the time of the observation on January 7, 2008 at 8:30 AM. 12. It was observed that water had accumulated under the steamer that spread to area where staff walked. This observation was made in the presence of Employee #2 who acknowledged the findings at the time of the observation on January 7, 2008 at 8:35 AM. Items #7 through #12 were observed in the presence of Employees #3, 4, and 26 during the environmental tour on January 7, 2008 between 8:30 AM and 11:30 AM. The findings were acknowledged by the aforementioned employees at the time of the observation. | F 323 | 12. Water under the Steamer 1. Water found accumulated under the steamer At the time of the survey was cleaned up and drip Pans were put in place to prevent further spillage. 2. All other equipment was evaluated to ensure that no water was accumulated underneath. 3. The cook involved was given a 1:1 inservice Regarding the use of drip pans in the steamer. The Nutritional Services Supervisors will monitor the Steamer on a daily basis to ensue compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/0 1. | 1/11/08 1/11/08 2/28/08 | |
| F 328 SS=D | 483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on an observation of one (1) of two (2) residents with a tracheostomy, it was determined that facility staff failed to practice aseptic technique during tracheostomy care for Resident #25. | F 328 | | | |

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| F 328 | <p>Continued From page 56</p> <p>The findings include:</p> <p>A review of Resident #25's record revealed a physician's order dated September 2, 2007, directing "Trach care every shift as needed."</p> <p>An observation of tracheostomy care for Resident #25 was conducted at approximately 2:30 PM on January 10, 2008. Employee #21 stated that the treatment was a clean technique. During the treatment it was observed that Employee #21 failed to clean the over-bed table or use a barrier on the table prior to providing tracheostomy care to the resident. He/she washed his/her hands and put on a pair of gloves from a box on the table. He/she removed the tracheostomy collar and tubing, and attached the oxygen tubing to an Ambu bag.</p> <p>He/she opened a packet that contained the tracheostomy dressings, placed the opened packet on the table, removed the dressing from the packet and placed them on the resident without a barrier. He/she removed his/her gloves, washed his/her hands and put on the gloves that were in the packet. He/she poured Normal Saline Solution (NSS) from a bottle into a small container from the packet. He/she placed the covering from the package on the comforter, removed the Ambu-bag from a plastic bag and placed it on the covering from the packet. He/she used a tissue and with his/her right gloved hand removed brown tinged mucus from the resident's comforter.</p> <p>Without changing his/her glove and/or washing his/her hands, the employee connected the Ambu-bag to the resident's tracheostomy and</p> | F 328 | <p>RESIDENT #25</p> <ol style="list-style-type: none"> 1. The nurse was inserviced immediately by the Clinical manager on the facility's protocol for Trach Care. The nurse were observed after the inservice Was given to ensure proper technique. 1/11/08 2. All nurses who are involved in the care of a Resident with a tracheostomy will be observed to Ensure their proper technique. 1/31/08 3. Protocol for Trach Care was reviewed with all Licensed staff focusing on consistent compliance To the protocol and potential adverse effects to the Resident due to breaks in technique. Non-compliance Will subject the employee to disciplinary actions. The Clinical Managers and Nursing Supervisors will monitor for compliance and report their findings to the DON. 2/28/08 4. The DON and Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08 5. 2/28/08 | | |

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| F 328 | Continued From page 57 attempted to oxygenate the resident. The employee interrupted oxygenating the resident to turn the oxygen on and used unwashed hands with unclean gloves to resume the process of oxygenating the resident with the Ambu-bag. The employee did not wash his/her hands or change his/her gloves. He/she inserted the suction catheter with his/her right gloved hand [wearing the same pair of gloves initially donned] into the resident's tracheostomy tube and proceeded to suction the resident. Employee # 21 used cotton swabs to clean around the inside of the tracheostomy tube and failed to remove the inner canula. The record was reviewed on January 10, 2008. | F 328 | | |
| F 371 SS=F | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review during the environmental and dietary tours, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: a damaged floor in the kitchen, soiled tilt grill, caulking above a sink, deep fryers, juice machine compressor, threshold of the walk-in refrigerator and freezer, convection ovens, cooking hoods and pantry ice machines, chicken base was stored in the oven and food in the unit pantry refrigerators were unlabeled, | F 371 | 1. Floor in the main kitchen 1. The floor area was cleaned and repairs were made Wherever possible. 2. Maintenance and Administration will consult with Corporate contractors to discuss future plans for the Repair of the kitchen floor. 3. The Nutritional Services Management staff and The Maintenance staff will monitor the condition of The kitchen floor on an on-going basis ensuring its Cleanliness and repair. 4. The Nutritional Services Director will report on the performance monitoring efforts and any action plans for improvement to the QA Committee which is chaired by the Administrator. 5. 2/28/08 | 1/29/08 2/28/08 2/28/08 2/28/08 |

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| F 371 | Continued From page 58 undated and/or expired. These observations were observed in the presence of Employee #2 in the main kitchen and Employees #3, 4 and 26 for the unit pantries on January 14, 2008 from 7:00 AM through 10:30 AM. The findings include: 1. The floor in the main kitchen, dish machine area and dried storage area was observed cracked, uneven, with peeling paint and soiled. 2. The outside of the tilt grill was observed soiled with accumulated grease and debris in one (1) of one (1) tilt grill observed. 3. Caulking above the sink by the tray line was observed soiled in one (1) of four (4) sinks observed. 4. Grease and debris build-up was observed on wires and valves for two (2) of two (2) deep fryers observed. 5. The compressor to the juice machine was soiled with dust, debris and grease in one (1) of one (1) juice machine observed. 6. The threshold of the walk-in refrigerator and freezer were observed soiled and damaged in two (2) of two (2) thresholds observed. 7. Two (2) of two (2) convection ovens were observed soiled on the exterior with grease and debris. 8. Cooking hoods above the oven were observed soiled with grease and debris in four (4) of eight (8) hoods observed. | F 371 | 2. Tilt Skillet 1. The tilt surface was cleaned and the grease was Removed at the time of discovery. 2. All other skillet surfaces were reviewed for Cleanliness. No other cleaning was necessary. 3. Cleaning standards and cleaning schedules Were reviewed with the cooks to ensure on-going Compliance. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 3. Caulking Above the Sink 1. Caulking was removed and replaced with new Caulking upon discovery. 2. All other caulking was reviewed for cleanliness And no other replacement was necessary. 3. The Nutritional Services Supervisors Will monitor all aspects of cleanliness in the kitchen On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 4. Grease Build Up in Fryers. 1. Fryers were removed from the cooking area and Thoroughly cleaned inside and returned to service. 2. Cooks were inserviced on the proper cleaning Of the deep fryers. 3. Cleaning standards and cleaning schedules Were reviewed with the cooks to ensure on-going Compliance. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 5. Compressor on the Juice Machine 1. The compressor motor was wiped down upon discovery. 2. All other compressors were reviewed to ensure Proper cleanliness. 3. Nutritional Services Supervisors will advise Assigned staff to include the compressor in the | 1/9/08 1/9/08 2/28/08 2/28/08 1/23/08 2/28/08 2/28/08 1/09/08 1/15/08 2/28/08 2/28/08 1/09/08 1/09/08 |

