New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING ______ B. WING ______	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	**1235 PELHAM PARKWAY NORTH BRONX, NY 10469**

(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) COMPLETE DATE
I260 SS=E	415.26 Organization and Administration This Regulation is not met as evidenced by: Physical Plant Violation - State Only NYCRR 710.1 (c) The erection, building, acquisition, alteration, reconstruction, improvement, extension or modification of a medical facility, including its equipment and services shall be governed by the following: (5) Proposals requiring a prior review limited to architectural and engineering matters. (i)(a) Proposals where total project cost does not exceed $3,000,000, and for which a certificate of need is not otherwise required under this Part, shall be subject to review under Article 28 of the Public Health Law limited to a determination of whether the proposal is consistent with applicable statutes, codes, rules and regulations relating to the structural, architectural, engineering, environmental, safety and sanitary requirement of licensed medical facilities where the proposal relates to the acquisition, relocation, installation or modification of: (1) medical equipment involving ionizing radiation or magnetic resonance; (2) facility areas relating to surgical or other invasive procedures, not otherwise requiring approval under this section; (3) inpatient units, relating to other than routine maintenance and repairs of routine purchase of equipment; and	I260		7/2/08

Office of Health Systems Management / Office of Long Term Care

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I260	Continued From page 1 (4) heating, ventilating, air conditioning, plumbing, electrical, water supply, fixed dietary, solid waste and/or sewage disposal, and fire protection systems, other than routine maintenance and repairs or routine purchases affecting such systems. NYCRR 710.7 Approval to start construction. (a) The applicant may seek approval to start construction of the project, or one or more phases thereof, upon the filing with the department completed contract documents consistent with all previous approvals. (b) If documents are not completed, the applicant may request approval to start construction upon submission of a certification by the applicant, construction manager or contractor, and the architect that completed working drawings and specifications shall be submitted within a time period specified in the applicant's request, that such construction shall be undertaken at the applicant's risk and that approval is understood to be contingent upon submission of the completed documents as a no-cost change order. (c) A request by the applicant pursuant to subdivision (a) or (b) of this section shall include an affidavit by the applicant's architect or engineer that the drawings: (1) are consistent with schematic and design development drawings previously approved and, if not, the affidavit shall identify the changes and reasons for such changes; and (2) are in compliance with the applicable provisions of this Title and all applicable local	I260		

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I260	Continued From page 2 codes, statutes and regulations. In addition, the applicant shall submit an up-dated functional stack diagram consistent with section 710.2(b)(10)(i)(b) of this Part. (d) When the submission under subdivision (a) or (b) of this section is deemed complete by the department, the applicant shall be advised in writing to commence construction pursuant to this Part. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that the physical environment was maintained in a safe manner in accordance with State requirements in that: 1. The facility did not file an architectural limited review in accordance with NYCRR 710.1, 710.7 and receive approval prior to commencing renovations. This was evidenced by the ongoing replacement of the second and third floor call bell system due to the system malfunctioning. 2. A safety plan had not been submitted to the New York State Department of Health (NYSDOH) for approval prior to work commencing. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings are: 1. During the initial environmental tour on 6/04/08 at 10:00 AM, it was noted that the facility was in the process of replacing the call bell system on the 2nd floor. In an interview at that time, the	I260		

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I260	Continued From page 3 Maintenance Director stated that problems with the call bell system had been noted since October or November of 2007, i.e. shorts in the system, but that he was no longer able to make all of the necessary repairs himself. He further stated that the call bell system on the 3rd floor would be replaced once the 2nd floor installation had been completed. In an interview at 8:30 AM on 6/5/08, the Administrator stated that a proposal for the replacement of the call bells had been received in October 2007. The call bell system on the 1st floor had been replaced about 3 months ago. However, he further stated that, because the only manufacturer of the call bell parts had relocated to Mexico, it had taken about 5 months to get all of the parts necessary to complete the installation on the 2nd and 3rd floors. The Administrator also stated that he had not submitted a limited review application to Albany and had not submitted a safety plan to the regional office of the NYSDOH for approval because he was replacing the existing system with the same exact parts. 10 NYCRR 710.1, 710.7 10 NYCRR 415.29	I260		
I310 SS=C	415.29 Physical Environment This Regulation is not met as evidenced by: NYCRR 415.29 (j)(6) Waste: (ii) facilities shall manage regulated medical waste in accordance with the provisions of Part 70 of this Title. 70-2.2 Containment and storage. (f) Regulated medical waste, with the exception of sharps as provided in subdivision (e) above, may be held in patient care areas for a period not	I310		7/11/08

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I310	Continued From page 4 to exceed twenty-four (24) hours and at a clinical laboratory for a period not to exceed seventy-two (72) hours, at which time the waste shall be moved to a storage area. (3) Regulated medical waste shall not be stored for a period exceeding thirty (30) days, except that a site generating under fifty (50) pounds of regulated medical waste per month and not accepting regulated medical waste for treatment from other facilities, may store waste for a period not exceeding sixty (60) days. Based on observation, record review and interviews, it was determined that the facility did not store regulated medical waste in accordance with Part 70 10NYCRR. This was evidenced by the regulated medical waste stored in the regulated medical waste room for over 30 days. This resulted in no actual harm with the potential for minimal harm. Findings are: On 6/09/08, at 12:30 PM during review of the facility's records, it was noted that regulated medical waste was not picked up for the following months since June 2007: October 2007, November 2007, February 2008, and May 2008. In an interview with the Director of Maintenance on 6/09/08 at 12:35 PM acknowledged that the waste was not picked up for those months. 10 NYCRR Part 70-2.2	I310		

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{I260} SS=E	415.26 Organization and Administration This Regulation is not met as evidenced by:	{I260}		7/2/08
{I310} SS=C	415.29 Physical Environment This Regulation is not met as evidenced by:	{I310}		7/11/08

Office of Health Systems Management / Office of Long Term Care

TITLE (X6) DATE

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{F 221} SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	{F 221}		7/11/08
{F 226} SS=D	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:	{F 226}		7/11/08
{F 250} SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 250}		7/11/08
{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:	{F 253}		7/11/08

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{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:	{F 281}		7/11/08
{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:	{F 323}		7/11/08
{F 329} SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	{F 329}		7/11/08

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{F 329}	Continued From page 2 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	{F 329}		
{F 365} SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	{F 365}		7/11/08
{F 371} SS=E	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:	{F 371}		7/11/08
{F 428} SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	{F 428}		7/11/08

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{F 428}	Continued From page 3 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	{F 428}		
{F 463} SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	{F 463}		7/11/08
{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:	{F 490}		

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F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS	F 221		7/11/08

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interview, the facility did not ensure that physical restraints in use were the least restrictive devices and that they were utilized for the least amount of time necessary. Specifically, (1) two full siderails were assessed as a enabler and not considered a restraining device for 7 of 30 residents (# 1,12,14,16,17,19, 20); (2) A resident's merry walker (a chair that assists in ambulation) was not released during mealtime for 1 of 3 residents reviewed for merry walkers.

This resulted in no actual harm with a pattern for potential for more than minimal harm that is not immediate jeopardy.

Findings include but not limited to:

SideRails

1a. Resident #12 has diagnoses including Dementia.

The resident's most current Minimum Data Set (MDS) (an assessment tool) dated 4/23/08 documented that the resident's cognitive skills for daily decision making as moderately impaired.

On 6/5/08, at 10:30AM, 2 full siderails were observed on the resident's bed. At that time, the

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RN (Registered Nurse) Unit Manager was interviewed The RN stated that the resident had 2 full siderails to assist him in turning in bed. She was unable to explain why there were no attempts to reduce the 2 full siderails to 2 half siderails.

