STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E669	A. BUILDING ____ B. WING ____	04/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE ISLAND NURSING HOME	2427 WEST 127TH STREET BLUE ISLAND, IL 60406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification. Complaint investigation #0890596/IL33387: no deficiency. An extended survey was conducted.	F 000		
F 159 SS=D	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	F 159		5/9/08

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

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 159	Continued From page 1 of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based upon family and staff interviews, and record review the facility failed to ensure that 1 (R3) of 10 resident in the sample resident funds was made available to their guardian. Findings Include: R3 was admitted to the facility 12/22/05 with a diagnosis including Psychosis, Alzheimer's Dementia, and has a guardian for healthcare and finance. During R3's family interview conducted on 4/1/08, the guardian stated, " I am not getting any money for my sister-in-law, ..they are not telling me about the money...I do not get any statements..I do not know if she has money in the resident funds."	F 159		

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F 159	Continued From page 2 E1(administrator) was interviewed on 4/1/08, and stated, " E2 (assistant administrator) keeps the books I will get her." E2 (asst. administrator) on 4/2/08 stated, "we have R3's money in the bank, we will give it to the guardian."	F 159		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility neglected to follow the physician's orders to obtain laboratory results for 1 of 10 residents (R5), who was readmitted to the facility following a hospitalization where she was treated for acute renal failure. The facility's failure resulted in a delay in notifying the physician of the elevated lab results and the resident receiving treatment and services for a period of 6 days. This failure resulted in Immediate Jeopardy. The facility was notified of the Immediate Jeopardy on April 8, 2008 at 9:30 AM. E1 (Administrator), E2 (Assistant Administrator)and E3 (Director of Nursing) were all present. Findings include: R5 is an 84 year old resident who was admitted to the facility on 4/28/04 with diagnoses including hypertension, dementia and diabetes mellitus, According to the most recent resident assessment instrument dated 2/2/08, facility staff identified that R5 has difficulties with long and	F 224		5/9/08

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short term memory recall; and moderately impaired cognitive skills for decision making.

On 10/12/07, R5 was transferred to the hospital for an evaluation. According to the hospital records, R5 was received with an elevated digoxin level and an elevated creatinine level. R5 was admitted to the hospital with diagnoses including digoxin toxicity and acute renal failure. R5 was readmitted to the nursing home on 10/17/07.

After readmission to the nursing home, R5 was not seen by the physician until 11/30/07. On 11/30/07, the physician gave orders for a digoxin level every 3 months, thyroid stimulation hormone levels and a basic metabolic panel. However, these labs were not drawn until 12/6/07.

On review of the laboratory results for 12/6/07, it was documented that R5 had an elevated creatinine level of 2.00 mg/dl. Again, there was no documentation in the Nurses' Progress Notes that the physician was notified of the elevated creatinine level. During an interview on 4/3/08, E3 (director of nursing) stated that she faxed a copy of the results to the physician. E3 confirmed during the interview that she did not notify the physician of the laboratory results. E3 failed to immediately notify the physician of the resident's abnormal lab results.

On 12/12/07 at 11 AM, E3 documented that R5 was "slumped over on bed states she doesn't feel well." The physician was notified and the resident was transferred to the hospital. R5 was admitted to the hospital with diagnoses including altered mental status, lethargy and renal failure.

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According to the facility policy for Physician Notification for Residents Change of Condition, "The resident's primary physician or designated alternate will be notified of any change in resident's physical or mental condition." The facility policy further indicates that critical lab values would be considered a change in condition, which would prompt physician notification. Facility staff failed to follow the policy for physician notification.

Facility staff failed to obtain laboratory results as ordered by the physician; and failed to ensure that the physician is made aware of abnormal laboratory results for R5. This facility failure resulted in a delay in treatment and services for a resident, who was admitted to the hospital with a diagnoses of acute renal failure.

Although the the Immediate Jeopardy was removed on April 9, 2008, when the facility identified that there were no other residents in the facility at risk, the facility remains out of compliance at a severity level II in order to allow for the implementation of the facility plan of correction for F224 and time for the facility to evaluate the efficacy of their interventions.