5. Compressor on the Juice Machine (continued)
Station clean up. The Supervisors will monitor
The areas for on-going cleanliness and compliance. 2/28/08
4. The Director of Nutritional Services will report
on the performance monitoring and any action plans
for improvement to the QA Committee which is
chaired by the Administrator 2/28/08
5. 2/28/08
6. Thresholds
 1. Thresholds to the Walk-in refrigerator and freezer
were cleaned immediately and the repair was scheduled
with Maintenance. 1/23/08
 2. All thresholds were evaluated for cleanliness
And repair. No other action was necessary. 1/23/08
 3. The Nutritional Services Supervisors 2/28/08
Will monitor the cleanliness of the kitchen thresholds
On an on-going basis to ensure compliance.
 4. The Director of Nutritional Services will report
on the performance monitoring and any action plans
for improvement to the QA Committee which is
chaired by the Administrator 2/28/08
 5. 2/28/08
7. Convection Oven Doors
 1. The exterior oven door was wiped down upon
Discovery. 1/8/08
 2. All other doors were evaluated for cleanliness and
No other action was necessary. 1/8/08
 3. The Nutritional Services Supervisors 2/28/08
Will monitor the cleanliness of the kitchen equipment
On an on-going basis to ensure compliance.
 4. The Director of Nutritional Services will report
on the performance monitoring and any action plans
for improvement to the QA Committee which is
chaired by the Administrator 2/28/08
 5. 2/28/08
8. Cooking Hoods Over Ovens
 1. Filters in the hood were removed and cleaned
as needed. 1/09/08
 2. All other filters were evaluated and no other
Action was necessary. 1/09/08
 3. The Nutritional Services Supervisors 2/28/08
Will monitor the cleanliness of the kitchen equipment
On an on-going basis to ensure compliance.
 4. The Director of Nutritional Services will report
on the performance monitoring and any action plans
for improvement to the QA Committee which is
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| F 371 | Continued From page 59 9. The spout and trays of ice machines on 3 North and 3 South were observed soiled with debris in two (2) of six (6) ice machines observed. 10. 4-16 ounce containers of chicken base were observed stored in the main oven. 11. Unit pantries were observed with unlabeled, undated or expired food as follows: 3 North refrigerator contained the following opened and undated items: One (1) package of hot dogs One (1) package of bologna One (1) package of yellow cheese One (1) package of salami One (1) plate of chicken, rice, stuffing and a biscuit was undated. 2 North refrigerator contained the following items that were opened: One (1) package of bologna dated December 10, 2007 One (1) red apple dated December 10, 2007 One (1) package of lettuce dated December 17, 2007 One (1) package of white cheese dated December 17, 2007 1 North refrigerator contained the one (1) container of yogurt that expired December 21, 2007. Employees #3, 4, and 26 acknowledged the above findings at the time of the observations. | F 371 | 9. Ice machine 1. The spout and tray of the ice machine were Cleaned upon discovery. 2. All other ice machines were evaluated and Cleaning done if necessary 3. Housekeeping supervisors will monitor the Cleanliness of the ice machines on an on-going Basis to ensure their sanitation. 4. The Director of Environmental Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 10. Chicken Base 1. The misplaced containers of chicken base were Immediately removed and stored properly. 2. All other areas of the kitchen were searched for Improperly stored containers to ensure proper Storage at all times. 3. Cooks were inserviced on the proper storage And handling of container foods. The Nutritional Services Supervisors will monitor the Proper storage of foods on an on-going basis to Ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 11. Unit pantry refrigerators 1. All undated, unlabeled and/or expired food was Removed immediately upon discovery. 2. All refrigerators were checked again to ensure That all food was labeled, dated and not expired. 3. The Night Supervisor and Clinical Managers will Monitor the food in the refrigerators on an on-going Basis to ensure that safe food handling is employed They will report their findings to the DON. 4. The Director of Nursing will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/09/08 1/9/08 1/31/08 2/28/08 1/09/08 1/09/08 1/15/08 2/28/08 1/09/08 1/09/08 1/31/08 2/28/08 |
| F 386 SS=D | 483.40(b) PHYSICIAN VISITS The physician must review the resident's total | F 386 | | |

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| F 386 | <p>Continued From page 60</p> <p>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 observation, staff interview and record review for three (3) of 30 sampled residents, it was determined that the physician's progress notes failed to include: review of the total plan of care for one (1) resident and address fluctuating weights for two (2) residents. Residents #1, 2, and 14.</p> <p>The findings include:</p> <p>1. The physician failed to review Resident #1's total program of care.</p> <p>A review of Resident # 1's record revealed the followings: A physician's order dated and signed March 1, 2007: " Remeron 15mg P.O. QHS [By Mouth at Bedtime] [to] increase appetite ..." A psychiatrist treatment plan dated November 29, 2007: (1) ... Haldol 0.5mg P.O. QHS x [for] 4 weeks then 0.25mg P.O. QHS [By mouth every night] x 2 weeks then stop. (2) Continue with Remeron as Rx [ordered]..." A physician's order dated November 29, 2007 and signed December 3, 2007: " D/C [discontinue] Haldol 1mg change to Haldol 0.5mg P.O. QHS x 4 weeks then Haldol 0.25 mg P.O.</p> | F 386 | <p>RESIDENT #1</p> <p>1. Orders were clarified by the physician upon discovery. 1/10/08</p> <p>2. Medical records audit of other residents of this Physician was completed to ensure that the same deficient practice did not occur. Corrections were made when necessary. 1/31/08</p> <p>3. Inservice was given to licensed nursing staff regarding the precision needed when transcribing physician orders. The Clinical Managers/designated, House Supervisors, and Charge Nurses will audit the Medical records on a continuous basis to ensure Compliance. 2/28/08</p> <p>4. The Director of Nurses will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 386 | <p>Continued From page 61</p> <p>QHS x 2 weeks then D/C. T.O. [Telephone Order]..."</p> <p>A review of the resident' s March 2007 Medication Administration Record (MAR) revealed that Remeron 15mg was administered March 1 and 2, 2007. Review of subsequent days and months revealed that the Remeron was not administered.</p> <p>A face-to-face interview was conducted with Employee #9 on January 11, 2008 at approximately 10:00 AM. He/she acknowledged that the physician failed to completely review the psychiatrist treatment plan of November 29, 2007 before signing the order of November 29, 2007. Employee # 9 continued, " Remeron was dropped accidentally from the resident's medication order when the resident returned from the hospital in March 2007 and again when the order was transcribed on November 29, 2007 ..." The record was reviewed on January 11, 2008.</p> <p>2. Physician failed to address Resident #2's fluctuation in weight.</p> <p>Resident #2 was admitted to the facility on May 1, 2007. The resident's weight documented on the admission MDS (Minimum Data Set) dated May 14, 2007 was 214 pounds.</p> <p>The review of the resident' s quarterly dietary notes dated August 7, 2007 indicated, "Wt. 7/5/07 178 pounds a 16.60% loss since admission. Significant wt loss currently 136.9% of IBW (ideal body weight). Adjusted AWR (average weight range) 170-180 pounds. Diet mechanical soft NAS (no added salt), NCS (no concentrated sweets) remains appropriate and were tolerated. Skin intact no open areas ..."</p> | F 386 | <p>2. RESIDENT #2</p> <p>1. Physician was notified immediately upon discovery And he visited to address the weight fluctuation Issue.</p> <p>2. Medical records audit of other residents of this Physician was completed to ensure that the same deficient practice did not occur. Corrections were made when necessary.</p> <p>3. Inservice was given to licensed nursing staff Regarding physician notification when significant Changes occur. The Clinical Managers/designed, House Supervisors, and Charge Nurses will audit the Medical records on a continuous basis to ensure Compliance.</p> <p>4. The Director of Nurses will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | 1/15/08 | 1/31/08 | 2/28/08 | 2/28/08 |