A review of the resident's Bed Mobility and SideRail Assessment indicates that the resident was assessed for siderails on 10/27/07, 1/27/08, 4/28/08 and 5/8/08 and noted that the resident needed 2 full siderails for turning in bed. The document further noted that there were no attempts made to reduce or discontinue the 2 full siderails.

On 6/6/08 at 2:30PM, the Physical Therapist was interviewed. He was told that a number of residents were observed in bed with 2 full siderails on 6/5/08 at 7:30AM. The Physical Therapist stated that the Interdisciplinary Team assesses each resident for bed mobility and the siderails on a quarterly basis. He further stated that a number of residents use the 2 full siderails as enablers to turn and position in bed and that the facility does not consider them to be restraints. He was unaware if attempts were ever made to reduce the 2 full siderails to 2 half siderails for residents utilizing them as enablers.

On 6/9/08 at 8:30AM, 2 half siderails were observed on Resident #12's bed. At that time, the RN, Unit Supervisor was asked when the 2 full siderails were reduced to 2 half siderails. The RN stated that the physician wrote an order on 6/8/08 and they were replaced the same day.

1b. Resident # 17 has diagnoses including Dementia.

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Continued From page 2

The resident's most current MDS dated 5/19/08 documented the resident's cognitive skills for daily decision making as moderately impaired.

A review of the resident's Bed Mobility and SideRail Assessment documents that the resident was assessed for siderails on 12/7/07,1/12/08,2/12/08, 3/6/08 and 4/08. The document further noted that 2 full siderails were used as an enabler and no attempts were made to reduce or eliminate the 2 full siderails.

On 6/9/08 at 10:00AM, the resident was observed in bed with 2 half siderails. The RN, Unit Manager was interviewed at that time, she stated that a number of resident beds with 2 full siderails were replaced with 2 half siderails, yesterday(6/8/08). The RN further stated the resident needs the 2 siderails to turn herself in bed but prior to 6/8/08 there had been no attempts to reduce the 2 full siderails to 2 half siderails.

Merry Walker

2. Resident #22 has diagnoses that include Dementia and Psychosis.

The resident was observed on 6/9/08 at 5:40PM eating her supper meal sitting in a merry walker. At that time, a Certified Nurse Aide (CNA) was asked, why the resident was eating her meal sitting in a merry walker and not a straight back chair. The CNA stated that she had attempted to place the resident in a straight back chair but the resident was restless and they have a lot of residents on the unit to hand feed.

On 6/10/08, at 7:30AM, the resident was observed inside the unit dining room being

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F 221	Continued From page 3 transferred from her merry walker to a straight back chair. The resident calmly sat in the straight back chair and proceeded to eat her meal. A review of the facility's policy for a Merry Walker Device notes that a Merry Walker is not to be used during meals, care and activities unless otherwise indicated by the interdisciplinary team. A review of the resident's care plan for ambulation dated 4/8/08 indicated that the merry walker was initiated on 1/2/08 to assist with ambulation. There was no documentation that the resident is to remain in a merry walker during meal time or any other time, if she is restless. 415.4(a)(2-7)	F 221		
F 226 SS=D	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 interview, the facility did not fully operationalize the identification, investigation and protection components of the abuse prohibition protocol. Specifically, the facility did not thorougly investigate and identify a case of resident to resident abuse. The facility did not develop a plan to protect Resident #18(victim) from resident to resident abuse or a plan for preventing Resident #9(abuser)from further aggressive behavior towards Resident #18(victim) and other residents. This was evident for 2 of 29 sampled	F 226		7/11/08

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residents (Resident# 9,18).

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Findings are:

1. Resident # 18 is an 88 year old female with diagnoses including Alzheimer's Dementia. A review of the Minimum Data Set (an assessment tool) revealed that her cognition is moderately impaired and there is symptomology of a mood disturbance, (i.e.; restlessness,anxious,sadness). Additionally, she is dependent on others for all activities of daily living and had been assessed by the multidisciplinary team to be appropriate for the use of a merrywalker (a restraint-type device that allows for ambulatory mobility).

A review of the Nurses Notes from January 2008 through April 2008 revealed an entry dated 2/21/08 describing an incident of resident to resident physical abuse. A review of the corresponding " Incident/Accident Report"(I/A) revealed that this had occurred at 1:20 PM on 2/21/08 in the dayroom area . The CNA (certified nursing assistant) assigned to supervise this area wrote a written report for the investigation stating that Resident #18 (victim) was sitting inside the merry walker when Resident # 9 (abuser) quickly rolled his wheelchair over to her and hit her in the face. The resident sustained an abrasion to the bridge of the nose and a discolored and swollen area to the right eye. Review of the I/A revealed the investigation was incomplete as the conclusion on the report was "no neglect/abuse" and the section which states "recommendations in order to prevent this from

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F 226	Continued From page 5 happening again" was left blank. . A review of Resident # 9 Nurse's Notes and Integrated Behavior Notes from November 2007 through April 23,2008 revealed several acts of physical violence against staff providing cares to him. A review of the 5/7/08 Comprehensive Care Plan for Resident # 9 provided no documented evidence that the plan of care was revised and implemented following the 2/21/08 episode with Resident #18 to prevent aggressive behavior towards Resident #18 and other residents. A review of the Comprehensive Care Plans for Resident # 18 revealed no documented evidence that the facility had operationalized the abuse prohibition policy to maintain a safe environment for Resident #18 and other residents who were in close proximity to Resident #9. An interview with the Director of Nursing (DON) on 6/9/08 in the morning revealed that both resident's were maintained on 30 minute visual observation checks as were all resident's who displayed any behavioral symptoms. She was unable to explain why an observation by the surveyor revealed both these resident's in close proximity to each other without staff supervision or why there were no updated care plans to protect and prevent Resident # 18 from physical abuse. 415.4(b)	F 226		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest	F 250		7/11/08

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practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews the facility did not ensure the provision of medically related social services to attain the highest practicable mental and psychosocial well-being for residents. Specifically, the Social Worker did not assess or counsel 2 residents involved in resident to resident abuse. This was evident for 2 out of 29 sampled residents (Resident # 9,18).

This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The findings are:

1. Resident # 18 is an 88 year old female with diagnoses including Alzheimer's Dementia. A review of the Minimum Data Set (an assessment tool) revealed that her cognition is moderately impaired and there is symptomology of a mood disturbance, (i.e.; restlessness, anxiety, sad, worried). Additionally, she is dependent on others for all activities of daily living.

A review of the Nurses Notes revealed an entry dated 2/21/08 describing an incident of resident to resident physical abuse. A review of the corresponding Incident/Accident Report investigation revealed that this incident occurred at 1:20 PM on 2/21/08 in the dayroom area. The CNA (certified nursing assistant) assigned to supervise the dayroom area wrote a written report

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for this investigation stating that Resident # 18 was sitting inside the merrywalker, when Resident # 9 (abuser) quickly rolled his wheelchair over to her and hit her in the face. The resident sustained an abrasion to the bridge of the nose and a discolored and swollen area to the right eye .

The Social Services notes were reviewed for February 2008 through June 2008 and showed no documented evidence that the Social Worker had assessed or counseled the resident or had been aware of this incident of physical abuse towards the resident. Additionally, a review of the quarterly "Social Service Evaluation" form done on 4/29/08 revealed no documented evidence that this incident had been acknowledged by the Social Worker or that there had been an assessment performed to determine if any emotional trauma was experienced by the resident.

An interview with the Social Worker on 6/10/08 at 11:00 AM revealed that she had no knowledge of this incident of physical abuse. She stated she had not read the Nurse's Notes prior to writing up the quarterly evaluation report for 4/29/08, therefore her quarterly evaluation was lacking information with concerns to this incident.