The facility took the following action to remove the immediacy:

1. Our Lady of Resurrection Laboratory draws all lab works for this facility. The lab supervisor will monitor all labs for critical values; with any critical labs, she will fax them to both the attending physician and this facility. She will also contact

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F 224	Continued From page 5 them by phone. The facility will also contact the physician by phone. If the attending physician does not respond after two attempts, this facility has a list of three other doctors who have agreed to respond to any contacts in regards to critical labs. 2. Current lab draws will be changed from Thursdays to Wednesdays. A monthly laboratory QA Meeting will be held with the nursing staff and the Medical Director to review all labs. A Quarterly QA meeting will be held with Department Heads, Medical Director, Pharmacy, Lab, Dietary and Facility Consultants. 3. On 4/8/08 the laboratory supervisor has reviewed and provided us with a list of all the critical labs drawn from October 2007 through our last lab draw. Through careful review of all the current resident critical labs results, we found that there were no resident at risk. We will continue to review all past critical labs for proper follow-up. 4. We have developed a new form to ensure that all critical labs were addressed immediately (see enclosure #2). Nursing staff will notify the DON or designee with all critical labs. 5. All nursing staff will be in-services on the new procedures for critical labs by Thursday, 4/9/08 and completed on 4/9/08. Quality Assurance Plan: The DON or designee will complete the critical lab form when any critical labs are received by the facility. Dates when corrective action will be completed:	F 224		

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F 224	Continued From page 6 Completion of corrective action will be 4/9/08. The Director of Nursing will monitor for compliance.	F 224		
F 226 SS=F	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to appoint an abuse prevention coordinator, in an effort to ensure that residents in the facility are free of mistreatment, neglect, misappropriation of resident property and abuse. Findings include: On review of the Facility Roster completed by staff on 4/2/01, the facility failed to identify an Abuse Prohibition Coordinator. During interviews on 4/1/08 and 4/2/08, E1 (administrator) and E2 (assistant administrator) both confirmed that the facility does not have an Abuse Prohibition Coordinator. During the survey, E1 was not able to present any allegations of abuse or neglect. E1 stated that he has not had any allegations of abuse or neglect within the the past year. E1 stated that if there were any allegations of abuse, they would be documented in the accident/incident. E1 denied that he was aware of any allegations of abuse.	F 226		5/9/08

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F 226	Continued From page 7 On review of the Incident Reports from June 2007 to the present, there was an incident report dated 2/9/08 of resident-to-resident physical abuse; and an incident report dated 12/25/07 of an allegation of resident-to-staff physical abuse. There was no evidence that the allegations of abuse were investigated. During interviews on 4/2/08 E3 (director of nursing) and E7 (director of social services) both stated that they were not sure who was responsible for investigating allegations of abuse and neglect. Facility staff failed to ensure prompt and through investigations of all allegations of abuse. This resulted in the facility's failure to protect the residents from abuse, neglect, mistreatment and misappropriation of property.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that activities provided meet the interests of the resident. Findings include: 1. The facility currently has a census of 26 residents. The activity calendar presented by E6 (activity director) for the month of April 2008 displays a television program at 9am, and a	F 248		5/9/08

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F 248	Continued From page 8 discussion at 10am on Tuesday- Fridays. There were no staff present in the activity area on Tuesday, 4/1 through Wednesday, 4/2/2008 during the above times to afford residents a discussion. Residents were observed seated in the area. In addition, R3 and R8 were observed in their rooms on 4/1/08 and 4/2/08 without activity involvement or provision during the above designated times. E6 was interviewed on 4/2/08 and stated," I am also the food supervisor, and I could not do it (activities), today and yesterday because my staff called in." 2. R9 physician order form indicates R9 may go to day program x 6 days a week, R9 has been observed in the facility day room 2 consecutive days watching tv. R9 is not on the facility list for day programs and he only grunted when asked if he would like to attend.	F 248		
F 253 SS=C	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 made during the environmental tour with E5/E1 (Director of Maintenance/Facility Administrator), and staff interview, the facility failed to maintain the floors, walls, ceilings, closet , windows and sills, the window curtains and portable commodes in a clean condition and/or in good repair in one of one corridor, one of one Clean Linen/Utility Room, one of one Dining Room and Dayroom,	F 253		5/9/08

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F 253	Continued From page 9 one of one Medication Room, 2 of 2 Common Bathrooms, and several resident rooms. Findings include: 1) The outside perimeter was observed with a broken flower pot at the entrance. Debris, dirt, and garbage and broken glass on three perimeters of the facility. (north, south, and east sides.) Broken window observed on the east side of the building with tape holding the window in place, another broken window was observed in the kitchen with cardboard taped in place. The screen door leading to the kitchen is in disrepair, and will not completely close this door is located directly off of the alley. A television was observed sitting on the ground in the dumpsite area. A metal shed observed in the dumpsite area rusted with a broken door that will not close all the way. 2) At the entrance door to the facility their was dirt and debris jammed into the threshold. In the corridor off the day room 6 boxes and a plastic tub was observed stacked on the floor with no pallet, the supply cabinet in the corridor was observed with items stack on the top (phone book, baskets,and office supplies). Walls and baseboards were observed with dried black and brown streaks in the reception and day room areas. The corners in the day room and reception area were observed with dirt. The baseboards in the day room were observed becoming unglued from the wall. 3) The main dinning room was observed with stained ceiling tiles brownish color and water stained. The wheel chair table was observed with cigarettes burns. Activities supplies stored	F 253		