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| F 386 | <p>Continued From page 62</p> <p>October 31, 2007, "Q2 (quarterly) Wt. 9/7 184 pounds, a 13.8% wt loss since admission..."</p> <p>November 12, 2007, "Wt. 11/1 186 pounds indicating a 12.8% loss x 180 day review; significant wt. loss. Resident continues to be above AWR. Currently 143% of IBW (Ideal Body Weight). BMI (Body Mass Index) 30.08. Wt loss was desirable ..."</p> <p>The review of the physician's progress notes dated November 1, 2007 indicated that the weight was stable. There was no evidence that the physician addressed the resident's change in weight.</p> <p>On January 8, 2008, at approximately 10:30 AM, a face-to-face interview was conducted with Employee #7 who acknowledged that the physician failed to address the resident's weight loss. The record was reviewed on January 7, 2008.</p> <p>3. The physician failed to address Resident #14's fluctuating weights which included a 28 pound (#) weight gain in one (1) month and an eight (8) pound weight loss on one (1) month.</p> <p>A review of Resident #14's record revealed the following recorded weights: July 10, 2007 118# August 4, 2007 118# September 4, 2007 146, re-weight 146 October 5, 2007 138# October 31, 2007 140# November 5, 2007 140#</p> <p>The physician saw the resident on September 25 and November 28, 2007. The physician's</p> | F 386 | <p>3. RESIDENT #14</p> <ol style="list-style-type: none"> 1. The physician was notified and addressed the Issue upon discovery. 1/15/08 2. Medical records audit of other residents of this Physician was completed to ensure that the same deficient practice did not occur. Corrections were made when necessary. 1/31/08 3. Inservice was given to licensed nursing staff regarding the precision needed when transcribing physician orders. The Clinical Managers/designated, House Supervisors, and Charge Nurses will audit the Medical records on a continuous basis to ensure Compliance. 2/28/08 4. The Director of Nurses will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator. 2/28/08 5. 2/28/08 | |

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| F 386 | Continued From page 63 | F 386 | | |
| F 412 SS=D | 483.55(b) DENTAL SERVICES - NF The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to provide an annual dental screen for Resident #5. The findings include: A review of Resident #5's record revealed "Dental Care Notes." According to the dentist's entry dated September 28, 2006, "Patient refused annual exam today." An entry by the dentist dated October 26, 2006 documented, "Patient refused exam." There was no evidence that the dentist attempted to perform an annual screen for 2007. A face-to-face interview was conducted with Employee #6 on January 8, 2008 at 10:00 AM. He/she acknowledged that a dental screen was | F 412 | <ol style="list-style-type: none"> 1. The resident was screened by the consultant Dentist. 1/09/08 2. All residents were reviewed to ensure that an Annual screening had taken place. The Dentist has Added an Administrator to his practice to keep a Tighter reign on the review dates on each resident. In addition, the dentist has purchased specialty Software to assist in resident scheduling. 1/31/08 3. The Unit Clerks will review all of the dental Evaluations every month to ensure that each resident is seen by the dentist upon admission and at least Annually thereafter. Any resident found with a dental Assessment that is more than a year old or coming Close to that date will be referred to the dentist and The Clinical Manager. The Clinical managers will Monitor the dental screenings on an on-going basis For compliance and will report their findings to the DON. 2/1/08 4. The Director of Environmental Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08 5. 2/28/08 | |

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| F 412 | Continued From page 64 not done for 2007. The record was reviewed January 8, 2008. | F 412 | | |
| F 425 SS=E | <p>483.60(a),(b) PHARMACY SERVICES</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</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> <p>Based on observations of five (5) of six (6) medication carts and staff interview, it was determined that the facility staff failed to date and initial 12 of 22 multi-dose medication vials when first opened and remove expired medication from the medication carts..</p> <p>The findings include:</p> <p>On January 10, 2008, between 9:00 AM and 12:00 PM, the medication carts and refrigerators</p> | F 425 | | |