2. Resident # 9 is a 67 year old male with diagnoses including dementia. A review of the Minimum Data Set (an assessment tool) dated 4/29/08 revealed that he had exhibited behaviors of agitation,anger and physical aggression/abuse towards others.

A review of the Nurse's Notes from November 2007 through June 9, 2008 revealed an entry dated 2/21/08 describing an incident, in which

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F 250	Continued From page 8 Resident #9 physically abused Resident # 18. Additionally, there were several entries made during this time describing acts of physical violence from Resident #9 towards the staff caring for him. A review of the " Integrated Behavior Notes" from November 2007 through May 2008 revealed several documented entries made describing episodes of physical violence towards staff. A review of Social Service Notes reviewed from November 2007 through June 9, 2008 revealed no documented evidence that this resident's violent behaviors were being addressed or acknowledged. Further review of the quarterly "Social Service Evaluation" dated 4/29/08 revealed that the Social Worker described the resident's mood/behavior as stable. An interview with the Social Worker on 6/9/08 at 11:00 AM revealed that she was completely unaware of the violent behaviors of this resident towards staff and Resident #18. The Social Worker further stated that she had not reviewed Nurses Notes or met with the resident at anytime since his admission on 10/30/07. 415.5(g)(1)(i-xv)	F 250		
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 observation and staff interview, the	F 253		7/11/08

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F 253	Continued From page 9 facility did not ensure that all resident rooms and common areas were maintained in a sanitary condition. This was evidenced by: 1. Floors were heavily soiled with dirt, dust, debris and paper wrappers. 2. Resident furnishings and equipment were soiled with dirt, dust and debris. 3. Pantry freezer compartments and pantry counter tops were soiled. These conditions were noted on 4 of 5 resident units and common areas (floors 1, 3, 4, 5). This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include but are not limited to: During environmental rounds on 6/4/08 between 8:15 AM and 12:30 PM, the following unsanitary conditions were noted: 1. Floors in resident rooms and common areas on 3 of 5 floors (floors 1, 3 and 4) were noted to be soiled with dirt, dust, food remnants, and a sticky substance. Examples include but are not limited to: the 1st floor pantry, resident rooms # 316, 318, 319, 3rd floor shower stall, 403, 406, 413, the corridor outside 416 and 417, and the floor near the 4th floor elevators. In an interview at 11:25 AM on 6/4/08, a housekeeper on the 3rd floor stated that the floors are cleaned daily. 2. Resident furnishings and resident use equipment were soiled with dirt, dust and a sticky foreign substance. Examples include but are not limited to: (a) The following over the sink light fixture pull	F 253		

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F 253	Continued From page 10 cords were soiled and sticky: resident rooms # 304, 305, 307, 308, 310, 314, 315. (b) Numerous call bell cords were noted to be dirty and sticky. Examples include but are not limited to: resident rooms # 301A and B, 304A and B, 308, 311A and B, 315A and B. (c) Overbed tables used during meals to assist with the feeding of residents were noted to be soiled with encrusted foreign substances on the table surfaces and metal stands. This was observed in the 1st floor dining room and for 10 of 14 tables in the 5th floor dining room. (d) The counter tops, bottles of hair products and floor in the 1st floor beauty parlor were soiled with a layer of dust and a sticky foreign substance. (e) The ceiling-mounted smoke detector in room # 315 was coated with a thick layer of dust. (f) The furniture in resident rooms # 304 and 317 were coated with a thick layer of dust, including the televisions, a radio and a shelf. 3. Pantry freezers, floors and counter tops were soiled with old food spills, dirt, and dust. Examples include but are not limited to: - First and fifth floor pantry freezer compartments were soiled with old frozen spills. - The perimeter of the sink and the adjacent counter top were soiled with a black foreign substance. Interview with the Director of Nursing at 9:30 AM on 6/7/08 revealed that she was unaware of the unsanitary conditions. NYCRR 415.29(j)(1)	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.	F 281		7/11/08

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility did not ensure that the Licensed Practical Nurse (LPN) observed Professional Standards of Practice in regards to the security of medications and implementation of physician orders. Specifically, (1) the LPN gave a ring of keys,including the keys to the medication room, medication cart, and narcotic box, to a Certified Nurse Assistant (CNA), (2) the treatment LPN did not apply the Collagenase on to the resident's wound as ordered by the physician, the LPN applied Collagenase (an enzymatic debriding ointment) to the Stage 3 ulcer as well as to the outside of the wound bed. This was evident for 1 of 29 sampled residents (Resident #1).

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Findings are:

1. During medication pass observation on the third floor unit on 6/5/08 at 9:00AM, the medication LPN was observed in the unit hallway at this time, preparing medications. During this time, a unit CNA requested the medication LPN's ring of keys. The medication LPN was observed to give the CNA the ring of keys. The CNA was observed to walk down the hallway with the keys away from the LPN.

Following Surveyor intervention, the CNA immediately returned the keys to the Medication LPN. Upon interview with the LPN at that time, as

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F 281	Continued From page 12 to why he gave the keys to the CNA, he replied that the CNA needed the key to open the soiled utility room (this key was included on the key ring). When the LPN was asked what keys were on the key ring, he replied that it contained all the keys to all the doors on the third floor unit, including the medication room, medication cart, and narcotic cabinet. He stated that he should not have given the CNA the medication keys, but that there were no extra keys on the unit to open the soiled utility room. The facility policy states re: Storage of Pharmaceuticals " a licensed nurse shall retain the (medication) key at all times" and further states "only the Charge Nurse or the RN Supervisor has access to the (medicine) cart and (medicine) cabinets. The Charge Nurse is responsible to assure the security of these cabinets." 2. Review of the physician's order on 5/21/08 for the treatment of Stage 3 ulcer was to apply Collagenase to the right leg ulcer site for Resident #1. During an observation of a dressing change for Resident #1 on 6/6/08 at 9:30AM, the treatment LPN applied the Collagenase ointment to the Stage 3 wound bed and to the skin surrounding it as well. This is contradictory to the physician's order. According to the manufacturer's information precautions state " the ointment should be applied carefully within the area of the wound, as transient erythema can occur in the surrounding tissue". 415.11(c)(3)(i)	F 281		
F 323	483.25(h) ACCIDENTS AND SUPERVISION	F 323		7/11/08

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F 323 SS=K	Continued From page 13 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, interview and record review, the facility did not ensure that the resident environment remains as free of accident hazards as possible as well as not providing adequate supervision and assistive devices related to the facility's call bell system of 2 for 5 resident floors (2 and 3) not being functional. Additionally, residents did not receive adequate supervision and assistive devices necessary to prevent accidents and injuries related to the presence of potentially dangerous items within the reach of residents with impaired judgement (i.e. cognitively impaired residents with wandering behavior). This was evidenced by: 1.) The resident call bell system on 2 of 5 nursing units (floors 2 and 3) was noted to have significant malfunctions and no alternative communications system was in place to compensate for the lack of a functioning system so that residents can obtain assistance. 2.) Wandering, cognitively impaired residents had access to: a. Unlocked and accessible electrical circuit breaker panel doors; b. An unlocked and unsupervised janitor's closet	F 323		

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containing potentially hazardous cleaning chemicals; and
c. Unattended steam tables.

This resulted in the potential for more than minimal harm that is Immediate Jeopardy and Substandard Quality of Care.