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F 253	Continued From page 10 on top of the supply cabinet in the main dinning area and on the floor next to the cabinet. The corners and baseboards were observed with dirt and black streaks. 4)The door frames in the following areas were observed with missing and chipping paints: (entrance to residents quarter, laundry room, clean linen room, medication room, residents room# 1,2,12). The vinyl covering was observed unattached from the wall the in the main hallway. There was holes observed in the wall behind the doors resident room# 2, and medication room. Resident room 2 was observed with 2 missing florescent light bulbs over bed#3. Resident room #1 was observed with paint peeling from ceiling , and closet doors in disrepair. Resident room #12 ws observed with excessive resident items stored on the floor, and a closet door unable to close due to being over stuffed with residents belonging. The night stand is in disrepair, and room #12 was observed with 2 residents occupancy and only one closet. 5) A dirty housekeeping buckets, mop wringers and carts was observed in the laundry room, resident equipment (canes, crutches,and walkers) observed stored in the laundry room, dirty gloves on the floor and sink with dirt build up observed. 6) The clean linen room was observed being utilized for storage of residents used personal supplies, (shaving cream, lotions, sanitary napkins, Baza cream). There was a dirty glove observed in the laundry room, along with dirt build up on the ledge of the water basin. There was an unrestrained oxygen tank observed on he floor.	F 253		

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F 253	Continued From page 11 7) There was clean tissue and clean paper towels was observed stored in the soiled utility room. The hopper was observed with a sign do no use, when asked E1 said that the plumber needs to repair because it does not work, The hopper was filled with filthy dirty and black water. The hopper was observed not flush, and E1, stated he did was unaware of the hopper not working.	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that care and services are provided in a manner that is consistent with professional standards of quality for 2 of 10 residents in the sample (R7 and R9); and for one resident outside the sample (R11), by failing to 1) follow the physician's order and manufacturer's recommendations for medication administration to ensure adequate absorption and to prevent adverse drug reactions; and failure to ensure that baseline labs are available (R11); 2) obtain Dilantin levels in an effort to ensure therapeutic drug levels (R9); and 3) failing to obtain blood pressure as ordered by the physican (R7). Findings include: 1. On 04/01/08 during the am medication pass,	F 281		5/9/08

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F 281	Continued From page 12 E3 (director of nurses) was observed giving R11 Lopid 600mg. one tablet at 10:50am, without food, and R11 refused to eat. The resident also complained of being tired and sleepy. The current physician order is Lopid 600mg tab one to give the medication 30 minutes before meals at 8:00am and 4:00pm. Based on review of the 03/04 medication administration record (MAR), the facility have given at least 27 doses of Lopid 600mg. during the month R11 is a 25 year old admitted to the facility 03/14/08 with diagnosis including Schizophrenia. Interview with R11 on 04/01/08 at 11:00am, as the resident lay in bed complaining about feeling tired, being sleepy, dizzy and throwing up about not eating and taking the Lopid. R11 stated, "This morning and yesterday evening I didn't feel like eating, and was given my meds. About five times I haven't felt like eating, they gave me pills. I told E4 (nurse) that they were giving me my medication without my food. Every time I refuse the meds without eating, they would make me take it. I take it anyway because I was afraid they (staff) would send me to the hospital." Again on 04/02/08 at 8:05am, R11 approached surveyor to say, "at 8:07am, they gave me the medicine." Referring to the only 8:00am medication the resident receives Lopid 600mg. by mouth. It was not until 9:15am that R11 received breakfast. Surveyor questioned the resident at 9:30am about eating breakfast. R11 stated, "I ate two minutes ago at 9:30am." This is 1.5 hours after the Lopid was administered.	F 281		

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At 1:50pm on 04/02/08, R11 was observed in the foyer area of the facility pacing around. R11 then stated, "I still feel dizzy and I'm not smoking marijuana."

E3 (director of nurses) was interviewed on 04/02 at 2:05pm about R11 receiving multiple doses of Lopid without eating. E3 stated, "He's (R11) not eating his food because we are putting stuff in food, and people are urinating in it. R11 is not eating and having dizziness. He (R11) doesn't want it, R11 said to discontinue it because he (R11) doesn't need it. I'm gonna call the medical doctor about him not eating and taking the meds, and see what he (doctor) wants me (E3) to do."