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| F 425 | Continued From page 65 were inspected on each unit. 1. The facility staff failed to date and initial opened multi-dose medication vials as follows: 1 North Unit Xalatan ophthalmic drops - three (3) vials Heparin Sodium injection 10,000 Units/ 4ml - one (1) vial PPD 5 TU/0.1ml - one (1) vial Lorazepam injection 2mg/ml, 30 vials - two (2) vials 1 South Unit Xalatan ophthalmic drops - four (4) vials Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 2 North Unit Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 2 South Unit Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 3 South Unit Heparin Sodium injection 10,000 Units/ 4ml - one (1) vial Employees # 6, 7, 8, 10, and 42 acknowledged that the vials listed above were not dated and/or initiated at the time of the observations. 2. The facility staff failed to remove expired medication from the medication cart. On January 8, 2008, at approximately 9:14 AM, during the medication pass, it was observed that | F 425 | 1. Multi-dose vials 1. Any multi-dose vials which was found at the time Of the survey not to be properly labeled and dated Were discarded and replaced by the pharmacy. 2. All multi-dose vials were evaluated for compliance With facility protocol for dating, timing and initialing When opening. Any discrepancies were dealt with Appropriately. 3. Inservices were given to all nursing staff regarding The facility protocol when opening a multi-dose Vial. Nurses who fail to follow the protocol will Be counseled up to and including discharge. The Clinical managers, House Supervisors, Infection Control Nurse will monitor this issue to ensure On-going compliance. 4. 4. The Director of Nursing will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 2. RESIDENT JH9 1. Resident was assessed for any adverse effects of this drug which had been expired for 9 days. A literature review showed that the medication's shelf life is stable for 52 months after the expiration date on the package. An occurrence report was completed. The physician and responsible party were notified. The nurse involved was counseled regarding the need to review the labeling of each medication prior to administration. 2. All medications in the refrigerator and in the medication carts were checked for expiration dates both on the medication containers and packages. No other expired medications were found. 3. Inservices were given to the licensed nursing staff administering medications to make sure to check both package and containers of medications for expiration dates prior to administering meds. Daily checks of medications on the medication cart and in the refrigerators will be done by the Charge Nurses and monitored by the Clinical Managers. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 | 1/09/08 1/9/08 2/28/08 2/28/08 1/15/08 1/15/08 2/28/08 2/28/0/ |

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| F 425 | Continued From page 66 Employee #19 administered Alupent Metered Dose Inhaler to Resident JH9. The medication in the canister expired December 2007. During a face-to-face interview on January 8, 2008 at approximately 9:20 AM with Employee #19 acknowledged that the medication was expired. | F 425 | | | |
| F 454 SS=D | 483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to ensure that there was no impediment to the closing of doors in the event of a fire as evidenced by four (4) doors observed propped open. The findings include: 1. During the environmental tour of the facility on January 7, 2008 between 8:15 AM and 8:45 AM the door to room 138 was observed propped open with a plastic bag tied to a door handle and closet handle. The door to room 247 was observed to be propped open with a wedge. These findings were acknowledged by Employees #3, 4 and 26 at the time of the findings: 2. During the environmental tour on January 7, 2008 at approximately 12:30 PM the hallway door to the Physical Therapy department was | F 454 | 1. Any door found improperly propped open at the Time of the survey was corrected immediately. 2. All doors were evaluated to ensure that none Were improperly propped open. 3. Maintenance supervisor will check the safety of doors during their preventative maintenance rounds and report their findings to the Director of Maintenance. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 | 1/7/08 1/7/08 2/28/08 2/28/08 | |

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| F 454 | Continued From page 67 observed to be propped open with a chair. The door to the Occupational Therapy room was observed to be propped open with a therapy weight. These findings were acknowledged by Employee #35 at the time of the observation. | F 454 | | |
| F 465 SS=C | 483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to provide a sanitary environment for residents as evidenced by the storage of soiled linen and trash bins in residents' tub and shower rooms. These observations were made in the presence of Employees #3, 4, and 13. The findings include: 1. The following was observed on January 7, 2008 from 7:15 AM to 7:45 AM in the residents' tub rooms: 2 North five (5) yellow bins for soiled linen and two (2) gray bins for trash. 2 South four (4) yellow bins and four (4) gray bins. 3 North five (5) yellow bins and two (2) gray bins. | F 465 | 1. The facility made some slight modification to One of the training toilet rooms on each one of the nursing units which will allow the storage of large bins currently used for soiled laundry to be stored in a separate room. 2. Storage of trash and medical waste will continue to be in the Soiled Utility Room. All soiled laundry and trash will be monitored for frequent collection to avoid unnecessary odors or clutter. 3. The Director of Maintenance and the Director of Environmental Services will partner to ensure the Swift conversion of these rooms for the storage of the bins that hold the soiled laundry. Once the conversion is completed, they will monitor on an on-going basis for the proper storage of these bins. 4. The Director of Maintenance and the Director Of Environmental Services will report their finding on | 2/28/08 1/09/08 2/28/08 |

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| F 465 | <p>Continued From page 68</p> <p>3 South four (4) yellow bins and three (3) gray bins.</p> <p>2. The following was observed on January 8, 2008 in the residents' tub rooms from 3:00 PM to 3:10 PM.</p> <p>2 South six (6) yellow bins and two (2) gray bins, (four (4) of the yellow bins contained) soiled linen.</p> <p>2 North six (6) yellow bins and three (3) gray bins (three (3) of the yellow bins contained soiled linen).</p> <p>3. The following was observed on January 14, 2008 from 8:25 AM to 8:35 AM in the residents' tub room:</p> <p>3 North six (6) yellow bins and three (3) gray bins, (1) gray bin contained trash.</p> <p>3 South six (6) yellow bins and three (3) gray bins with trash.</p> <p>According to the 2001 Edition of Guidelines For Design and Construction Of Hospital And Health Care Facilities: 8.2.C6. Soiled utility or soiled holding room. This shall contain a clinical sink or equivalent flushing rim fixture with a rinsing hose or bedpan sanitizer, handwashing station, soiled linen receptacles, and waste receptacles in number and type as required by the functional program.</p> <p>On January 7, 2008 at approximately 7:45 AM, a face-to-face interview was conducted with Employee #13. He/she acknowledged the storage of the bins in the tub room. He/she indicated that the bins were used for soiled linen</p> | F 465 | <p>Continued from Page 68</p> <p>Their monitoring efforts to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | |

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| F 465 | Continued From page 69 and trash, and were emptied at the end of each shift in preparation for the on-coming staff. | F 465 | | | |
| F 490 SS=E | 483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administrator failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety. The findings include: 1. Facility staff failed to ensure that residents having pressure sores received the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Cross reference 483.25 (c) Pressure sores F 314 - Identified as actual harm. Failed: to assess for a pressure wound identified with eschar, and utilize a barrier under pressure wounds. 2. Facility staff failed to ensure that the resident environment remained free of accident hazard and that each resident received adequate supervision and assistive devices to prevent accidents. Cross reference 483.25(h) Accidents and Supervision F323 - Identified as harm. Failed to provide adequate supervision: for residents with multiple falls and sustained injury; a resident | F 490 | 1. See response to 483.25© Pressure Sores F314. 2. See response to 483.25(h) Accidents and Supervision F323. | 2/28/08 2/28/08 | |