Findings are:

A sample of call bells on the 2nd and 3rd floors were tested at 11:30 AM on 6/4/08. The following was noted:
- The dome lights over the doors at rooms #302 and 303 did not work.
- Activation of the toilet call bell in room #314 resulted in the dome light over room #320 lighting only. Activation of other toilet call bells on the unit also resulted with the dome light over room #320 lighting.
- Activation of the 3rd floor tub room toilet call bell resulted in the activation of the room #14 button at the nurse's station in lieu of the button for the tub room.
- The panels in the medications room on the 2nd and 3rd floor had not been connected to the call bell system.

All of the call bells on the 2nd and 3rd floor were tested between 10:30 AM - 11:30 AM on 6/5/08 and the following was noted:

2nd floor:
- Eight of twenty bedside call bells lit above the door and rang but did not light at the nurse call bell panel.
- Five of fifteen toilet call bells did not light at the nurse call bell panel (most resident rooms have shared toilets between two rooms).

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F 323	Continued From page 15 These conditions affected twenty-four of thirty-eight residents on the 2nd floor. Additionally, two of two tub room toilets did not light at the nurse call bell panel. 3rd Floor: - Four of twenty bedside call bells did not light at the nurse call bell panel while two of twenty bedside call bells lit at an un-numbered button on the nurse call bell panel. - Five of fifteen toilet call bells did not ring at the nurse call bell panel. - Nine of fifteen toilet call bells lit at multiple resident room dome lights and multiple buttons on the nurse call bell panel and/or the wrong button on the panel. These conditions affected thirty-four of thirty-eight residents on the 3rd floor. Additionally, two of two tub room toilet call bells lit at the tub room call bell button as well as the buttons for rooms # 503 and 514 on the nurse call bell panel. Interviews were conducted with the 2nd and 3rd floor staff on 6/5/08 between 10:30 AM and 11:30 AM regarding how they would identify the location of a resident calling for assistance. A 2nd floor Certified Nurse's Aide (CNA) and the unit Charge Nurse stated that they would get up and check in the corridor for the location of the activated call bell light above residents' doors. The 3rd floor Charge nurse, as well as another nurse and a CNA also stated that they would check in the corridor for which light was activated above a resident's door. These staff members were unable to explain how they would identify the source of the call if either multiple lights were lit up simultaneously or, conversely, if only a signal had been received but no lights were lit up.	F 323		

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In an interview at 3:05 PM on 6/5/08, the Maintenance Director stated that problems with the call bell system had started to build up in November or December of 2007, i.e. a few call bells had malfunctioned. Although he had been able to fix the call bells at first, the Maintenance Director stated that he was unable to repair the call bells when the lights malfunctioned.

In an interview at 2:45 PM on 6/5/08, the Assistant Administrator stated that it is the facility's policy to provide hand-held "tea" bells for residents in the event of a call bell malfunction. The facility's residents had not been provided with a temporary, alternate means of communicating distress or need for assistance with the nursing staff, during the time period from November 2007 to June 2008.

Upon surveyor intervention, the facility began installing personal magnetic tab monitors (i.e. the type used for monitoring residents at risk for falling) on the 2nd and 3rd floors, as per interview with the Assistant Administrator at 3:15 PM on 6/5/08.

Immediate jeopardy was identified on 6/5/08 due to the fact that problems with the call bell system had been identified by the facility back in October 2007, but had not been addressed in a timely manner. Additionally, the facility did not implement an alternative communication system for residents to alert nursing staff when in need of assistance/supervision or in the event of an emergency.

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MORRIS PARK NURSING AND REHAB CENTER	**1235 PELHAM PARKWAY NORTH** **BRONX, NY 10469**

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2.) Wandering, cognitively impaired residents had access to:
a. Unlocked, open electrical circuit breaker panel doors were noted on
5 of 5 resident units (floors 1 - 5).
The following was noted:

During environmental rounds from 6/4/08 through 6/9/08 between 8:00 AM and 4:00 PM, it was noted that each resident floor is equipped with two electrical circuit breaker panels located directly outside of the day rooms and adjacent to the pay phones. The panels were located approximately 4 to 5 feet above the floor and were provided with plastic wrap tie locking straps. All of the ties were either cut or disengaged and the panel doors were open and accessible to unauthorized personnel and confused residents. Residents were observed to be sitting directly under these unlocked panels throughout the survey.

In an interview at 9:45 AM on 6/4/08, the Maintenance Director stated that he would look into installing locks with a master key for each circuit breaker panel.

b. The 3rd floor janitor's closet door was unlocked and the room, which contained cleaning chemicals, was unsupervised. The following was noted:
At 8:10 AM on 6/9/08, the door to the 3rd floor janitor's closet was unlocked, open and the closet was unattended. The closet contained potentially hazardous chemicals. The chemicals included spray buff, bleach cleanser, Tilex mildew remover, and Windex glass cleaner. These chemicals contained warning labels indicating "Keep out of reach of children", "May be harmful if

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F 323	Continued From page 18 swallowed", and "May cause mild eye and skin irritation". In an interview at that time, the housekeeper on the unit stated that the door should be closed all the time. c. Unsupervised steam tables were noted on 4 of 5 resident units. The following was noted: During the recertification survey, from 6/5/08 through 6/10/08, unattended steam tables that were being used to serve the breakfast meal were observed on the following units: -Unit #2 on 6/9/08 from 8:20 AM - 8:25 AM -Unit #3 on 6/5/08 and 6/6/08 from 8:30 AM - 8:50 AM -Unit #4 on 6/9/08 from 8:30 AM - 8:50 AM -Unit #5 on 6/10/08 from 8:30 AM - 8:50 AM Cognitively impaired residents had been identified by the facility to reside on these units and residents were observed to be unattended at times in the vicinity of the hot steam tables at the times noted above. Interviews with CNAs on the 3rd and 4th floor units at 8:30 AM on 6/5/08 and 6/6/08 revealed that the steam tables would not be removed until the kitchen staff came up to remove them. 10NYSCRR 415.29 NYCRR 713-1.19(2)(b),(2)(g)(1)(2)	F 323		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		7/11/08

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F 329	Continued From page 19 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility did not ensure that each resident was free from the use of antipsychotic medication without: adequate indications for their usage, behavior monitoring or gradual dose reduction. Specifically, 1. a resident who was on an antipsychotic medication (medications used to help manage behaviors) did not have any documented evidence of behaviors to substantiate the continued use and sustained dosage of the drug , 2. a resident who was receiving multiple antipsychotic drugs did not have any documented evidence for the effectiveness or adverse reactions of these medications. This was evident for 2 out of 29	F 329		

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sampled residents (Residents # 11, 1).

This resulted in no actual harm with potential for more than minimal harm.

The findings are:

1. Resident # 11 is a 75 year old female with diagnoses including Mental Retardation and Organic Brain Syndrome. Reviews of the Minimum Data Sets (an assessment tool) dated 10/3/07 and 3/25/08 revealed that the resident is dependent on others for all activities of daily living, had severely impaired cognition and had exhibited no mood or behavioral symptoms.

The resident was observed several times throughout the morning of 6/6/08 sitting quietly in the dayroom area on the 4th floor unit with other residents and staff.

A review of Physician's Orders and the Medication Administration Records from March 26, 2007 through June 5, 2008 (16 months) revealed that the resident had been receiving an antipsychotic medication called Risperdal during this time period. The dose and frequency of this medication remained consistent throughout this timeframe as follows:" Risperdal 1mg tablet orally every morning and Risperdal 1.5mg tablet orally at bedtime".

A review of the Nurses and Social Service progress notes from August 2007 through June 5,2008 revealed no documented evidence of on-going behavior monitoring and assesssments. In addition, the" Weekly Behavior Documentation Forms", (a form used by the facility to monitor resident behaviors) were not completed for the

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resident.