After E3 and surveyor reviewed the clinical record, there were no labs baseline or other (serum cholesterol level) results available for review.

In addition, R11 has been receiving another medication that may effect cholesterol levels, FazaClo (Clozaril) 100mg by mouth every am, and 300mg every hour of sleep, and as of 04/08 began receiving FazaClo 400mg at hour of sleep.

Based on the review of the Nursing 2008 Drug Handbook authored by Lippincott, Williams, and Wilkins, "Gemfibrozil is utilized for types 4 and 5 hyperlipidemia unresponsive to diet and other drugs; to reduce risk of coronary heart disease in patients with type IIb hyperlipidemia who can't tolerate or who are refractory to treatment with bile-acid sequestrants or niacin. Adults: 1,200mg (by mouth) P.O. daily in two divided doses, 30 minutes before morning and evening meals. Adverse reactions: fatigue, headache, vertigo,

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F 281	Continued From page 14 constipation, diarrhea, nausea and vomiting." 2. R1 was admitted to the facility with a diagnosis including NIDDM (Non Insulin Dependent Diabetes Mellitus), and physician orders in part request a Blood Glucose monitoring BID (twice a day) once a week. The facility March 2008 MAR (medication administration record) was reviewed on 4/1/08 and only depicts the monitoring conducted at 6am on 3/23/08 and 3/30/08. E3(director of nursing) was informed, and stated," I will get it." E3 returned to surveyor on 4/3/08, and presented the same March 2008 MAR with the 4pm slots for 3/23 and 3/30/08 filled in. The administrator(E1) was informed, and surveyor presented the previous MAR that was void of the information. The facility failed to ensure R1 blood glucose was monitored according to the physician order. 3. R9 was admitted to the facility with a diagnosis including seizures, upon the review of the clinical record 4/2/08 a phenytoin level 6.1mcg/ml, which low(normal 10 - 20mcg/ml). Upon further review of the clinical record there no noted evidence of the physician ever being notified of the out of range lab result. When asked E3 (Director of Nursing) said that the physician was notified, when asked if it was documented E3 said that it should be in the nursing notes. E3 was unable to present any evidence that the physician had ever been notified of the out of range lab result for R9.	F 281		
F 309 SS=J	483.25 QUALITY OF CARE Each resident must receive and the facility must	F 309		5/9/08

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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, record review, and interview the facility failed to provide the necessary care and services for 1 of 10 sampled residents (R5), by failing to notify the physician of critical laboratory results to ensure prompt treatment and services for a resident hospitalized with a diagnosis of acute renal failure.

This failure resulted in Immediate Jeopardy. The facility was notified of the Immediate Jeopardy on April 8, 2008 at 9:30 AM. E1 (Administrator), E2 (Assistant Administrator)and E3 (Director of Nursing) were all present.

Findings include:

R5 is an 84 year old resident who was admitted to the facility on 4/28/04 with diagnoses including hypertension, dementia and diabetes mellitus, According to the most recent resident assessment instrument dated 2/2/08, facility staff identified that R5 has difficulties with long and short term memory recall; and moderately impaired cognitive skills for decision making.

On review of the Lab Order Detail Report Sheet, it was documented that E3 (director of nursing)

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was notified of a critical digoxin level for R5 on 10/11/07 at 10:21 AM. According to the laboratory results, R5 had a digoxin level of 2.4 (0.5 -2.0 normal range).

On review of the Nurses' Progress Notes dated 10/11/07 at 8:00 PM, facility staff documented, "received in report resident digoxin level 2.4 (high)" and "MD paged 2 times during the shift no response." During a telephone interview on 4/7/08 at 1:00 PM, E9 (medical director) stated that he did not recall the facility paging him on 10/11/07.

On review of the Nurses's Progress Notes for the following day (10/12/07 at 7 AM), facility staff documented that R5 had an elevated digoxin level of 2.4. According to the Nurses' Progress note the lab results were "endorsed to 7-3 nurse."

On 10/12/07 at 10:00 AM, facility staff documented that the E9 (physician) was notified of the critical lab results. E9 gave orders for the resident to be transferred to the hospital for an evaluation. R5 was admitted to the hospital with a diagnoses of acute renal failure and digoxin toxicity.

The hospital Nephrology Department Consultation Report dated 10/16/07, confirmed that R5 had an elevated digoxin level of 3.08 on her admission to the hospital; and an abnormal creatinine level of 2.8 (0.4 -1.2 normal range).

The hospital physician documented, "It is possible she has underlying chronic kidney disease from diabetes and hypertension or ischemic nephropathy. There is definitely a component of acute renal failure related to

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volume depletion and ongoing use of nonsteroidal antiinflammatory drugs." The physician suggested that R5 not receive any nonsteroidal antiinflammatory drugs; and to avoid the use of metformin.

R5 was readmitted to the nursing home on 10/17/07. On readmission, the recommendation to avoid Metformin was not followed, as there was documentation to support that R5 was receiving this medication when she returned to the facility. In addition, there were no physician orders for monitoring laboratory results to determine renal function.

After readmission to the nursing home, R5 was not seen by the physician until 11/30/07. On 11/30/07, the physician gave orders for a digoxin level every 3 months, thyroid stimulation hormone levels and a basic metabolic panel. However, these labs were not drawn until 12/6/07.

On review of the laboratory results for 12/6/07, it was documented that R5 had an elevated creatinine level of 2.00 mg/dl. Again, there was no documentation in the Nurses' Progress Notes that the physician was notified of the elevated creatinine level. During an interview on 4/3/08, E3 stated that she faxed a copy of the results to the physician. E3 confirmed during the interview that she did not notify the physician of the laboratory results. E3 failed to immediately notify the physician of the resident's abnormal lab results.

On 12/12/07 at 11 AM, E3 documented that R5 was "slumped over on bed states she doesn't feel well." The physician was notified and the

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resident was transferred to the hospital. R5 was admitted to the hospital with diagnoses including altered mental status, lethargy and renal failure.

According to the facility policy for Physician Notification for Residents Change of Condition, "The resident's primary physician or designated alternate will be notified of any change in resident's physical or mental condition." The facility policy further indicates that critical lab values would be considered a change in condition, which would prompt physician notification. Facility staff failed to follow the policy for physician notification.

Facility staff failed to ensure that the physician is made aware of abnormal laboratory values. The facility's failure to promptly notify the physician, resulted in a delay in treatment and services for a resident who was hospitalized with a diagnosis of acute renal failure.

Although the the Immediate Jeopardy was removed on April 9, 2008, when the facility identified that there were no other residents in the facility at risk, the facility remains out of compliance at a severity level II in order to allow for the implementation of the facility plan of correction for F224 and time for the facility to evaluate the efficacy of their interventions.

The facility took the following action to remove the immediacy:

1. Our Lady of Resurrection Laboratory draws all lab works for this facility. The lab supervisor will monitor all labs for critical values; with any critical

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F 309	Continued From page 19 labs, she will fax them to both the attending physician and this facility. She will also contact them by phone. The facility will also contact the physician by phone. If the attending physician does not respond after two attempts, this facility has a list of three other doctors who have agreed to respond to any contacts in regards to critical labs. 2. Current lab draws will be changed from Thursdays to Wednesdays. A monthly laboratory QA Meeting will be held with the nursing staff and the Medical Director to review all labs. A Quarterly QA meeting will be held with Department Heads, Medical Director, Pharmacy, Lab, Dietary and Facility Consultants. 3. On 4/8/08 the laboratory supervisor has reviewed and provided us with a list of all the critical labs drawn from October 2007 through our last lab draw. Through careful review of all the current resident critical labs results, we found that there were no resident at risk. We will continue to review all past critical labs for proper follow-up. 4. We have developed a new form to ensure that all critical labs were addressed immediately (see enclosure #2). Nursing staff will notify the DON or designee with all critical labs. 5. All nursing staff will be in-services on the new procedures for critical labs by Thursday, 4/9/08 and completed on 4/9/08. Quality Assurance Plan: The DON or designee will complete the critical lab form when any critical labs are received by the facility.	F 309		

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F 309	Continued From page 20 Dates when corrective action will be completed: Completion of corrective action will be 4/9/08. The Director of Nursing will monitor for compliance.	F 309		
F 323 SS=E	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 observation and interviews, the facility has failed to eliminate physical features within the environment that can cause an unexpected, unintended event that could result in bodily harm to a resident by failing to: Findings include: 1) During the initial tour an interview with R1. R1 stated that she has a concern regarding an electrical outlet in her room. R1 stated every time a plug is pulled from the outlet it would spark, R1 stated that this event has been occurring over the past 2 weeks and she has notified the facility. Upon direct observation the electrical outlet mentioned by R1 was brownish burned in color and was the outlet plate has been cracked. The outlet was brought to the attention of E1(facility administrator) and E1 stated he was aware of the	F 323		5/9/08

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F 323	Continued From page 21 problem and the electrician has been in and cut of the power the the mentioned outlet,and would return with parts needed to repair the outlet. 2) During the environmental tour 1 of 2 toilet were observed to be loose and unstable, E5 (maintenance director) and E1 were present. E5 stated he did know the toilet was loose. 2 of 2 toilets observed had the wrong type of toilet seat, both toilets bowls were elongated fitted with standard toilet seats. 3) Upon the environmental tour 10 of 18 handrails were found to be loose and unsteady. 4) During the initial tour a chemical cleaning agent was observed on the over bed table in residents room #10. R1 when interviewed stated that she uses the cleaning agent to disinfect her living area.	F 323		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that a resident with an unplanned weight loss receive the necessary care and services to maintain adequate nutritional health and to prevent further weight loss for 1 of 10 residents (R5), who had no dietary interventions to address a significant	F 325		5/9/08

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weight loss.

Findings include:

R5 is an 84 year old resident who was admitted to the facility on 4/28/04 with diagnoses including hypertension, dementia and diabetes mellitus, According to the most recent resident assessment instrument dated 2/2/08, facility staff identified that R5 has difficulties with long and short term memory recall; and moderately impaired cognitive skills for decision making. According to the resident assessment, R5 does not require assistance with feeding.

On review of the Yearly Weight Record for R5, facility staff documented the weights as follows: 205 lbs. (5/07); 199 lbs. (6/07); 200 lbs. (7/07); 195 lbs. (8/07); 193 lbs. (9/07); 183 lbs. (10/07); 180 lbs. (11/07); 178 lbs (12/07); 173 lbs. (1/08); 180 lbs. (2/08); and 180 lbs. (3/08). According to the documentation, R5 had a weight loss of 25 pounds over a period of 10 months. R5 had a consistent unplanned weight loss that was not addressed by facility staff.

On review of the Nutritional Risk Assessment Note dated 3/8/07, Z1 (former consultant registered dietitian) documented that R5 informed her that she did not like the foods that are served and that she skips meals and will eats snack foods brought in by her family. Z1 further documented that R5 had "poor intake my be related to pain in legs/foot and/or change in mood." Z1 instructed facility staff to 1) continue with the present diet; 2) encourage meal participation; 3) monitor weight, intakes, labs and skin status; 4) encourage intakes of foods/fluids;

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F 325	Continued From page 23 5) add a multivitamin; and 6) refer to registered dietitian as needed. There was no documentation or evidence that facility staff implemented any of the above dietary recommendations. On review of the Yearly Weight Record, R5 continued to lose weight. According to the Consultant Dietitian Progress Notes dated 9/6/07, Z1 documented that R5 has had, "weight loss in the past 6 months; but no significant weight changes in the past 1 or 3 months." Z1 failed to implement dietary approaches to address the resident's unplanned weight loss. On 4/1/08, 4/2/08 and 4/3/08, R5 was observed in bed resting during the lunch meal. R5 stated that she did not want anything to eat; and reported that she was not feeling well. There were no observations of facility staff encouraging the resident to participate in meals. During an interview on 4/7/08 at approximately 10:45 AM, E2 (assistant administrator) stated that Z1 no longer works for the facility; and that she was last at the facility September 2007. According to E2, the new consultant registered dietitian (E8) started working for the facility February 2008. E2 confirmed during the interview that the facility was without a registered dietitian for 5 months. The facility failed to employee the services to a registered dietitian. This resulted in the facility's failure to ensure that R5's unplanned weight loss is addressed in an effort to promote adequate nutritional health and to prevent further weight loss.	F 325		
F 332	483.25(m)(1) MEDICATION ERRORS	F 332		5/9/08

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F 332 SS=D	Continued From page 24 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and a reconciliation of physician orders against the actual medications observed administered, the facility failed to ensure that they are free of a medication error rate that is not greater than 5%. There were 42 opportunities observed, with a total of 3 errors which resulted in a medication error rate of 7.14% for 3 of 3 sampled residents (R11, R7 and R12). Findings include: On 04/01/08 during medication pass accompanied by E3 (director of nurses) that began at 9:50am and ended at 3:00pm, the following was noted: - At 10:50am, E3 was observed to administer Lopid 600mg. one tablet by mouth to (R11). At the time, the resident remained in bed and complained of being tired and did not eat breakfast. A review of the current physician orders states, "Lopid 600mg. tab by mouth twice a day (BID), thirty minutes before meal." Interview with E3 about administering Lopid to the resident, and the resident refused to eat. E3 stated, "I gave him (R11) the medication because I was under the assumption he was going to eat this morning. I'm talking about Cholesterol pill." - During the afternoon medication pass, E3 was	F 332		

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F 332	Continued From page 25 observed to administer Calcium 500mg. one tablet (chewable) and Apresoline/Hydralazine 25mg. one tablet to (R7) at 2:00pm. The resident was given both pills in a cup with a glass of water and R7 swallowed them without any food. However, the chewable tablet was swallowed along with the un-chewable table. The current physician order is to give Calcium 500mg. (Carbonate) tablet by mouth (three times a day/8am, 1pm, 4pm) TID with meals; and Hydralazine 25mg. one tablet by mouth (four times a day/6am, 1pm,6pm, 10pm) QID. E3 was asked about R7 swallowing a chewable tablet, and the medication that was not given with food. E3 stated, "He (R7) had been taking the chewable and swallowing it. He ate lunch at the program. I will get an order to have the 12:00pm med changed when he goes out to the program." - E3 administered two consecutive drops to (R12's) right eye, and then two drops to the left eye, without a wait time frame between the administration of the drops. R12's current physician is Artificial Tears, instill two drops into each eye (four times a day/6am, 1pm, 5pm,9pm) (QID). On 04/02/08 at 10:00am E3 responded to not waiting at least three minutes between eye drop administration by saying, "I didn't wait long enough."	F 332		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National	F 363		5/9/08

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F 363	Continued From page 26 Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based upon observations, record and staff interviews the facility failed to ensure that the menus for the lunch meal were followed. Findings Include: During the lunch meal observations for Monday 4/1/08 at approximately 10:15am after surveyor observed the absence of several items on the menu, E6 (food service supervisor) stated," we do not have some of the foods that are on the recipe and the menu." The facility identified lunch menu in part specified," Beef Stew with Potatoes and Peas; Green Peppers Slaw; Tapioca Pudding; Buttermilk biscuit" Observations revealed the absence of the following ingredients for the lunch meal and confirmed by the interview of E6 who stated," for the beef stew, we do not have vegetable oil; canned tomato puree; crumbled bay leaf; celery fresh chopped; frozen peas; frozen diced carrots; and frozen diced potatoes. We do not have buttermilk biscuits, tapioca pudding also, I will send to the store and get them. We are waiting for our shipment." E6 was interviewed on 4/1/08 regarding the ingredients for the dinner meal for 4/1/08 that depicted taco salad/ground beef; tomato/lettuce/cheese; tortilla rounds; bananas	F 363		

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F 363	Continued From page 27 and pineapple with marshmallows, and replied,"We only have the ground beef."	F 363		
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based upon observations, record review and staff interviews the facility failed to provide mental health services for 2 (R8 and R9) of 10 residents in sample. Findings Include: 1. R8 was admitted to the facility with a diagnosis including Schizoaffective. R8 was observed on 4/1/08 through 4/3/08 seated in lobby. R8 expressed a concern regarding loss of contact with son, and asked for assistance. R8 is not on the facility list for day programs, and stated," I get anxious around people..I am schizoid." E7(social worker) was interviewed on 4/2/08 and stated," I am trying to find her son, and we are having someone to come in and assess 8 for a program to help her."	F 406		5/9/08

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F 406	Continued From page 28 2. R9 was admitted to the facility with a diagnosis including Bipolar. R9 was observed on 4/2/08 through 4/3/08 seated in day room watching tv in the same seat. . R9 expresses inappropriate behavior toward others when approached. R9 is an identified offender with statute citation including (theft, unlawful use of weapon criminal trespass vehicle,). R9 has a incident of altercation with staff dated 12/06/08. R9 physician order form indicates R9 may go to day program x 6 days a week, R9 has been observed in the facility day room 2 consecutive days watching television. R9 is not on the facility list for day programs and he only grunted when asked if he would like to attend.	F 406		
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure that resident rooms meet the minimum required square footage of 80 square feet in multiple resident bedrooms. The findings include: 1) Resident room 11, a 3 bed room, was measured to provide 66 square feet per resident bed. 2) Resident room 12, a 3 bed room, was measured to provide 74 square feet per resident bed.	F 458		

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F 492 SS=F	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 interviews, the facility failed to operate in compliance with State laws and regulations. Findings include: On review of the employee personnel files for 8 of 8 recently hired certified nursing assistants, it was determined that there was no documentation to support that the facility staff obtained employee Health Care Worker Background Checks within 10 days of hire, as required by the State regulation. During an interview on 4/3/08, E2 (assistant administrator) confirmed that she had not submitted the necessary documents to obtain background check information for recently hired employees. During an interview on 4/8/08, it was determined that E2 was not aware that the background checks should be initiated within 10 days of hire.	F 492		5/9/08
F 496 SS=F	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification	F 496		5/9/08

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that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

This REQUIREMENT is not met as evidenced by:
Based on review of facility personnel records and interviews, the facility failed to verify that individuals allowed to work as nursing assistants have met competency requirements, for 8 of 8 employee records reviewed.

Findings include:

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F 496	Continued From page 31 On 4/3/08, facility staff presented 8 personnel records for the most recently hired certified nursing assistants. On review of the records, it was determined that there was no information regarding the competency status. During an interview, E2 (assistant administrator) stated that E3 (director of nursing) was responsible for obtaining information to determine if competency has been met. During an interview E3 stated that she had obtained information from the nurse aide registry regarding competency status, but was not able to explain the method (telephone confirmation or Internet) that she used to obtain this information. E3 was not able to present documentation that the facility determined competency status for the most recently hired certified nursing assistants.	F 496		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated	F9999		

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thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.
2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

Section 300.1010 Medical Care Policies
h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care
a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on observation, record review, and interview the facility failed to provide the necessary care and services for 1 of 10 sampled residents (R5), by failing to notify the physician of critical laboratory results to ensure prompt treatment and services for a resident hospitalized with a diagnosis of acute renal failure.

Findings include:

R5 is an 84 year old resident who was admitted to the facility on 4/28/04 with diagnoses including hypertension, dementia and diabetes mellitus. According to the most recent resident assessment instrument dated 2/2/08, facility staff identified that R5 has difficulties with long and short term memory recall, and moderately impaired cognitive skills for decision making.

In the Lab Order Detail Report Sheet it was documented that E3 (director of nursing) was notified of a critical digoxin level for R5 on 10/11/07 at 10:21 AM. According to the laboratory results, R5 had a digoxin level of 2.4 (0.5 -2.0 normal range).

In the Nurses' Progress Notes dated 10/11/07 at 8:00 PM, facility staff documented, "received in report resident digoxin level 2.4 (high)" and "MD paged 2 times during the shift no response." During a telephone interview on 4/7/08 at 1:00 PM, E9 (medical director) stated that he did not

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recall the facility paging him on 10/11/07.

In the Nurses' Progress Notes for the following day (10/12/07 at 7:00 AM), facility staff documented that R5 had an elevated digoxin level of 2.4. According to the Nurses' Progress note the lab results were "endorsed to 7-3 nurse."

On 10/12/07 at 10:00 AM, facility staff documented that the E9 (physician) was notified of the critical lab results. E9 gave orders for the resident to be transferred to the hospital for an evaluation. R5 was admitted to the hospital with a diagnoses of acute renal failure and digoxin toxicity.

The hospital Nephrology Department Consultation Report dated 10/16/07, confirmed that R5 had an elevated digoxin level of 3.08 on her admission to the hospital; and an abnormal creatinine level of 2.8 (0.4 -1.2 normal range).

The hospital physician documented, "It is possible she has underlying chronic kidney disease from diabetes and hypertension or ischemic nephropathy. There is definitely a component of acute renal failure related to volume depletion and ongoing use of nonsteroidal antiinflammatory drugs." The physician suggested that R5 not receive any nonsteroidal antiinflammatory drugs; and to avoid the use of metformin.

R5 was readmitted to the nursing home on 10/17/07. On readmission, the recommendation to avoid Metformin was not followed, as there was documentation to support that R5 was receiving this medication when she returned to the facility. In addition, there were no physician

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orders for monitoring laboratory results to determine renal function.

After readmission to the nursing home, R5 was not seen by the physician until 11/30/07. On 11/30/07, the physician gave orders for a digoxin level every 3 months, thyroid stimulation hormone levels and a basic metabolic panel. However, these labs were not drawn until 12/6/07.

On review of the laboratory results for 12/6/07, it was documented that R5 had an elevated creatinine level of 2.00 mg/dl. Again, there was no documentation in the Nurses' Progress Notes that the physician was notified of the elevated creatinine level. During an interview on 4/3/08, E3 stated that she faxed a copy of the results to the physician. E3 confirmed during the interview that she did not notify the physician of the laboratory results. E3 failed to immediately notify the physician of the resident's abnormal lab results.

On 12/12/07 at 11 AM, E3 documented that R5 was "slumped over on bed states she doesn't feel well." The physician was notified and the resident was transferred to the hospital. R5 was admitted to the hospital with diagnoses including altered mental status, lethargy and renal failure.

According to the facility policy for Physician Notification for Residents Change of Condition, "The resident's primary physician or designated alternate will be notified of any change in resident's physical or mental condition." The facility policy further indicates that critical lab values would be considered a change in condition, which would prompt physician

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F9999	Continued From page 36 notification. Facility staff failed to follow the policy for physician notification. Facility staff failed to ensure that the physician is made aware of abnormal laboratory values. The facility's failure to promptly notify the physician, resulted in a delay in treatment and services for a resident who was hospitalized with a diagnosis of acute renal failure. (A)	F9999		