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| F 490 | Continued From page 70 who sustained a burn; a resident observed by facility staff with a cigarette burning his/her pants; a resident found in an electrical closet and in another resident ' s bed; 14 of 44 smokers found with smoking paraphernalia; and nine (9) of 35 residents identified as elopement risks without pictures at the front door. | F 490 | | |
| F 492 SS=D | 483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that the facility staff failed to report four (4) unusual occurrences to the state agency and failed to document the usage of Lorazepam on the Medication Administration Record (MAR) for three (3) supplemental residents. Residents #18, 21, F3, F1, JH4, JH6 and JH7. The findings include: According to 22 DCMR, 3232.4, "Each incident shall be documented in the resident' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." | F 492 | | |

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| F 492 | <p>Continued From page 71</p> <p>1. Facility staff failed to report to the State Agency that Resident #18 sustained a cigarette burn to the right thigh.</p> <p>A review of the resident ' s record revealed a physician ' s order dated October 21, 2007 at 7:00 AM: " Clean open area on RT [right] thigh from smoking burns with NSS [normal saline solution] apply Bactroban ointment and cover site daily " .</p> <p>A face-to-face interview was conducted on January 10, 2008 at approximately 10:00 AM with Employee #25, who confirmed that an incident report was not sent to the state agency for the above cited incidence. The record was reviewed on January 8, 2008.</p> <p>2. Facility staff failed to report to the State Agency that Resident #21 was found in an electrical closet and found in another resident' s bed.</p> <p>A. Review of Resident #21 revealed the following nurse's note dated November 26, 2007 at 8:00 AM, " Resident observed sleeping in [his/her] room at 6 AM. At 6:30 AM resident observed sitting in the chair by the part of the nursing station. Resident was seen in the hallway (2 South) at 7 AM. When resident was not seen returning back to the unit, writer and CNA went in search for resident. Resident was found at 8 AM on 3rd floor in stable condition, was brought back to the unit and had [his/her] breakfast."</p> <p>A face-to-face interview was conducted with Employee #44 on January 9, 2008 at 1:00 PM. He/she stated. "We found the resident in the electrical closet at about 8:00 AM."</p> <p>A face-to-face interview was conducted with</p> | F 492 | <p>1. RESIDENT #18</p> <p>1. The facility has reported this incident to the State upon discovery.</p> <p>2. Other incident reports and 24 hour reports were Reviewed to ensure that the same deficient practice Of reporting for cigarette burns had not occurred.</p> <p>3. The Assistant Administrator will ensure that all Incidents are reported to the state agency in a timely Manner. In addition, the facility will ensure that in her Absence that this task is assigned to ensure compliance on an on-going basis.</p> <p>4. The Assistant Administrator will report on the Numbers of incidents reported to the state agency At the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> <p>2. RESIDENT #21</p> <p>1. The facility has reported this incident to the State upon discovery.</p> <p>2. Other incident reports and 24 hour reports were Reviewed to ensure that the same deficient practice Of reporting residents found in storage closets had not occurred.</p> <p>3. The Assistant Administrator will ensure that all Incidents are reported to the state agency in a timely Manner. In addition, the facility will ensure that in her Absence that this task is assigned to ensure compliance on an on-going basis.</p> <p>4. The Assistant Administrator will report on the Numbers of incidents reported to the state agency At the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | <p>1/15/08</p> <p>1/15/08</p> <p>2/28/08</p> <p>2/28/08</p> <p>1/15/08</p> <p>1/15/08</p> <p>2/28/08</p> <p>2/28/08</p> |
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| F 492 | <p>Continued From page 72</p> <p>Employee #4 on January 9, 2008 at approximately 1:10 PM. He/she stated, " That room [electrical closet] should always be locked. I can't explain why it was unlocked that morning."</p> <p>The resident was concurrently being monitored every 15 minutes as a result of facility staff identifying him/her as an elopement risk. The elopement monitoring sheets for November 26, 2007 for 7:00 AM, 7:15 AM, and 7:30 AM are signed with the notation of" eating breakfast" and initiated. The three (3) entries are lined through. The entry for 7:45 AM has no location or initials. There is a line drawn through the entry slot for 7:45 AM.</p> <p>B. According to a nurse' s note dated December 8, 2007 at 11:00 PM,"Upon conducting my rounds, noted resident [Resident #21] in [Resident F3's] bed. Was told several occasions to go in [his/her] own bed. But [he/she] refused. Supervisor told [Resident #21] to go to [his/her] room and still [he/she] refused. [He/she] then got out of [Resident F3's] bed and they both sit in hallway. [Resident #21] was very agitated. Medication was offered to [him/her]. [He/she] refused ... [Physician notified]." Resident F3's roommate was in his/her bed at the time of this occurrence.</p> <p>Resident #21's quarterly Minimum Data Set (MDS) assessment, completed October 19, 2007, was reviewed. He/she was coded for long and short-term memory problems and with moderately impaired cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed August 8, 2007 included dementia.</p> | F 492 | <p>2B. RESIDENT #21</p> <p>1. The facility has reported this incident to the State upon discovery. 1/15/08</p> <p>2. Other incident reports and 24 hour reports were Reviewed to ensure that the same deficient practice Of reporting for residents found in other Resident's beds had not occurred. 1/15/08</p> <p>3. The Assistant Administrator will ensure that all Incidents are reported to the state agency in a timely Manner. In addition, the facility will ensure that in her Absence that this task is assigned to ensure compliance on an on-going basis. 2/28/08</p> <p>4. The Assistant Administrator will report on the Numbers of incidents reported to the state agency At the QA Committee which is chaired by the Administrator. 2/28/08</p> <p>5. 2/28/08</p> | |

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| F 492 | <p>Continued From page 73</p> <p>Telephone interviews were conducted with the CNAs assigned to be with Resident #21 with one-on-one monitoring. Both Employee #31 and Employee #40 stated that they did not recall the incident.</p> <p>A face-to-face interview was conducted on January 10, 2008 at 10:00 AM with Employee #25, who confirmed that an incident report was not sent to the state agency for either aforementioned incident. The record was reviewed January 9, 2008.</p> <p>3. Facility staff failed to notify the state agency regarding Resident F3 who was found in bed with Resident #21.</p> <p>A face-to-face interview was conducted on January 10, 2008 at 8:30 AM with Employee #24. He/she stated, "I didn't do any follow-up [with the responsible party or the resident] because I didn't think this was a behavior issue [when Resident #21 was found in bed with Resident F3]. The two(2) residents have developed a friendship and I didn't think this was anything unusual."</p> <p>Resident F3's quarterly MDS assessment completed November 20, 2007 coded the resident for long and short term memory problems with modified independence of cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed April 20, 2007 included Dementia. The record was reviewed January 9, 2008.</p> <p>A review of Resident F3 nurses' notes and social worker's notes revealed that there was no evidence in the record that the state agency was</p> | F 492 | <p>3. RESIDENT #F3</p> <ol style="list-style-type: none"> 1. The facility has reported this incident to the State upon discovery. 2. Other incident reports and 24 hour reports were Reviewed to ensure that the same deficient practice Of reporting for residents found in other Resident's beds had not occurred. 3. The Assistant Administrator will ensure that all Incidents are reported to the state agency in a timely Manner. In addition, the facility will ensure that in her Absence that this task is assigned to ensure compliance on an on-going basis. 4. The Assistant Administrator will report on the Numbers of incidents reported to the state agency At the QA Committee which is chaired by the Administrator. 5. 2/28/08 | 1/15/08 1/15/08 2/28/08 2/28/08 | |