An interview with the Registered Nurse Supervisor on the 4th floor unit on 6/6/08 at 10:45 AM revealed that the resident's behavior had been stable for many months with only an occasional verbal disruption and was being given the ordered Risperdal daily. She was unable to produce any documented evidence of behavior monitoring.

An interview with the Attending Physician on 6/6/08 at 11:00 AM revealed that he had not attempted a gradual dose reduction with the antipsychotic because the resident's behavior had remained stable for many months and he did not think it was necessary to reduce the dosage. Following surveyor intervention on 6/6/08 at 11:00AM, the physician stated that he would review the medication.

2.Resident #1 is a 91 year old female with diagnoses including Dementia with agitation. Reviews of the Minimum Data Sets (MDS) on 2/21/08 and 5/23/08 revealed that the resident is moderately impaired in cognition and decision making. Many mood and behavior indicators were present including:sad expression and frequent crying. Extensive assistance is required for activities of daily living.

On 6/6/08 at 10:15AM, the Resident was observed by Surveyor during dressing changes to her lower legs. At that time, she was lethargic while resting on her bed during the procedure.

A review of Physician Orders revealed that the resident was on psychoactive medications

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including: Seroquel 25mg at bedtime for Psychosis ordered on 4/14/08, Haldol 1mg twice a day for Agitation ordered on 5/09/08 and Depekene 500mg at bedtime for Dementia with behavior disturbance ordered on 5/23/08.

A review of the Behavior Care Plan showed the last entry on 2/28/08 and noted that the resident has" long and short term memory loss and many mood indicators that are easily redirected". The Inter-Disciplinary Team Review of Psychotropic Drug Use form revealed that the last entry was on 1/23/08. This stated "psych review of 1/17/08 to continue management and monitor behavior". There were no nurse's notes regarding behavior since 2/22/08. Depekene was started on 5/23/08 and there was no documentation in nurses notes that the medication had been started and no documentation as to resident's behavior or reaction to the new medication.

Interview with the RN Supervisor on 6/6/08 at 11:00AM revealed that staff should monitor resident's behavior daily after a new psychiatric medication is "ordered or there is a change in behavior". RN Supervisor stated that the resident's behavior is much calmer now since Depekene which was started on 5/ 23/08, but there is no documentation in the nurse's notes to support this fact.

Resident #14's physician was interviewed on 6/6/08 at 2:00PM. He stated that this is a difficult case and that she is "up and down" per the nurses and has not attempted gradual dose reduction of the psychotropics. After Surveyor intervention, the physician stated "I will review her case since you said she is lethargic". The physician assessed the resident and decided to

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F 329	Continued From page 23 discontinue the Haldol medication. Follow up progress note of 6/9/08 documented "Haldol given with no clear benefit". 415.12(l)(1)	F 329		
F 365 SS=D	483.35(d)(3) FOOD Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility did not ensure that a resident received the mechanically altered diet as prescribed by the physician. Specifically, a resident who had been prescribed to receive liquids at a nectar thick consistency was given regular consistency liquids during a meal. This was evident for 1 out of 29 sampled resident's (Resident # 11). This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The findings are: Resident # 11 is a 75 year old female with diagnoses including Mental Retardation, Organic Brain Syndrome and Dysphagia (difficulty swallowing). A review of her Minimum Data Set (an assessment tool) dated 3/25/08 revealed that she requires extensive assistance from others during meals. A review of the swallowing evaluation	F 365		7/11/08

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F 365	Continued From page 24 assessment by the speech pathologist on 2/5/08 revealed that this resident was at risk for aspiration and required nectar thickened liquids and pureed consistency solids. Physician orders for May 2008 and June 2008 revealed a diet order for "....pureed consistency with nectar thickened liquids" as was recommended by the speech pathologist on the 2/5/08 evaluation. During a lunch meal observation on 6/4/08 at 12:05 PM on the 4th floor unit, Resident # 11 was seated in the hallway and was drinking from a brown colored cup that was on her meal tray. After consuming some of the liquid in this cup she began to cough. A diet card that was placed on the food tray read "nectar thickened liquids." The fluid observed in the brown cup was a thin liquid preparation. Each time the resident drank she immediately started coughing. After surveyor intervention the Registered Nurse Supervisor immediately removed the cup stating that there had been a mistake and the liquids in the cup were not nectar thickened. An interview with the Registered Nurse Supervisor at the time of this occurrence revealed that there had been an error when the meal tray was delivered to the resident and the coffee she had been drinking was not the prescribed nectar thick consistency. 415.14(d)(3)	F 365		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		7/11/08

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This REQUIREMENT is not met as evidenced by:
Based on observation and staff and resident interviews, it was determined that the facility did not store, prepare and serve food under sanitary conditions. This was evidenced by:

1. Chicken was improperly stored, cleaned and cooked, as evidenced by:
   a. Defrosting chicken was not stored in a manner to prevent cross contamination.
   b. Raw chicken was not cleaned properly to ensure that all feathers are removed prior to cooking.
   c. Chicken was not sufficiently baked to ensure thorough cooking.
2. Undated, unlabelled and/or outdated food products were stored in the kitchen walk-in refrigerators.
3. The kitchen ice machine catch basin grill was soiled with a pink mildew-like residue.
4. Bare-hand contact was observed during the breakfast meal observation on the 1st floor.
5. Three of five pantry refrigerator freezer compartments lacked thermometers.

These conditions were noted in the kitchen and in the nursing unit pantries.

This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Findings are:

During the initial tour of the kitchen between 8:15

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F 371	Continued From page 26 AM and 9:00 AM on 6/4/08, the following unsanitary conditions were noted: 1. Raw chicken was improperly stored, and not sufficiently cleaned and cooked to remove feathers and ensure adequate and complete cooking. The following was noted: a. During the initial tour of the kitchen at 8:30 AM on 6/4/08, one aluminum cookie sheet containing at least 20 raw pieces of chicken parts was noted to be defrosting on the second shelf of the walk-in refrigerator. Blood was noted to be dripping onto the shelf and floor below. In an interview at that time, the cook stated that the chicken should be stored on the lowest shelf. b. During the resident council meeting at 2:00 PM on 6/5/08, 7 of 15 residents present expressed concerns about the chicken being served undercooked and with feathers. Upon investigation at 8:40 AM on 6/9/08, approximately 40 to 50 raw chicken legs and thighs were noted to be stored in a large plastic bin in the kitchen food prep area. Feathers were noted in 5 or 6 pieces of the chicken. In an interview at that time, the cook stated that the chicken had already been cleaned. c. At 12:20 PM on 6/9/08, 3 pieces of breaded and baked chicken were removed from resident unit steam tables and examined. Upon examination, feathers were noted in two of the three pieces and the third piece was noted to be pink and undercooked. In an interview at that time, the Food Service Director stated that the chicken had been cleaned as per the facility's policies. She also stated that she would talk to the cook about cooking the chicken thoroughly.	F 371		

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In a separate interview at 1:10 PM on 6/9/08, the Assistant Administrator stated that she would discuss the matter with the distributor.

2. The following undated, unlabelled and/or outdated food items were noted to be stored in the walk-in refrigerators:
a. One partially full 6 lb. can of cut sweet potatoes was undated.
b. One partially full 6 lb.12 oz. can of tapioca pudding was undated.
c. One approximately 1/4 full aluminum pan of lasagna was undated and unlabelled.
d. One plastic pitcher of juice was unlabelled and undated.
e. One partially full jar of gefilte fish was undated and the contents were coated with a thick (approximately 2 inches) layer of a white foreign substance.
f. One container of tuna fish salad and one foil-covered pan of noodles were undated and unlabelled.

In an interview at 12:00 PM on 6/4/08, the Food Service Supervisor stated that the gefilte fish must have been in the back of the refrigerator. She also stated that the lasagna and the noodles had been used the previous night. She further stated that the tuna fish is made every morning as an alternate. According to the Food Service Supervisor, it is the facility's policy to date all of the food items.

3. During the initial tour of the kitchen at 8:30 AM on 6/4/08, the plastic grill over the ice machine catch basin was noted to be coated with a layer of a pink mildew-like substance.

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In an interview at 8:50 AM on 6/4/08, the Assistant Administrator stated that the ice machine is cleaned monthly.

4. During observation of the breakfast meal on the 1st floor at 7:40 AM on 6/5/08, a CNA was observed to butter a piece of bread with her bare hands. In an interview at that time, the CNA stated that she usually uses a knife and fork to handle the bread, but that she must have been rushing.

5. During the environmental rounds between 8:00 AM and 9:00 AM on 6/6/08, it was noted that thermometers were lacking in 3 of 5 unit pantry refrigerator freezers (floors 2, 3, 4).
In an interview at that time, the Maintenance Director stated that he would bring this to the attention of the Food Service Supervisor.

Review of facility nutritional services policies at 1:00 PM on 6/9/08 revealed the following:
- Foods are to be properly covered and labeled prior to storage and are to be dated to date of prep or date of delivery.
- Leftovers should be placed in a shallow pan, covered, labelled, and dated. Leftovers are discarded after 24 hours.
- Signs of spoilage are to be reported to the Supervisor.
- Poultry is to be washed before cooking.
- Thermometers are to be placed so that they are easily visible for checking and will be in all walk-in or reach-in refrigerators and freezers.
- Disposable gloves are to be worn when handling and serving food in the kitchen and food service in the dining room.
- Raw foods are to be stored on bottom shelving.

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F 371	Continued From page 29 14-1.43(e) 14-1.44 14-1.80(a) 14-1.82(a)	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility did not ensure that the Pharmacist identified and reported drug irregularities and the need for gradual dose reductions to the physician during monthly reviews of each resident's drug regimen. Specifically, 1. a resident who was on the same dose of an antipsychotic medication for 16 months, without behavior monitoring, was not referred for gradual dose reduction. 2. a resident who had Parkinson's Disease was placed on Haldol, an antipsychotic medication which is contraindicated in the presence of Parkinson's Disease (as documented in the 2008 Physician's Desk Reference) and this irregularity was not reported to the physician.This was evident for 2 out of 29 sampled resident's (Resident # 11, 9). This resulted in no actual harm with the potential for more than minimal harm.	F 428		7/11/08

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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
F 428	Continued From page 30	F 428		

The findings are:

1. Resident # 11 is a 75 year old female with diagnoses including Mental Retardation and Organic Mood Disorder. A review of the Minimum Data Sets (an assessment tool) dated 10/3/07 and 3/25/08 revealed the resident with severely impaired cognition with no mood or behavior symptoms present.

A review of the Physician Orders and Medication Administration Records from March 2007 through June 6, 2008 indicated that the resident received Risperdal 1 mg orally every morning and 1.5 mg orally at hour of sleep.

A review of the Nurses notes from August 2007 through June 5,2008 revealed no behavior monitoring to justify the daily use of this antipychotic medication.

A review of the monthly medication regimen reviews from September 2007 through June 6,2008 revealed no documented evidence that a recommendation for a gradual dose reduction or possible discontinuation of the Risperdal was recommended to the physician.

An interview with the Pharmacist on 6/6/08 at 1:30 PM indicated that she agreed that a gradual dose reduction should have been recommended to the attending physician but could not explain why this had not be done.

2. Resident #9 is a 67 year old male with diagnoses including Parkinson's Disease and Dementia. A review of the Minimum Data Set

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F 428	Continued From page 31 dated 4/29/08 revealed mood and behavior symptoms of anxiety, agitation and physical aggression towards others. A review of Physician Orders and Medication Administration Records for November 2007 through April 2008 indicated that Resident #9 had been receiving Haldol twice a day at various intervals during this time period due to agitated behavior. It was discontinued on 4/24/08 when the consulting psychiatrist assessed the resident's adverse side effects including Extra Pyramidal Side Effects(EPS). A review of the monthly Medication Regimen reviews done for November 2007 through April 2008 showed no documented evidence that the pharmacy consultant had noted an irregularity nor had made any recommendations with concerns to the use of Haldol in the presence of Parkinson's Disease. An interview with the consulting Pharmacist on 6/6/08 at 1:45 PM revealed that Haldol use for a resident with Parkinson's Disease is contraindicated, but was unable to explain why this irregularity was not documented and reported to the physician and Director of Nursing. 415.18(c)(1)	F 428		
F 463 SS=K	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced	F 463		7/11/08

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F 463	Continued From page 32 by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the existing call bell system on two of five units (2nd and 3rd floors) was maintained as intended by the manufacturer. This was evidenced by: 1. Significant call bell system malfunctions which would not alert nursing staff to respond to residents who need assistance in a timely manner; and 2. The lack of an alternate communication system in place to compensate for the malfunctions in the existing call bell system. This resulted in the potential for more than minimal harm that is Immediate Jeopardy. Findings are: On 6/4/08 between 8:15 AM and 11:30 AM, the following problems with the nurse's call bell system were noted on the 2nd and 3rd floor units: - Call bells on the 3rd floor were not functioning properly, i.e. call bells in rooms #302, 303, 304 and 314 did not light or ring, while the call bell in room #305 rang incessantly when pulled. - Activation of the toilet call bell in room #314 resulted in the dome light over room #320 lighting only. Activation of other toilet call bells on the unit also resulted with the dome light over room #320 lighting. - Activation of the 3rd floor tub room toilet call bell resulted in the activation of the room #14 button at the nurse's station in lieu of the button for the tub room. - The panels in the medication rooms on the 2nd and 3rd floors had not been connected to the call	F 463		

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F 463	Continued From page 33 bell system yet. In an interview at 10:00 AM on 6/4/08, the Maintenance Director stated that the call bell system on the 2nd floor was in the process of being replaced. He also stated that the old nurse station panels on the 2nd and 3rd floors had not worked properly and had been replaced with the old 4th and 5th floor panels, respectively. (Note: The last two digits on the 4th and 5th panels corresponded with the room numbers on the 2nd and 3rd floors, such that #203 would light at #403 on the panel). A technician was observed to be working on the 2nd floor call bell system at this time. In an interview with both the Assistant Administrator and Administrator at 8:30 AM on 6/5/08, the following was revealed: In an effort to correct a call bell deficiency from the previous re-certification survey (8/7/07) new call bell annunciators had been installed in the medication rooms on floors 1, 2, and 3 in 9/07. (The call bells on the 4th and 5th floors had been replaced a few years ago and were functioning properly and a new system had been installed on the 1st floor approximately 3 months ago). According to the Assistant Administrator, it became apparent around October 2007 that the newly installed annunciators were not compatible with the call bell panels at the nurse stations. As a result, the facility decided to replace the call bell system on floors 1 - 3 with the same system and a proposal for the work was secured on 10/30/07. According to the Administrator, the work had been delayed due to the fact that the switches for the call bells were only being produced by one company, and that company had relocated to Mexico. Consequently, work on the 2nd floor did not	F 463		

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resume until 6/3/08.

All of the call bells on the 2nd and 3rd floor were tested between 10:30 AM - 11:30 AM on 6/5/08 and the following was noted:

2nd floor:
- Eight of twenty bedside call bells lit above the door and rang but did not light at the nurse call bell panel.
- Five of fifteen toilet call bells (most resident rooms have shared toilets between two rooms) did not light at the nurse call bell panel.