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| F 492 | <p>Continued From page 74</p> <p>notified of this incident. The record was reviewed on January 10, 2008.</p> <p>4. Facility staff failed to document the usage of Lorazepam on the Medication Administration Record (MAR) for four (4) of seven (7) residents. Residents F1, JH4, JH6, JH7.</p> <p>22 DCMR 3226.6, "Administration of Medication" stipulates, "Each dose of medication shall be properly and promptly recorded and initialed in the resident's medical record by the person who administers it."</p> <p>1 South On January 10, 2008, at approximately 3:15 PM, during the inspection of the control substances, Employee #33 was asked to check the blister packs of the PRN Lorazepam tablets with the MAR. The Lorazepam blister package for Resident F1 had 11 of 30 tablets missing. The physician's order form dated January 2, 2008, documented, "Lorazepam 1 mg tab po every 8 hours as needed for severe agitation."</p> <p>The refill order date on the medication label of the PRN Lorazepam was December 26, 2007. There was no documentation on the MAR that the medication was administered to Resident F1 for December 2007 and January 2008.</p> <p>During a face-to-face interview, on January 10, 2008, at approximately 3:30 PM, with Employee #33, he/she acknowledged that there was no documentation of administration for Lorazepam on the MARs.</p> <p>2 North On January 10, 2008, at approximately 2:30 PM,</p> | F 492 | <p>4. RESIDENTS F1, JH4, JH6, JH7</p> <p>1. Medication occurrence report was completed On all nursing units which were not able to account For the usage of Lorazepam: 1 South, 2 North, and 3 North. Pharmacy was also notified.</p> <p>2. The remaining units: 1 North, 2 South and 3 South Were audited for the use and documentation of Lorazepam. Corrections were made whenever necessary.</p> <p>3. Inservices were given to the licensed staff about Signing Lorazepam out as a controlled substance And be counted and accounted for at the Beginning and the end of each shift when Counting narcotics. The Clinical Mangers will Monitor this practice to ensure compliance.</p> <p>4. The Director of Nurses will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | 1/10/08 1/10/08 1/10/08 2/28/08 | |

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| F 492 | <p>Continued From page 75</p> <p>during the inspection of the control substances on the medication cart, Employee #8 was asked to check the blister packs of the PRN Lorazepam tablets with the MAR. The Lorazepam blister package had 3 of 30 tablets missing. The physicians order form dated December 3, 2007, documented, "Lorazepam 1 mg tab po every 8 hours as needed for severe agitation."</p> <p>The refill order date on the medication label of the prn Lorazepam was November 15, 2007. There was no documentation on the MAR that the medication was administered to resident JH4 for November 2007, December 2007 and January 2008.</p> <p>During a face-to-face interview, on January 10, 2008, at approximately 2:40 PM, Employee #8 acknowledged that there was no documentation of administration for Lorazepam tablets on the MARs.</p> <p>3 North</p> <p>On January 10, 2008, at approximately 2:00 PM, during the inspection of the control substances on the medication cart, the Employee #19 was asked to check the blister packs of the PRN Lorazepam tablets with the MAR for Resident JH6 and JH7.</p> <p>The Lorazepam blister package for Resident JH6 had 19 of 30 tablets missing. The physician's order form for JH6 dated December 24, 2007, documented, "Lorazepam 1 mg tab po every 8 hours as needed for agitation." The order date on the medication label of the prn Lorazepam was October 25, 2007. There was no documentation on the MARs that the medication was administered to resident JH6 for October 2007, November 2007, December 2007 and January</p> | F 492 | | |

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| F 492 | Continued From page 76 2008. The Lorazepam blister package for Resident JH7 had three (3) of 30 tablets missing. The physician's order form for JH7 dated November 5, 2007, documented, "Lorazepam 1 mg tab po every 6 hours as needed for agitation ". The refill order date on the medication label of the prn Lorazepam was September 26, 2007. There was no documentation on the MARs that the medication was administered the resident JH7 for September 2007, October 2007, November 2007, December 2007 and January 2008 During a face-to-face interview, on January 10, 2008, at approximately 2:20 PM, Employee #29 acknowledged that there was no documentation of administration for Lorazepam tablets on the MARs. | F 492 | | |
| F 493 SS=E | 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 staff interview and record review, it was determined that the governing body failed to integrate, coordinate and monitor the facility's practices related to resident care and safety. | F 493 | | |

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| F 493 | Continued From page 77 The findings include: 1. Facility staff failed to ensure that residents having pressure sores received the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Cross reference 483.25 (c) Pressure sores F 314 - Identified as actual harm. Failed: to assess for a pressure wound identified with eschar, and utilize a barrier under pressure wounds. 2. Facility staff failed to ensure that the resident environment remained free of accident hazard and that each resident received adequate supervision and assistive devices to prevent accidents. Cross reference 483.25(h) Accidents and Supervision F323 - Identified as harm. Failed to provide adequate supervision: for residents with multiple falls and sustained injury; a resident who sustained a burn; a resident observed by facility staff with a cigarette burning his/her pants; a resident found in an electrical closet and in another resident ' s bed; 14 of 44 smokers found with smoking paraphernalia; and nine (9) of 35 residents identified as elopement risks without pictures at the front door. | F 493 | 1. See response to 483.25© Pressure Sores F314. 2. See response to 483.25(h) Accidents and Supervision F323. | 2/28/058 2/28/08 |
| F 514 SS=E | 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 | F 514 | | |

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| F 514 | <p>Continued From page 78</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview for four (4) of 30 sampled residents and 15 of 54 supplemental residents, it was determined that facility staff failed to consistently document the use of bilateral leg splints for one (1) resident; and monitor 18 residents requiring behavior monitoring every 15 minutes or every hour. Resident's #5, 20, 21, 24, C3, E5, M1, M2, M3, M5, M6, M7, M8, M9, M10, M11 and S2.</p> <p>The findings include:</p> <p>1. A review of Resident #5's record revealed a physician's telephone order dated October 22, 2007 and signed by the physician November 5, 2007, directing, "Patient fitted with bilateral knee extension orthotic for night time. Use only 6 hrs [hours] on."</p> <p>A review of the October and November 2007 Treatment Administration Record, revealed that the splints were not applied from October 22 through 31, 2007 and November 1 through November 8, 2007 as indicated by the nurses initials.</p> <p>A face-to-face interview was conducted with Employee #6 on January 8, 2007 at approximately 2:30 PM. After reviewing the record, he/she acknowledged that the leg splints were not signed as having been applied as per the physician's order. The record was reviewed</p> | F 514 | <p>1. RESIDENT #5</p> <p>1. The physician was notified immediately upon Discovery of the issue. An occurrence report was Generated and inservices to the night shift Were given to ensure their understanding.</p> <p>2. Orders for all devices were audited to ensure That documentation was available to show that the Devices were applied appropriately and consistently.</p> <p>3. Clinical Managers, House Supervisors and Chare Nurses will monitor the application of such devices To ensure compliance on an on-going basis and Will report their findings to the DON.</p> <p>4. The Director of Nurses will report on the Performance monitoring and any action plans for Improvement to the QA Committee which is chaired By the Administrator.</p> <p>5. 2/28/08</p> | 1/10/08 1/15/08 2/28/08 2/28/08 | |

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| F 514 | <p>Continued From page 79 January 8, 2008.</p> <p>2. Facility staff failed to monitor residents wandering behavior every 15 minutes or every hour.</p> <p>A review of the behavior monitoring sheets for October, November and December 2007 were conducted on January 9, 2008. Monitoring sheets consisted of four (4) columns, time, location, RN/LPN signature and supervisor signature.</p> <p>The following inconsistent documentation was observed:</p> <p>Resident #20: Required 15 minute monitoring; on December 17, 2007 there was no RN/LPN signature for 12:00 AM through 6:45 PM.</p> <p>Resident #21: Required 15 minute monitoring and on November 26, 2007 the resident was monitored one-on-one. On November 30, 2007 there was no supervisor signature for 6:00 AM and from 11:00 PM through 11:45 PM. On December 19, 2007 there was no RN/LPN signature from 12:00 PM through 11:00 PM. On December 20, 2007 all columns were blank from 11:15 PM through 11:45 PM. On December 24, 2007 there was no RN/LPN signature at 4:45 PM and all columns were blank from 11:15 PM through 11:45 PM. On December 26, 2007 all columns were blank from 9:00 PM through 11:45 PM. On December 27, 2007 all columns were blank from 12:00 AM through 6:45 PM.</p> <p>Resident #24: Required hourly monitoring. On</p> | F 514 | <p>2. RESIDENTS #20, 21, 24, C3, E5, M1, M2, M3, M5, M6, M7, M8, M9, M10, M11, S2</p> <p>1. The behavior monitoring sheets for the residents Cited at the time of the survey have been reviewed. Sheets started for 1/10/08 are complete and Accurate providing documentation in a timely Manner.</p> <p>2. All behavior monitoring sheets were reviewed For accurate and timely documentation. Night Supervisors review each sheet to ensure the same Deficient practice does not reoccur. The sheets are Reviewed daily at the nurse manager's 8 am Stand up meeting to ensure timely, accurate and Appropriate documentation.</p> <p>3. Inservices were given to all nursing staff who Provide documentation on the behavior monitoring Sheets. Nurses who fail to follow the facility policy Will be subject to disciplinary actions, The Clinical Mangers, House Supervisors and Charge Nurses. will Monitor this practice to ensure compliance.</p> <p>4. The Director of Nurses will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator.</p> <p>5. 2/28/08</p> | <p>1/10/08</p> <p>1/10/08</p> <p>2/28/08</p> |

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| F 514 | <p>Continued From page 80</p> <p>October 4, 2007 the RN/LPN signed at 12:00 AM, 3:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 2:00 PM, 4:00 PM and 11:00 PM.</p> <p>Resident C3: Required 15 minute monitoring. On October 7, 2007 the location was blank from 8:00 AM through 11:00 PM with the RN/LPN and supervisor signature present for 6:00 PM and 9:00 PM.</p> <p>On October 14, 2007 the location and RN/LPN signature was blank for 8:45 AM through 11:45 PM and the supervisor signed at 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM and 9:00 PM.</p> <p>On October 24, 2007 the location and RN/LPN signature was blank for 4:15 PM through 4:45 PM.</p> <p>On October 27, 2007 a line was drawn down the column for RN/LPN signature from 5:30 PM through 11:15 PM.</p> <p>On November 11, 2007 the location and RN/LPN signature were blank for 3:45 PM.</p> <p>On November 24, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM.</p> <p>On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM.</p> <p>On November 29, 2007 the location and RN/LPN signature was blank for 11:45 PM.</p> <p>Resident E5: Required 15 minute monitoring. On October 13, 2007 all columns were blank for 5:00 PM through 11:00 PM.</p> <p>On November 4, 2007 the RN/LPN signed was every 30 minutes not every 15 minutes from 7:00 AM through 3:30 PM.</p> <p>On November 16, 2007 a line was drawn down from 3:30 PM and up from 4:45 PM in the RN/LPN signature column. A single signature</p> | F 514 | | |

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| F 514 | <p>Continued From page 81</p> <p>appeared at 8:15 PM. The supervisor signed at 6:00 PM and 9:00 PM.</p> <p>On December 3, 2007 the location and RN/LPN signature was blank for 7:15 PM through 11:45 PM with a supervisor signature at 9:00 PM.</p> <p>On December 6, 2007 there was no supervisor signature for the entire day.</p> <p>On December 25, 2007 location and RN/LPN signature was blank for 12:00 Am through 6:00 AM. There was no column for the supervisor to sign and no supervisor signature for the whole day.</p> <p>Resident M1: Required 15 minute monitoring. On October 18, 2007 2:00 PM through 3:30 PM there was no RN/LPN signature.</p> <p>On December 17, 2007 there was no RN/LPN signature for 12:00 AM through 6:45 AM.</p> <p>Resident M2: Required 15 minute monitoring. On October 18, 2007 all columns were blank from 1:45 PM through 3:00 PM.</p> <p>On December 17, 2007 there was no RN/LPN signature from 12:00 AM through 6:45 AM, however, the supervisor signed every two (2) hours.</p> <p>Resident M3: Required 15 minute monitoring. On October 14, 2007 2:15 PM through 3:00 PM location was blank. The RN/LPN signed from 2:15 PM through 3:00 PM and the supervisor signed at 3:00 PM on October 14, 2007.</p> <p>On October 28, 2007 the RN/LPN signed at 6:15 PM. There was a line drawn from 6:15 PM through 9:45 PM with a signature at 9:15 PM. The supervisor signed at 9:00 PM.</p> <p>On November 14, 2007 the RN/LPN signed every 30 minutes from 12:00 AM through 4:45 PM.</p> <p>On November 29, 2007 there was no RN/LPN</p> | F 514 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095022 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 01/14/2008 |
| NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING FACILITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020 | | |
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| F 514 | <p>Continued From page 82</p> <p>signature or location from 11:15 PM through 11:45 PM and at 3:45 PM. There was no supervisor signature at 6:00 AM, 6:00 PM and 9:00 PM.</p> <p>Resident M5: Required 15 minute monitoring. On October 14, 2007 there was no RN/LPN signature or location from 5:00 PM through 11:45 PM. The supervisor signed at 6:00 PM and 9:00 PM. On November 4, 2007 there was no RN/LPN signature from 3:45 PM through 4:45 PM. On November 8, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 11, 2007 the location and RN/LPN signature was blank for 3:45 PM. On November 15, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 21, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM.</p> <p>Resident M6: Required 15 minute monitoring. On October 14, 2007 location and RN/LPN signature was blank for 9:30 PM through 11:45 PM. On November 15, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 21, 2007 the location and RN/LPN signature was blank for 4:45 PM. On November 24, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. December 20, 2007 the location and RN/LPN signature were blank for 12:00 PM through 1:00 PM. The supervisor signed at 12:00 PM and 3:00</p> | F 514 | | | |

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| F 514 | <p>Continued From page 83 PM.</p> <p>Resident M7: Required hourly monitoring. On October 14, 2007 the location was blank for 8:00 AM through 11:00 PM. The RN/LPN signature and supervisor signature were signed for the whole day.</p> <p>Resident M8: Required 15 minute monitoring. On October 7, 2007 there was no RN/LPN signature from 5:30 PM through 11:45 PM but the supervisor signed at 6:00 PM and 9:00 PM.</p> <p>On December 3, 2007 all columns were blank from 12:00 AM through 3:00 PM and no supervisor signatures at 6:00 PM and 9:00 PM.</p> <p>On December 7, 2007 the location and RN/LPN signature were blank for 11:45 AM through 2:45 PM with a supervisor's signature at 12:00 PM and 3:00 PM and no supervisor signature at 6:00 PM and 9:00 PM.</p> <p>December 9, 2007 the location, RN/LPN and supervisor signatures were blank for 7:45 AM through 11:45 PM.</p> <p>December 25, 2007 there was no RN/LPN signature for 12:00 PM through 7:00 AM but the supervisor signed for 12:00 PM, 3:00 AM and 5:00 AM.</p> <p>Resident M9: Required 15 minute monitoring. On November 16, 2007 a line was drawn down from 3:00 PM and up from 11:00 PM with a nurse's signature at 9:00 PM and no supervisor signature for 3:00 PM, 6:00 PM and 9:00 PM.</p> <p>On December 3, 2007 the location and RN/LPN signature were blank for 3:30 PM through 11:45 PM but the supervisor signed at 3:00 PM, 6:00 PM and 9:00 PM.</p> <p>Resident M10: Required 15 minute monitoring.</p> | F 514 | | |

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| F 514 | <p>Continued From page 84</p> <p>On November 16, 2007 a line was drawn down from 3:30 PM and up from 4:45 PM with the nurse's signature at 4:15 PM and on the same day a line drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 8:45 PM. The supervisor signed for 3:00 PM, 6:00 PM and 9:00 PM.</p> <p>On November 24, 2007 a line was drawn down from 3:15 PM and up from 4:545 PM with the nurse signature at 4:40 PM and on the same day a line was drawn down from 5:00 PM and up from 11:45 PM with a nurse's signature at 9:30 PM. The supervisor signed at 3:00 PM, 6:00 PM and 9:00 PM.</p> <p>On December 25, 2007 the location and RN/LPN signature were blank for 12:00 AM through 6:00 AM. There was no supervisor signature for the entire day.</p> <p>Resident M11: Required 15 minute monitoring. On October 8, 2007 the location and RN/LPN signature were blank from 8:00 AM through 11:00 AM with no column for the supervisor signature for the entire day.</p> <p>On November 16, 2007 a line was drawn down from 4:00 PM and up from 4:45 PM with the nurse's signature at 8:00 PM. On a second sheet for the same day a line was drawn down from 4:00 PM and up from 4:45 PM with the nurse's signature at 4:15 PM and for the same day, a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 9:00 PM. The supervisor signed at 3:00 PM, 6:00 PM and 11:00 PM.</p> <p>On November 24, 2007 a line was drawn down from 4:00 PM and up from 11:00 PM with the nurse's signature at 8:00 PM. A second sheet from November 24, 2007 had a line drawn down from 5:00 PM and up from 11:45 PM with the</p> | F 514 | | | |

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| F 514 | <p>Continued From page 85</p> <p>nurse's signature at 9:00 PM. The supervisor signed at 3:00 PM, 6:00 PM and 11:00 PM. On November 25, 2007 the nurse's signed at 4:00 PM with an arrow going up to 3:15 PM and down to 4:45 PM and on the same day a line was drawn from 6:15 PM down and up from 11:45 PM with the nurse's signature at 7:15 PM.</p> <p>On December 25, 2007 a line was drawn through the location column from 5:15 PM through 7:00 AM. There was no RN/LPN or supervisor signature for the entire day. A second sheet for December 25, 2007 the location and RN/LPN signature were blank for 12:00 AM through 6:00 AM.</p> <p>Resident S2: Required hourly and 15 minute monitoring. On November 20, 2007 a line was drawn down from 4:00 PM and up from 11:00 PM with the nurse's signature at 7:00 PM.</p> <p>On November 24, 2007 a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 7:45 PM. The supervisor signed at 6:00 PM and 9:00 PM.</p> <p>On November 25, 2007 a line was drawn down from 4:00 PM and up from 4:45 PM with the nurse's signature at 4:15 PM and on the same day a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 7:45 PM. The supervisor signed at 6:00 PM and 9:00 PM.</p> <p>On December 3, 2007 there was no nurse's signature from 7:15 AM through 1:45 PM. The supervisor signed the entire day.</p> <p>On December 25, 2007 the location, RN/LPN and supervisor signatures were blank for 12:00 AM through 6:00 AM.</p> | F 514 | | |