These conditions affected twenty-four of thirty-eight residents on the 2nd floor.
Additionally, two of two tub room toilets also did not light at the nurse call bell panel.

3rd Floor:
- Four of twenty bedside call bells did not light at the nurse call bell panel while two of twenty bedside call bells lit at an un-numbered button on the nurse call bell panel.
- Five of fifteen toilet call bells did not ring at the nurse call bell panel.
- Nine of fifteen toilet call bells lit at multiple resident room dome lights and multiple buttons on the nurse call bell panel and/or the wrong button on the panel.

These conditions affected thirty-four of thirty-eight residents on the 3rd floor.
Additionally, two of two tub room toilet call bells lit at the tub room call bell button as well as the buttons for rooms # 503 and #514 on the nurse call bell panel.

Interviews were conducted with 2nd and 3rd floor staff members on 6/5/08 between 10:30 AM and 11:30 AM regarding how they would identify the

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location of the resident calling for assistance. A 2nd floor Certified Nurse's Aide (CNA) and the unit Charge Nurse stated that they would get up and check in the corridor for the location of the activated call bell light above residents' doors. The 3rd floor Charge nurse, as well as another nurse and a CNA also stated that they would check in the corridor for which light was activated above a resident's door. These staff members were unable to explain how they would identify the source of the call if either multiple lights were lit up simultaneously or, conversely, if only a signal had been received but no lights were lit up.

In an interview at 3:05 PM on 6/5/08, the Maintenance Director stated that problems with the call bell system had started to build up in November or December of 2007, i.e. a few call bells had malfunctioned. Although he had been able to fix the call bells at first, the Maintenance Director stated that he was unable to repair the call bells when the lights malfunctioned.

Review of the facility's call bell maintenance logs at 1:30 PM on 6/6/08 revealed that every call bell is tested weekly and that the 2nd and 3rd floor call bells were last tested on 5/23/08. Review of the available maintenance logs (for the months of March through June 2008) at 11:10 AM on 6/9/08 revealed the following:
- Call bells in 10 rooms on the 2nd floor had malfunctioned.
- Call bells in 6 rooms on the 3rd floor had malfunctioned.

Problems with the call bells were identified as far back as November or December 2007, and were noted repeatedly in the maintenance logs since March of 2008, including 5/16/08, (when the call

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F 463	Continued From page 36 bell in the toilet of room #304 was noted to activate the dome light over room #320), and again during the recertification survey beginning on 6/4/08. The facility's residents had not been provided with a temporary, alternate means of communicating distress or need for assistance with the nursing staff. It was not until surveyor intervention that, as per an interview at 3:15 PM on 6/5/08 with the Assistant Administrator, personal magnetic tab monitors (i.e. the type used for monitoring residents at risk for falling) were being installed on the 2nd and 3rd floors as a temporary measure. Immediate jeopardy was identified on 6/5/08 due to the fact that problems with the call bell system had been identified by the facility back in October 2007, but had not been addressed in a timely manner. Additionally, the facility did not implement an alternative communication system for residents to alert nursing staff when in need of assistance/supervision or in the event of an emergency. 10NYCRR 415.29 NYCRR 713-1.19(g)(1)(2)	F 463		
F 490 SS=K	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 observation and interview, the Administrator failed to oversee and supervise the	F 490		7/11/08

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F 490	Continued From page 37 Director of Maintenance to ensure that the facility's call bell system on the second and third floors, was maintained and functioning properly to ensure for the safety of the residents. This was evident for 24 of 38 residents on the second floor and 34 of 38 residents on the third floor. This resulted in the potential for more than minimal harm that is Immediate Jeopardy. Findings are: During the initial environmental tour of the facility units on 6/04/08 at 8:15AM it was noted that the call bell system on the second and third floors was malfunctioning in a number of residents bedrooms and bathrooms on both floors. This affected 24 of 38 residents on the second floor and 34 of 38 residents on the third floor. The absence of a fully operational call bell system on these two floors placed a total of 58 residents at risk of immediate jeopardy in that they would be unable to alert staff for needed assistance in case of an emergency. Interview with the Director of Maintenance on 6/05/08 at 3:05PM indicated that there was a delay since 10/07 in obtaining the necessary required parts to repair the system. He also stated that the facility did not notify the New York State Department of Health (NYSDOH) of their plans to replace the malfunctioning call bell system. In addition, the facility administration did not submit a safety plan to NYSDOH to ensure that the affected residents would be protected, prior to the commencement of the replacement of the call bell system. Interview on 6/5/08 at 8:30AM with the Assistant	F 490		

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F 490	Continued From page 38 Administrator and Administrator revealed that the delay in ordering the necessary parts for the call bell system since 10/07 was due to the fact that the one company that they used had relocated to Mexico. They acknowledged that since they had partially paid this company, they would wait for delivery of the parts. Interview with the Assistant Administrator on 6/5/08 at 2:45PM indicated that it was the facility's policy to provide "tea" bells to the residents in the event of a call bell system malfunction. The residents had not been provided with a temporary, alternate means of communicating or alerting the nursing staff when in need of assistance/supervision. 415.26	F 490		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not ensure that all hazardous areas are maintained in a safe manner in that five gallon gas containers and a gas powered blower were stored in the housekeeping store room. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The findings are: On 6/09/08 at 1:20 PM, during environmental rounds, the housekeeping storage room, located on the ground floor, had two five-gallon containers of gasoline along with a	K 029		7/11/08

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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K 029	Continued From page 1 gasoline-powered blower stored with housekeeping supplies and chemicals. The storage of gasoline and chemicals within the same area could cause a hazardous condition to occur. In an interview with the Director of Maintenance on 6/09/08 at 1:20 PM, he stated that all gas containers and items containing gasoline would be removed. 2000 NFPA 101; 19 10 NYCRR 415.29 10 NYCRR 711.2(a)(1)	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 2000 NFPA 101 Life Safety Code states: Chapter 3.3 General Definitions 3.3.121 requires that means of egress provide a continuous and unobstructed way of travel from any point in a building or structure to a public way consisting of three separate and distinct parts: (1) the exit access, (2) the exit, and (3) the exit discharge. 2000 NFPA 101- Section 19.2 Means of Egress Requirements 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access	K 038		7/11/08

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K 038	Continued From page 2 shall be in accordance with Chapter 7. 7.1.10 Means of Egress Reliability. Section 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.5 Headroom. Means of egress shall be designed and maintained to provide headroom as provided in other sections of this Code and shall be not less than 7 ft 6 in. (2.3 m) with projections from the ceiling not less than 6 ft 8 in. (2 m) nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two-thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft 8 in. (2 m). Headroom on stairs shall be not less than 6 ft 8 in. (2 m) and shall be measured vertically above a plane parallel to and tangent with the most forward projection of the stair tread. 7.2.1.6.1 Delayed Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved,	K 038		

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K 038	Continued From page 3 supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS Based on observation and interview, the facility did not ensure that exit access is arranged so that exits are readily accessible at all times. This was evidenced by: 1. One of five delayed egress doors did not release upon testing. 2. The exterior resident smoking area was located in the path of egress from the main entrance. 3. The interior and exterior portions of the delivery corridor had storage along the means of egress. 4. Deadbolts were present in visitor bathrooms on the ground floor. 5. Wall-mounted mirrors present along the corridors on five of five resident floors projected less than 6 ft. 8 in. above the finished floor.	K 038		

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K 038	Continued From page 4 This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings are: During environmental rounds from 6/04/08 to 6/09/08 the following was observed: 1. While checking the release of the delayed egress doors throughout the facility, the delayed egress door located on the ground level by the delivery door located by the elevator, did not release after 15 seconds of pressure. In an interview at 1:15 PM on 6/9/08, the Director of Maintenance stated that the door should have released from the magnet. He also stated that releasing mechanisms on the exterior doors provided with delayed egress are not routinely checked. 2. The exterior resident smoking area is located in the path of egress from the main entrance to the sidewalk adjacent to Pelham Parkway. In particular, 3 to 5 residents were observed to be seated between 8:00 AM and 4:00 PM on 6/4/08 - 6/6/08 and at the same times on 6/9/08 in individual plastic chairs along one side of this path. In addition, the single ashtray in use was non-conforming, i.e. it was not weighted and lacked a self-closing compartment for the disposal of cigarettes and ashes. In an interview at 1:25 PM on 6/9/08, the Director of Maintenance stated that the ashtray would be replaced and that he would speak to administration regarding an alternate smoking area.	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING 01 B. WING	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

(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
K 038	Continued From page 5 3. At 1:20 PM on 6/9/08, the interior and exterior paths of egress in the delivery area were congested with equipment and supplies. For example, garbage cans, clean laundry carts and racks, and housekeeping equipment were stored in the interior corridor leading to the Pelham Parkway side of the building. In addition, cardboard boxes were stored in the exterior portion of this path of egress. In an interview with the Director of Maintenance on 6/09/08 at 1:25 PM revealed that the means of egress should be clear at all times. 4. The men's and women's visitor bathroom doors, located on the ground floor had deadbolts present inside of the door. This would prevent immediate access into or out of the room in the event of emergency. In an interview with the Director of Maintenance on 6/09/08 at 1:30 PM revealed that the deadbolts would be removed. 5. Wall-mounted mirrors located in the corridors on five of five resident floors (three per floor), were mounted less than the required six feet eight inches above the floor. In particular, the mirrors, which were located directly outside the dining rooms and nurse's stations on each floor, were mounted approximately six feet above the floor. An interview with the Director of Maintenance on 6/09/08 at 1:25 PM revealed that the mirrors have always been there. 2000 NFPA 101; 19.2.3.3, 7.1, 3.3 10 NYCRR 711.2(a)(1)	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING 01 B. WING	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

(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
K 045 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not ensure that the illumination of all means of egress is arranged so that the failure of any single lighting fixture will not leave the area in total darkness. This was evidenced by inadequate lighting in two of two stairwells. (North and South Stairwells) This resulted in no actual harm with the potential for minimal harm. Findings are: During life safety rounds from 6/04/08 to 6/09/08 between 8:00 AM and 2:00 PM, it was observed that the North and South stairwells lacked adequate lighting on each landing necessary to provide a safe exit in case of an emergency. In particular, each landing was provided with single-bulb light fixtures only. In an interview on 6/4/08 at 10:45 AM, the Director of Maintenance confirmed that the light fixtures only had one bulb present. 2000 NFPA 101; 19.2.8 10 NYCRR 711.2(a)(1)	K 045		7/11/08
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		7/11/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING 01 B. WING	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

(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
K 072 SS=C	Continued From page 7 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility did not ensure that the means of egress were continuously maintained free of all obstructions or impediments to full use in the case of fire or other emergency. This was evidenced by the storage of unattended resident and nursing equipment congesting exit access corridors on five of five resident floors. This resulted in no actual harm with the potential for minimal harm. Findings are: On 6/4/08 through 6/6/08 and on 6/9/08 between 8 AM and 2:30 PM the following was observed: (not all inclusive): 1. On the fifth floor, wheelchairs, chairs, overbed tables and linen carts were observed unattended and not in use in the corridor. 2. On the third floor, wheelchairs, chairs, overbed tables and linen carts were observed unattended and not in use in the corridor. 3. On the first floor, wheelchairs, Geri chairs and	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING 01 B. WING	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	**1235 PELHAM PARKWAY NORTH** **BRONX, NY 10469**

(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
K 072	Continued From page 8 a chair scale were observed stored along the corridor not in use. An interview with the Director of Maintenance on 6/09/08 at 1:30 PM revealed that these items should not be stored in the corridor when not in use. 2000 NFPA 101; 19.1, 7.1.10.1 10 NYCRR 415.29 10 NYCRR 711.2(a)(1)	K 072		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 2000 NFPA 101 LSC Chapter 7.9.2.3- Emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. 1999 NFPA 99 Chapter 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant	K 144		7/11/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING 01 B. WING	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

(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
K 144	Continued From page 9 parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 1999 NFPA 110 Emergency and Standby Power Systems- Routine Maintenance and Operational Testing - 6-4. Operational Inspection and Testing 1999 NFPA 110 Chapter 6-4.2 -Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. Based on record review and interview, the facility's documentation was not adequate and lacked certain information as per NFPA 110. This resulted in no actual harm with a potential for minimal harm. Findings are: On 6/09/08 at 11:30 AM, review of the facility's logs for testing the emergency generator in the calendar year June 2007 through June 2008 revealed that the generator was tested under	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING **01** B. WING	**06/10/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	**1235 PELHAM PARKWAY NORTH** **BRONX, NY 10469**

(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
K 144	Continued From page 10 load, but the documentation lacked adequate information such as transfer time, hour meter reading, amperage, oil and water temperatures, etc. In an interview on 6/09/08 at 12:45 PM, the Maintenance Director stated that he could not attain certain information from the generator since the door to the generator set was locked and that all gauges were behind the door. 1999 NFPA 99: 3-4.4.4.1, 3-4.2.2.2 2000 NFPA 101 LSC: 19.2.9.1, 7.9.2.2, 7.9.2.3 1999 NFPA 110: 6-4.2 10 NYCRR 415.29	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	R **06/13/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS PARK NURSING AND REHAB CENTER	**1235 PELHAM PARKWAY NORTH** **BRONX, NY 10469**

(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
{K 000}	INITIAL COMMENTS	{K 000}		
{K 029} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by:	{K 029}		
{K 038} SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	{K 038}		
{K 045} SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	{K 045}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335347	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	R **06/13/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{K 045}	Continued From page 1 This STANDARD is not met as evidenced by:	{K 045}		
{K 072} SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by:	{K 072}		
{K 144} SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	{K 144}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335347	A. Building B. Wing	7/18/2008

Name of Facility	Street Address, City, State, Zip Code
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0221 Reg. # 483.13(a) LSC	07/18/2008	ID Prefix F0226 Reg. # 483.13(c) LSC	07/18/2008	ID Prefix F0250 Reg. # 483.15(g)(1) LSC	07/18/2008
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	07/18/2008	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	07/18/2008	ID Prefix F0323 Reg. # 483.25(h) LSC	07/18/2008
ID Prefix F0329 Reg. # 483.25(l) LSC	07/18/2008	ID Prefix F0365 Reg. # 483.35(d)(3) LSC	07/18/2008	ID Prefix F0371 Reg. # 483.35(i)(2) LSC	07/18/2008
ID Prefix F0428 Reg. # 483.60(c) LSC	07/18/2008	ID Prefix F0463 Reg. # 483.70(f) LSC	07/18/2008	ID Prefix F0490 Reg. # 483.75 LSC	07/18/2008
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/10/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
9/18/2008

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
2	A. Building B. Wing	7/18/2008

Name of Facility	Street Address, City, State, Zip Code
MORRIS PARK NURSING AND REHAB CENTER	1235 PELHAM PARKWAY NORTH BRONX, NY 10469

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix I260 Reg. # 415.26 LSC	Correction Completed 07/18/2008	ID Prefix I310 Reg. # 415.29 LSC	Correction Completed 07/18/2008	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/10/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO