

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

PRINTED: 09/09/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335723	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2009
NAME OF PROVIDER OR SUPPLIER EAST HAVEN NURSING AND REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 EASTCHESTER ROAD 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
F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility did not ensure that the services provided to the residents are in accordance with professional standards of quality. This was evident in four (4) of thirty (30) sampled residents. (Resident #4, #11 and #14)</p> <p>This resulted in no actual harm with potential for more than minimal harm.</p> <p>The findings are:</p> <p>1) Resident #4 is an 88 year old female with a diagnoses which include: Diabetes Mellitus, Hypertension, Anemia, Congested Heart Failure, and Breast Cancer.</p> <p>The Minimum Data Set (MDS) 2.0 dated 5/22/09 documented that the resident has a short term memory problem, and long term memory intact with modified decision making skills.</p> <p>The physician's interim order dated 5/5/09, and the monthly order dated 5/12/09 and 6/9/09 documented: "Insulin Lantus 10 units subcutaneously at bedtime."</p> <p>The Medication Administration Record dated 5/13/09 to 6/9/09 documented that the resident refused the Lantus Insulin injection every single day. The Lantus Insulin injection was not administered for 28 days.</p>	F 281		7/25/09
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.

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 335723	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/27/2009
Name of Facility EAST HAVEN NURSING AND REHAB C		Street Address, City, State, Zip Code 2323 EASTCHESTER ROAD 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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed 07/25/2009	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 07/20/2009	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 08/03/2009
ID Prefix <u>F0334</u> Reg. # <u>483.25(n)</u> LSC _____	Correction Completed 08/03/2009	ID Prefix <u>F0428</u> Reg. # <u>483.60(c)</u> LSC _____	Correction Completed 08/03/2009	ID Prefix <u>F0431</u> Reg. # <u>483.60(b), (d), (e)</u> LSC _____	Correction Completed 08/03/2009
ID Prefix <u>F0498</u> Reg. # <u>483.75(f)</u> LSC _____	Correction Completed 08/03/2009	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 08/01/2009	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

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

Followup to Survey Completed on: 6/15/2009	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335723	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2009
NAME OF PROVIDER OR SUPPLIER EAST HAVEN NURSING AND REHAB C		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 EASTCHESTER ROAD BRONX, NY 10469		
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I560 SS=D	<p>713-1 Standards of Construction for New Existing NH</p> <p>This Regulation is not met as evidenced by: NYCRR 713-1.18(d)(2)(i): Outdoor air intakes shall be located as far as practical but not less than 25 feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks, or from areas which may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than six feet above ground level or if installed above the roof, three feet above roof level.</p> <p>This requirement is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that the air intake for the roof top air handling unit serving low side corridors is at least 25 feet from the linen chute exhaust ventilation system.</p> <p>The findings include: On June 9, 2009 and June 10, 2009, at 10:00 AM to 2:30 PM, it was observed that the facility has installed an air handling unit on the roof, serving the low side resident corridors. The air intake louvers for the unit are only 4 feet from the exhaust ventilation for the linen chute, instead of the minimum 25 feet. On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that air intake for the low side air handler will be extended and redirected away from the linen chute exhaust opening.</p> <p>NYCRR 713-1.18(a)(2)(iii) Backflow preventers (vacuum breakers) shall be installed on hose bibbs, janitor's sinks, bed pan</p>	I560		8/10/09

Office of Health Systems Management / Office of Long Term Care

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

New York State Department of Health

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I560	Continued From page 1 flushing attachments and on all other fixtures to which hoses or tubings can be attached. This requirement is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that the water fixtures with hoses attached in resident rooms are equipped with backflow preventers (vacuum breakers) (room #'s 427, 426, 424, 429, 430, 433). The findings are: On June 9, 2009 and June 10, 2009, it was observed that the facility has hoses attached to the water fixture for the bathing area located in resident rooms. Backflow preventers (vacuum breakers are lacking on these water fixtures, examples are: room #'s 427, 426, 424, 429, 430, 433, 220, 219, 120). On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that backflow preventers are being installed on all water fixtures to which hoses are attached. NYCRR 713-1.19 electrical requirement 713-1.19 (g) In general patient areas, each room shall be served by at least one calling station and each bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. Calls shall register with the floor staff and shall activate a visible signal in the corridor at the patients' door, in the clean workroom, in the soiled workroom, and in the nourishment station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at the corridor intersections. In rooms containing two or more calling stations, and remain lighted as long as the voice circuit is operating.	I560			

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I560	Continued From page 2 This requirement is NOT MET as evidenced by: Based on observation, it was determined that the facility did not ensure that the nurses call is designed and maintained to activate a visible signal in the soiled workroom and the nourishment stations, on the 2nd floor and the 4th floor. The findings are: On June 9, 2009 and June 10, 2009, at 10:00 AM to 2:30 PM, it was observed that the nurses' call registering stations provided in the soiled workrooms and the nourishment stations (pantry areas) on 2nd floor and 4th floor are not maintained to activate a visible signal when a call is placed from the resident room or the toilet room. On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that the burnt out bulbs within the call registering stations in the soiled workrooms are being replaced.	I560			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 2	(Y2) Multiple Construction A. Building 01 - EAST HAVEN NURSING HOME B. Wing	(Y3) Date of Revisit 8/17/2009
Name of Facility EAST HAVEN NURSING AND REHAB C		Street Address, City, State, Zip Code 2323 EASTCHESTER ROAD BRONX, NY 10469

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>1560</u>	Correction Completed <u>08/10/2009</u>	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>713-1</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

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

Followup to Survey Completed on: 6/15/2009	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO

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F 281	<p>Continued From page 1</p> <p>There was no documented evidence that the physician was notified of the resident's refusal of the Insulin injection.</p> <p>The laboratory reports on Glucose results documented the following: On 4/7/09=206H(high), 4/9/09=189H, 4/15/09=98, 5/15/09=128H, 6/3/09=149H</p> <p>On 6/10/09 at 10 A.M., the Attending Physician was interviewed and stated that he was only made aware on 6/9/09 that the resident keeps on refusing the Lantus Insulin.</p> <p>On 6/10/09 at 10:30 A.M., the Registered Nurse Manager(RNM) was interviewed and stated that the physician should have been made aware at least during the first day or two after trying to encourage the resident. The nurse further stated that the resident's medication must be administered as ordered to prevent complications.</p> <p>On 6/10/09 at 3:30 P.M., the registered nurse supervisor was interviewed and stated that when a resident refuses the medication, the physician must be informed through the 24 hour report and it should be followed up by the 7-3 shift.</p> <p>2) Resident #11 was admitted to facility on 2/29/08 with diagnoses that include Hypertension, Constipation, Dementia, and Acute Appendicitis.</p> <p>The Minimum Data Set (MDS) 2.0 Assessment dated 5/18/09 documented that the resident's cognition as moderately impaired, and her bowel and bladder status as incontinent.</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>The comprehensive care plan dated 3/11/09 documented for resident's altered elimination and a goal that the resident will have a bowel movement at least every three days.</p> <p>The resident's care flow sheet from April 26, 2009 to May 1, 2009 revealed no documented evidence of bowel movements recorded on all shifts for six (6) days.</p> <p>On 6/11/09 at 10:30 a.m., the unit registered nurse supervisor was interviewed and stated that all the residents' bowel and bladder functions are documented in the residents' care flow sheets. The supervisor further stated that if the Certified Nurse Assistant(CNA) notices that the resident has not had a bowel movement in three days, the CNA "usually" alert the nurse, who in turn will notify the physician for interventions. The supervisor further stated that the CNAs' flow sheets are reviewed by the assigned registered nurses on a weekly basis to ensure completion and accuracy of documentation.</p> <p>On 6/11/09 at 10:45 a.m., the unit registered nurse supervisor was interviewed and stated that she didn't know why there were blank spaces and no documented bowel movements for the resident from April 26, 2009 to May 1, 2009 on the resident care flow sheets.</p> <p>The nurse's note dated 5/01/09 for the 7-3 shift documented that the resident was noted to be pale and sweating, with an oxygen saturation of 90% and a blood pressure of 80/60. The unit physician was notified and ordered the resident to be transferred to the hospital for further evaluation.</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>The hospital emergency room nurse's note dated 5/01/09 at 3:13 p.m. documented the resident to be in "obvious mild-moderate discomfort from pain." A physician's examination dated 5/01/09 at 5:30 p.m. documented "hard brown stool" on rectal exam, and a diagnosis of Rectal Fecal Impaction.</p> <p>The hospital discharge summary dated 5/05/09 documented that the resident was "found to have fecal impaction which was disimpacted."</p> <p>3) Resident #14 is a 67 year ols male with a diagnoses which include: Cerebro Vascular Disease, Arthritis, and Schizophrenia.</p> <p>The Minimum Data Set (MDS) 2.0 assessment dated 3/13/09 documented that the resident has short and term memory problems, and modified independence in decision making skills. The MDS documented that the resident is occasionally incontinent of bowel, frequently incontinent of bladder, and is on scheduled toileting plan. The MDS further documented that the resident requires one person assistance to perform the ADL(Activities of Daily Living).</p> <p>The "Resident Care Flow Sheet" dated 2/09 and 6/09 under Bowel Movement documented that on 2/15, 2/16, 2/17, 2/18, and 2/19 for 5 days; on 6/1, 6/2, 6/3 for 3 days, and on 6/7, 6/8, 6/9, and 6/10 for 4 days marked "0"=(meaning) no bowel movement. This flow sheet also further documented instructions such as: "...Notify nurse if no bowel movement for 3 days."</p> <p>There was no documented evidence in the</p>	F 281			

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F 281	Continued From page 4 medical record that the physician was notified of the resident having no bowel movements on the above mentioned dates. Review of the nurses notes dated 2/20/09 documented that the resident complained of pain to the lower back and was seen by the physician. The physician's order dated 2/20/09 documented: "Lactulose 30 ml.(milliliter) by mouth at bedtime, Milk of Magnesia 30 ml. by mouth now, x-ray of Abdomen: Fecal Stasis." Review of the abdominal x-ray result documented: "Retained stool more in rectum, no obstruction." On 6/12/09 at 10 A.M., the registered charge nurse was interviewed and stated that the nurse on duty, upon knowing that the resident did not move his or her bowels for 3 or more days, the nurse must go and assess the resident and the physician must be notified.	F 281		
F 282 SS=D	415.11(c)(3)(i) 483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility did not ensure that the resident received services in accordance with the written plan of care. This	F 282		7/20/09

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F 282	Continued From page 5 was evident in one (1) of thirty (30) sampled residents. (Resident #3) This resulted in no actual harm with potential for more than minimal harm. The finding is : Resident # 3 was admitted with diagnoses that include Anoxic Brain Damage, Tracheostomy, Pulmonary Embolism and Hypertension. The Minimum Data Set (MDS) 2.0 Assessment dated 3/12/09 documented the residents cognition as Persistent Vegetative State. A review of Physicians orders dated 5/21/09, documented an order to check GT(gastrostomy tube) residuals Q(every) 24 hours.A review of the resident's MAR(medication administration record) revealed that the order was transcribed as 7-3 and 3-11,which reflects residuals being done twice per day. An interview was conducted with the unit Registered Nurse on 6/10/09 at 11:00am.The RN stated that the Physician's order was transcribed incorrectly and would be addressed immediately by the Physician and the nurses involved.	F 282			
F 309 SS=G	415.11(c)(3)(ii) 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/20/09	

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to ensure that the residents received the necessary care and services to maintain their highest practicable physical, mental and psychosocial well being in accordance with the comprehensive assessment and plan of care. Specifically, the facility failed to monitor resident's bowel status to prevent fecal impaction, and resident's laboratory blood values for Coumadin use. This was evident in two (2) of thirty (30) sampled residents. (Resident #11, and #19) This resulted in actual harm for Resident #11, and no actual harm with potential for more than minimal harm for Resident #19. The findings are: 1) Resident #11 is a 79 year old female admitted to facility on 2/29/08 with diagnoses which include Hypertension, Constipation, Dementia, and Acute Appendicitis. The Minimum Data Set (MDS) 2.0 Assessment dated 5/18/09 documented the resident's cognition as moderately impaired, and bowel and bladder status as incontinent. The Comprehensive Care Plan for the resident's "Altered Elimination" dated 3/11/09 and documented a goal that the resident will have a bowel movement at least every three days. The resident's care flow sheet from April 26, 2009	F 309		

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NAME OF PROVIDER OR SUPPLIER EAST HAVEN NURSING AND REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 EASTCHESTER ROAD BRONX, NY 10469		
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F 309	<p>Continued From page 7</p> <p>to May 1, 2009 revealed no documented evidence of bowel movements on the day, evening, and night shifts.</p> <p>There was no documented evidence that the licensed nurses and the physicians were notified of the resident not having regular bowel movements for approximately 6 days from April 26, 2009 to May 1, 2009.</p> <p>A review of the resident's care flow sheets for the month of April 2009 documented blank spaces for: week one for the RN/MDS coordinator's signatures, week two for the evening RN shift/supervisor's signatures, and week three for the night shift RN's signatures.</p> <p>The nurse's note dated 5/01/09 for the 7-3 shift documented that the resident was pale and sweating, with an oxygen saturation of 90% and a blood pressure of 80/60. The unit Physician was notified and ordered the resident to be transferred to the hospital for evaluation. The resident was transferred from the facility and admitted to the hospital.</p> <p>A review of the hospital emergency room nurse's note dated 5/01/09 at 3:13 p.m., documented the resident to be in "obvious mild-moderate discomfort from pain." A Physician's examination dated 5/01/09 at 5:30 p.m. documented "hard brown stool" on rectal exam, and a diagnosis of Rectal Fecal Impaction.</p> <p>A review of the hospital discharge summary dated 5/05/09 documented that the resident was "found to have fecal impaction which was disimpacted."</p> <p>On 6/11/09 at 10:30 a.m., the unit Registered</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>Nurse (RN) supervisor was interviewed and stated that all residents' bowel and bladder functions are documented on the residents' care flow sheets. The RN supervisor stated that if the Certified Nurse Assistant (CNA) notices that the resident has not had a bowel movement in three days, they "usually" alert the nurse, who in turn will notify the Physician for interventions. The supervisor further stated that the CNA care flow sheets are reviewed by the assigned RNs on a weekly basis to ensure completion and accuracy of documentation.</p> <p>An interview was conducted with the RN unit supervisor on 6/11/09 at 10:45 a.m. The supervisor stated that she didn't know why there were blank spaces and no documented bowel movements for the resident from April 26,2009 to May 1,2009.</p> <p>On 6/11/09, at 11 A.M., an interview with the Certified Nurse Aide (CNA) was conducted as well. The CNA stated that she had no recollection of the resident having no bowel movements. She further stated that when a resident does not have a bowel movement for 3 days, the CNA is supposed or expected to report and notify the licensed nurse, so the nurse can notify the physician.</p> <p>2) Resident #19 is a 49 years old male with diagnoses which includes Atrial fibrillation, Cardiomyopathy, Congested heart failure, End stage renal disease on hemodialysis, and Cervical fusion status post surgery.</p> <p>The Minimum Data Set (MDS) 2.0 dated 4/29/09 documented the resident as independent in</p>	F 309		

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F 309	<p>Continued From page 9 cognition.</p> <p>The Comprehensive Care Plan (CCP) for Anticoagulant therapy/Risk for bleeding updated on 6/3/09 documented that the resident was on Coumadin for Atrial Fibrillation, Cardiomyopathy, and history of Deep vein thrombosis. The CCP further documented that nursing, dietary, and the medical doctor are the responsible clinicians to monitor lab values PT/PTT(ProThrombin Time)/INR, and report to the physician accordingly. It also documented that the Coumadin was discontinued on 6/3/09.</p> <p>The physician's order dated 4/30/09 documented "Coumadin 5 mg (milligrams) PO (by mouth) HS (at hour of sleep) INR (International Normalized Ratio) at HD(hemodialysis) weekly..."</p> <p>The physician's order dated 5/4/09 documented to "Transfer to.....hospital.....pneumonia.... (infiltration)."</p> <p>The Emergency Room (ER) summary of treatment dated 5/4/09 documented "...Patient's INR is 5.6 since there is no sign of bleeding, recommend not giving dose tonight and tomorrow night and re-check in 2 days."</p> <p>The physician's order dated 5/5/09 documented "...Discontinue Heparin, hold Coumadin x 3 days and restart."</p> <p>The medication administration record dated from 5/5/09- 5/7/09 documented that Coumadin 5 mg was held. It further documented that Coumadin was restarted and given from 5/8/09-5/14/09.</p> <p>The facility could not provide documented</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>evidence that a repeat INR was obtained prior to restarting Coumadin 5 mg which was on hold for an elevated INR level of 5.6.</p> <p>The medication administration record for May 2009 documented that the resident received Coumadin 5 mg PO HS on 5/8/09.</p> <p>The laboratory report for the week ending of 5/9/09 documented an INR result of 5.6 (Reference range=2.0-3.0), and Prothrombin Time (PT) 72.3 (Reference range=9.2-14.0).</p> <p>The laboratory reports dated 5/11/09 documented that the INR 6.1 high (Reference range= 2.0-3.0), PT 79.3 (Reference range= 9.2-14.0). Further review of the laboratory reports it was noted on 5/13/09 an INR result of 5.0 high and PT result of 63.8 high.</p> <p>The physician's order dated 5/14/09 documented "transfer to...hospital for eval (evaluation) of position of c(cervical)/spine rod."</p> <p>The nurse's note dated 5/14/09 documented "Alert resident complained of new pain in the neck MD (medical doctor) made aware. Ordered to transfer to...(hospital) for eval (evaluation)...got call to MD from dialysis about INR 5.0...resident left the building..."</p> <p>The ER discharge summary dated 5/15/09 documented "...INR 8.4, given Vitamin K 2.5 mg, to hold Coumadin for 3 days..."</p> <p>The physician's order dated 5/15/09 documented to "Hold Coumadin for 3 days. It further documented for this day to transfer resident to... (hospital) ...for neurosurgery procedure."</p>	F 309			

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F 309	Continued From page 11 On 6/12/09 at 1:15 P.M., the physician was interviewed and stated "usually when the INR is above 3 the Coumadin is held for 3 days. After 3 days it is expected that the INR goes down." On 6/12/09 at 6 P.M., the Director of Nursing (DON) was interviewed and stated that "Nursing calls the physician to notify of abnormal Lab results and follows the physician orders. They (nursing) would call for results if the MD specifies on an order to find out results and report to MD." On 6/15/09 at 11:30 A.M., the Medical Director was interviewed and stated that "when Coumadin is stopped for three days it should restart with a lowered dose or repeat INR prior to giving it and monitoring." On 6/15/09 at 2 P.M., the registered nurse supervisor of the dialysis center was interviewed and stated, "normally the blood is drawn and sent to the lab. The lab would call the dialysis center for abnormal values, and the nurse from the dialysis center would notify the physician or facility." She further stated that "Normally, the blood is drawn, Fed Ex to a laboratory in Florida, done either on Tuesdays or Mondays and reported on Wednesdays."	F 309		
F 334 SS=E	415.12 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334		8/3/09

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F 334	<p>Continued From page 12</p> <p>representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the</p>	F 334			

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F 334	<p>Continued From page 13 following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility did not ensure that the resident/resident's legal representative was provided education regarding the risks and benefits of the Influenza Vaccine. This was evident for ten (10) of thirty four (34) sampled residents. (Residents #1, #3, #5, #7, #9, #13, #14, #16, #17, and #29)</p> <p>This resulted in no actual harm with potential for more than minimal harm.</p> <p>The findings include but no limited to :</p> <p>1) Resident #1 is a 54 year old male admitted to the facility on 8/6/07 with diagnoses which include: Depression, Gastroesophageal Reflux Disease, Incontinence of urine, Anemia, Right</p>	F 334		

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F 334	<p>Continued From page 14</p> <p>lower lobe Pneumonia, Seizure Disorder, history of Dehydration, history of Hypotension.</p> <p>The Minimum Data Set 2.0 assessment dated 3/13/09 documented the Resident to have short term and long term memory deficits with modified independence for decision making.</p> <p>The immunization record on the resident's chart shows that the influenza vaccine was administered on 10/10/08. There were no documented evidence that health education was provided to the resident and/or family regarding the vaccination.</p> <p>The registered nurse unit supervisor was interviewed on 6/12/09 at 1:30 P.M. regarding the education given for the influenza vaccine. She stated that the only thing they do is take/monitor the vitals signs and then monitor the patient for 3 days following administration of the vaccine.</p> <p>2) Resident #3 was admitted to the facility on 5/03/02 with diagnoses that include Anoxic Brain Damage, Pulmonary Embolism, and Sepsis.</p> <p>The Minimum Data Set 2.0 assessment dated 12/10/08 documented the Resident to be in a Persistent Vegetative State.</p> <p>The Physician's order sheet/Flu Vaccine Protocol dated 10/23/08 documented an order for one dose of Trivalent Influenza vaccine 0.5 cc in (deltoid) I'M (intramuscular)</p> <p>The facility vaccine flow sheet for the Annual Influenza Virus documented the influenza vaccine was administered to the resident on 10/31/08.</p>	F 334			

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F 334	Continued From page 15 A nurses note dated 10/31/08 at 3 p.m. documented that the resident's daughter (next of kin) was informed of the administration of the vaccine. There was no documented evidence that the resident's daughter was educated on the risks and benefits of the vaccine prior to administering the vaccine. 3) Resident #9 is a 86 year old female admitted to the facility on 9/3/08. She has the following diagnoses; Chronic Airway Obstruction, Senile Dementia, Atrial Fibrillation, Hypertension, Depressive Disorder, Hypercholesteremia, right eye Blindness, Arteriosclerotic Heart Disease, Glaucoma, Bilateral Cataracts, severe Aortic Stenosis, Chronic Obstructive Pulmonary Disease and Hyperlipidemia. The Minimum Data Set 2.0 assessment dated 5/15/09 documented the Resident to have short term and long term memory deficits with moderately impaired decision making abilities. The immunization record on the resident's chart documented that the influenza vaccine was administered on 11/24/08. There were no records found to show any attempt at health education regarding the vaccination to the resident and/or family. The Registered Nurse Unit Supervisor was interviewed on 6/12/09 at 1:30 P.M. regarding education given for the influenza vaccine. She stated that the only thing they do is take/monitor vitals and then monitor the patient for 3 days following administration of the vaccine.	F 334			

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F 334	<p>Continued From page 16</p> <p>4) Resident #16 is a 80 year old female admitted to the facility on 08/14/2003 with diagnoses which include Dementia, Hypothyroidism, Coronary Artery Disease and Psychosis.</p> <p>The Minimum Data Set (MDS) 2.0 assessment dated 5/8/2009 documents the resident as having severely impaired cognition.</p> <p>The Physician's Order Sheet/Flu Vaccine Protocol dated 01/23/09 documents an order for one dose of Trivalent Influenza vaccine 0.5 cc in (deltoid) I.M. (intramuscular)</p> <p>The Facility's Immunization Record documented that the resident received the influenza vaccine on 1/30/2009.</p> <p>The Comprehensive Care Plan (CCP) for Education Assessment, Plan and Evaluation dated 9/16/05 was reviewed. There is no documented evidence that the resident/resident's legal representative was given education regarding the risks/benefits of the flu vaccine.</p> <p>The Licensed Practical Nurse (LPN) was interviewed on 6/11/2009 at 10:00 A.M. and stated that the nurses ask the residents/resident's legal representative if they want the flu vaccine and if so give the flu vaccine. The LPN further stated that they educate the residents/resident's legal representative on the flu vaccine but don't formally document that they educated them.</p> <p>The Director of Nursing (DNS) was interviewed on 6/12/09 at 10:30 A.M. and stated that the facility educated the residents on the Flu Vaccine at the Resident Council Meetings in September</p>	F 334		

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F 334	Continued From page 17 and October 2008. The DNS further stated that when a resident wants the flu vaccine she has a concern that if they tell the resident about the side effects they will change their minds and refuse the flu vaccine.	F 334		
F 428 SS=D	<p>415.12 483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility did not ensure that the pharmacist reported irregularities to the attending Physician and to the Director of Nursing. This is evident for one (1) of thirty (30) sampled residents. (Resident #4)</p> <p>This resulted in no harm with potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #4 is an 88 year old female with a diagnoses which include: Diabetes Mellitus, Hypertension, Anemia, Congested Heart Failure, and Breast Cancer.</p>	F 428		8/3/09

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F 428	<p>Continued From page 18</p> <p>The Minimum Data Set (MDS) 2.0 dated 5/22/09 documented that the resident has a short term memory problem, and long term memory intact with modified decision making skills.</p> <p>The physician's interim order dated 5/5/09 and the monthly order dated 5/12/09 and 6/9/09 documented: "Insulin Lantus 10 units subcutaneously at bedtime."</p> <p>Review of the Medication Administration Record (MAR) dated 5/13/09 to 6/9/09 indicated that the resident refused the Lantus Insulin every single day and that the Lantus injection was not administered for a total of 28 days.</p> <p>There was no documented evidence that the physician was notified of the resident's refusal of the Lantus Insulin injection.</p> <p>There was no documented evidence in the medical record that a pharmacy consultant reviewed/addressed the MAR dated 5/13/09 to 6/9/09.</p> <p>Review of the Glucose laboratory reports revealed the following results: on 4/7/09= 206 H(high) (Reference range=70-115), on 4/9/09=189H, on 4/15/09=98, on 5/15/09=128H, on 6/3/09=149H.</p> <p>On 6/10/09 at 10 A.M., the attending physician was interviewed and stated that he was only made aware on 6/9/09 that the resident keeps on refusing the Lantus Insulin.</p> <p>On 6/12/09 at 12:30 P.M., the pharmacy consultant was interviewed and stated that she</p>	F 428		

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F 428	Continued From page 19 comes to the facility about 2-3 times a week to review all resident's physician's orders, Medex(MAR), medication refrigerators, etc." I came on 6/1/09 and I noted the Kayexalate but I did not see the Lantus. I should have seen it but I missed it. I usually note refusals in the MAR as early as 2-3 days and communicate to the nurse and to the Physician." On 6/10/09 at 10:30 A.M., the nurse manager was interviewed and stated that the Physician should have been aware at least during the first day or two after trying to encourage the resident. On 6/10/09 at 3:30 P.M., the nurse-in- charge was interviewed and stated that when a resident refuses the medication, the Physician must be informed through the 24 hour report, and it should be followed up by the 7-3 shift.	F 428		
F 431 SS=D	415.18(c) 483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		8/3/09

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F 431	<p>Continued From page 20</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility did not ensure that expired medication was discarded appropriately according to the manufacturer's specifications. This was evident in one (1) of four (4) units. (Unit 1st floor)</p> <p>This resulted in no harm with potential for more than minimal harm.</p> <p>The finding is:</p> <p>On 6/9/09 at 9:30 A.M., during the initial tour, the first floor medication refrigerator contained an open vial of Lantus Insulin. It was dated 5/6/09, and had not been discarded after 28 days from the date of opening.</p> <p>On 6/10/09 at 10 A.M., the Registered Nurse</p>	F 431		

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F 431	Continued From page 21 (RN) Unit Manager was interviewed. The RN stated that the opened vial of Lantus Insulin found in the medication refrigerator, should have been discarded after 28 days from its opening date. The vial was then discarded by the RN. Review of the Manufacturers specification for Lantus Insulin dated March 2007 documented, "Opened vials, whether or not refrigerated, must be used within 28 days." They may be discarded if not used within 28 days."	F 431		
F 498 SS=D	415.18(d) 483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility did not ensure that the nurse aides demonstrated competency in skills and techniques necessary to care for residents' needs, as evidenced by: 1) not notifying the licensed nurses, (Registered/Licensed nurses) when the residents did have bowel movements for 3 or more days, and 2) The CNA was observed pulling the resident backwards while in the recliner chair from the resident's room to the dayroom. This was evident in four (4) of thirty (30) sampled residents. (Resident #11, #14, #20, and #29) This resulted with actual harm on Resident # 11,	F 498		8/3/09

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F 498	<p>Continued From page 22 and with potential for more than minimal harm to Resident #14, #20, and #29.</p> <p>The findings are:</p> <p>1) Resident # 11 is a 79 year old female admitted to facility on 2/29/08 with diagnoses which include Hypertension, Constipation, Dementia, and Acute Appendicitis.</p> <p>The Minimum Data Set (MDS) 2.0 Assessment dated 5/18/09 documented that the resident's cognition was moderately impaired and her bowel and bladder status as incontinent.</p> <p>A review of the Comprehensive Care Plan for residents "altered elimination" dated 3/11/09 documented a goal that the resident will have a bowel movement at least every three days.</p> <p>An interview was conducted on 6/11/09 at 10:30 a.m. with the unit Registered Nurse (RN) Supervisor. The supervisor stated that all the residents bowel and bladder functions are documented on the residents care flow sheets. The supervisor further stated that if the CNA (certified nurse assistant) notices that the resident has not had a bowel movement in three days, they (CNA) "usually" alert the nurse, who in turn will notify the Physician for interventions. The supervisor further stated that the CNA flow sheets are reviewed by assigned Registered Nurses on a weekly basis.</p> <p>A review of the resident care flow sheets for the month of April 2009 revealed blank spaces for: week one MDS/RN's signature, week two night RN's signature, and for week three for the evening RN's signature.</p>	F 498			

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F 498	<p>Continued From page 23</p> <p>A review of the residents care flow sheet from April 26, 2009 to May 1, 2009 revealed no documented evidence of bowel movements during the day, evening, and night shifts.</p> <p>There was no documented evidence that the licensed nurses and the physicians were notified of the resident not having regular bowel movements for approximately 6 days from April 26, 2009 to May 1, 2009.</p> <p>An interview was conducted with the unit supervisor on 6/11/09 at 10:45 a.m. The supervisor stated that she didn't know why there were blank spaces and no documented bowel movements for the resident from April 26,2009 to May 1,2009.</p> <p>An interview with the Certified Nurse Aide (CNA) was conducted as well. The CNA stated that she had no recollection of the resident having no bowel movements. She further stated that when a resident does not have a bowel movement for 3 days, the CNA is supposed or expected to report and notify the licensed nurse, so the nurse can notify the physician.</p> <p>The nurse's note dated 5/01/09 for the 7-3 shift documented the resident to be pale, sweating, an oxygen saturation of 90%, and a blood pressure of 80/60. The unit Physician was notified and ordered the resident to be transferred to the hospital for evaluation. The resident was transferred from the facility and admitted to the hospital.</p> <p>A review of the hospital emergency room nurse's note dated 5/01/09 at 3:13 p.m. documented the</p>	F 498			

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F 498	<p>Continued From page 24</p> <p>resident with "obvious mild-moderate discomfort from pain." A Physician's examination dated 5/01/09 at 5:30 p.m. documented "hard brown stool" on rectal exam, and a diagnosis of Rectal Fecal Impaction.</p> <p>A review of the hospital discharge summary dated 5/05/09 documented that the resident was "found to have fecal impaction which was disimpacted."</p> <p>2) Resident #14 is a 67 year old male with diagnoses which include: Cerebral-Vascular Disease, Arthritis, and Schizophrenia.</p> <p>On 6/9/09 at 9:15 A.M. lying in bed and on 6/10/09 at 10 A.M. sitting in a wheelchair in the day room, appeared to be comfortable.</p> <p>The Minimum Data Set (MDS) 2.0 dated 3/13/09 documented that the resident has short and long term memory problems and modified independence in decision making skills. It is also indicated that the resident is occasionally incontinent of bowel, frequently incontinent of bladder, and is on a scheduled toileting plan; under hygiene; bathing and transfer documented that the resident requires one person assistance to perform the activities of daily living.</p> <p>Review of the "Resident care Flow Sheet" dated 2/09 under Bowel Movement, documented that on 2/15, 2/16, 2/17, 2/18, and 2/19 for 5 days ; on 6/1, 6/2, and 6/3 for 3 days; and on 6/7, 6/8, 6/9, and 6/10 for 4 days were marked "0"=meaning no bowel movement. This Flow Sheet also further documented instructions such as: "...Notify Nurse if no bowel movement for 3 days."</p>	F 498		

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F 498	<p>Continued From page 25</p> <p>There was no documented evidence in the medical record that the Certified Nurse Assistants (CNAs) notified the licensed nurses (RNs/LPNs) when the resident did not have bowel movements on the above mentioned dates.</p> <p>Review of the nurse's notes dated 2/20/09 documented that the resident complained of pain to the lower back, and was seen and examined by the Physician.</p> <p>The Physician's Order dated 2/20/09 documented: "Lactulose 30 ml.(milliliter) by mouth at bedtime, Milk of Magnesia 30 ml by mouth now, x- ray of abdomen: Fecal Stasis."</p> <p>Review of the Abdominal x-ray dated 2/21/09 revealed: "Retained stool, more in rectum, no obstruction."</p> <p>On 6/11/09 at 1 P.M., the CNA was interviewed and stated that she should have notified the nurse after noting that the resident did not move his bowel for 4 days.</p> <p>On 6/12/09 at 10 A.M., the RN Charge Nurse was interviewed and stated that the CNA is supposed to report to the nurse if there is no bowel movement for 3 days.</p> <p>3) Resident #20 is an 85 year old with a diagnoses which include: Bilateral Lower leg Stasis Ulcer, Gastro-Esophageal Reflux Disease, and Anemia.</p> <p>On 6/9/09 at 9:30 A.M., and on 6/10/09 at 12:00 Noon, observed the resident alert and oriented to date, time, and person with dressing on both lower</p>	F 498		

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F 498	<p>Continued From page 26</p> <p>extremities.</p> <p>The MDS(Minimum Data Set) 2.0 dated 5/5/09 documents that the resident 's short and long term memory is intact and independent in decision making skills.</p> <p>Review of the "Resident Care Flow Sheet"(RCFS) dated: 11/08 documented that from 11/1 to 11/11/08 for 11days its marked 0=no Bowel Movement (BM), and 13 blanks/no entry between day, evening, and night shifts within the inclusive dates above. Further review of the RCFS dated 12/08 indicated that on 12/25, 12/26, 12/27, and 12/28 for 4 days marked 0=no BM, and 3 blanks/no entry; on 2/09 same flow sheet indicated that on 2/25, 2/26, 2/27, and 2/28 for 4 days marked 0=no BM, and 2 blanks/no entry.</p> <p>There was no documented evidence that the licensed nurse was aware that the resident did not have a bowel movement on the above listed dates.</p> <p>On 6/12/09 at 10 A.M., the resident was interviewed and stated that he never had any problem in moving his bowels.</p> <p>On 6/12/09 at 11 A.M., the Certified Nurses Aide (CNA) was interviewed and stated that as far as she knew, the resident is very alert and goes to the bathroom by himself, and the CNAs assigned on those days did not ask the resident if he had a bowel movement or not, and it should not be left blank.</p> <p>On 6/12/09 at 12:00 Noon, the Registered Nursing Supervisor was interviewed and stated that it is the responsibility of the assigned CNA to</p>	F 498		

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F 498	<p>Continued From page 27</p> <p>enter the number of bowel movements in the shift, and report to the licensed nurse for no bowel movements after 3 days.</p> <p>4) Resident #29 is an 83 year old female with a diagnoses which include: Dementia, Dysphagia, Hypertension, and Cancer of the colon.</p> <p>The Minimum Data Set (MDS) 2.0 dated 5/21/09 documented that the resident has short and long term memory problems, and severely impaired decision making skills. The resident is totally dependent of one person in locomotion in and off the unit. It is indicated that the resident's range of motion has limitation on both sides of leg and foot, and partial loss of voluntary movement.</p> <p>The physician's order dated 5/19/09 documented: "Out of bed to reclining geriatric chair daily..."</p> <p>The comprehensive care plan dated 3/27/09 revised 6/8/09 documented: "Assist with all ALS's (Activities of Daily Living)...treat resident as normal individual and allow freedom of movement..."</p> <p>On 6/12/09 at 12:45 P.M., observed the resident sitting in a recliner chair being pulled backwards by a CNA from the resident's room to the dayroom.</p> <p>On 6/12/09 at 12:50 P.M., the CNA was interviewed and stated that that is how she always takes the resident to the dayroom because it is hard to push the geri-recliner, and it is easier to pull backwards.</p> <p>On 6/12/09 at 1 P.M., the Registered Nursing</p>	F 498			

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F 498	Continued From page 28 Supervisor was interviewed and stated that the staff was in-service lately on how to transfer residents while in the recliner. The resident is supposed to be pushed not pulled for the resident's safety and dignity.	F 498		
F 514 SS=D	415.26(d) 483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility did not ensure that the resident's clinical record was maintained in a completed and accurate manner as evidenced by: altering the clinical record after it has been initially recorded and reviewed. This was evident for one (1) of thirty (30) sampled residents. (Resident #4) This resulted in no harm with potential for more than minimal harm. The finding is: Resident #14 is a 67 year old male with a	F 514		8/1/09

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F 514	<p>Continued From page 29</p> <p>diagnoses which include: Cerebro Vascular Disease, Arthritis, and Schizophrenia.</p> <p>The Minimum Data Set (MDS) 2.0 assessment dated 3/13/09 documented that the resident has short and long term memory problems, and modified independence in decision making skills. It is also documented that the resident is occasionally incontinent of bowel, frequently incontinent of bladder, and is on scheduled toileting plan; under hygiene, bathing and transfer, the MDS documented that the resident requires one person assistance to perform the Activities of Daily Living.</p> <p>Review of the "Resident Care Flow Sheet" dated 2/09 under Bowel Movement documented that on 2/15, 2/16, 2/17, 2/18, and 2/19 for 5 days; on 6/1, 6/2, and 6/3 for 3 days, and on 6/7, 6/8, 6/9, and 6/10 for 4 days were marked "0"=(meaning) no Bowel Movement (BM). This flow sheet also further documented instructions, "...Notify Nurse if no bowel movement for 3 days."</p> <p>On 6/10/09 at 10 A.M., the resident's record was requested for further review and noted alterations on 4 different dates on: 6/3/09, 6/7/09, and 6/9/09 day shift and on 6/9/09 night shift.</p> <p>The Unit Charge Nurse was not available for interview at this time.</p> <p>On 6/10/09 at 10:30 A.M., the Director of Nursing(DNS) was interviewed and stated that after she investigated the records being altered, she acknowledged that the record was obviously altered. The DNS also stated that this is not tolerated in the facility, and that the plan of correction is underway.</p>	F 514		

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K 034 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: I. Section 7.2.2.5.4 states that Stairs serving five or more stories shall be provided with signage within the enclosure at each floor landing. The signage shall indicate the story, the terminus of the top and bottom of the stair enclosure, and the identification of the stair enclosure. The signage also shall state the story of, and the direction to, exit discharge. The signage shall be inside the enclosure located approximately 5 ft. (1.5 m) above the floor landing in a position that is readily visible when the door is in the open or closed position. 7.2.2.5.4.</p> <p>This standard is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that 2 of 2 exit stairways serving basement to 5th floors are provided with signage within the stair enclosure at each floor landing in accordance with LSC 7.2.2.5.4.</p> <p>This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy.</p> <p>The findings include: On June 9, and June 10, 2009, at 10:00 AM to 2:30 PM, it was observed that the facility building is a 5 story building. The exit stairways are serving basement to the 5th floor. The stairways lack the signage with regard to the story, the identification of stair, the termination of the top</p>	K 034		8/10/09

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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335723	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2009
NAME OF PROVIDER OR SUPPLIER EAST HAVEN NURSING AND REHAB C			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 EASTCHESTER ROAD BRONX, NY 10469		
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K 034	<p>Continued From page 1</p> <p>and bottom of the stair enclosure, the floor and direction of the exit discharge in accordance with 7.2.2.5.4. Stair signage with the information in accordance with 7.2.2.5.4 must b installed at each floor landing within all exit stairways. On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that the stair singage is being ordered and will be installed within all stairways.</p> <p>II. Section 7.2.2.5.3 states that there shall be no enclosed, usable space within and exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. Exception: Enclosed, usable space shall be permitted under stairs, provided that the space is separated from the stair enclosure by the same fire resistance as the exit enclosure. Entrance to such enclosed usable space shall not be from within the stair enclosure. (See also 7.1.3.2.3)</p> <p>This Standard is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that the storage room off the exit stair "E" enclosure which is separated from the stairway has entrance only from the outside instead of from within the stair enclosure in accordance with the exception rule described under 7.2.2.5.3, of the Life Safety Code.</p> <p>This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy.</p> <p>The findings include: On June 9, 2009 and June 10, 2009, at 10:00 AM</p>	K 034			

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K 034	Continued From page 2 to 2:30 PM, it was observed that the door to the storage room, identified as household storage, in the basement, opens directly into the exit stair "E" enclosure. Although, the storage area is separated from the exit stairway, the entrance to the storage room is from within the stair enclosure instead of from the outside of the stair enclosure. On June 10, 2009, at approximately 2:30 PM, the facility Director of building services stated that the possibility of an entrance from outside of the stair enclosure to the storage room will be explored. 711.2 (a)(1)	K 034		
K 038 SS=E	II. 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: Section 7.2.1.5.4 states that a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches (86 cm) and not more than 48 inches (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.	K 038		8/10/09

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K 038	<p>Continued From page 3</p> <p>This standard is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that the facility did not ensure that the egress doors from the rooms are free from the door fastening devices which would require more than one releasing operation and the door fastening device provided at the doors are the familiar type devices with an obvious method of operation under all lighting condition (examples are: beauty parlor, household storage room, linen chute discharge room, physical therapy room door leading to the recreation area, social service office).</p> <p>This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy.</p> <p>The findings include: On June 9, 2009 and June 10, 2009, it was observed that the doors to the rooms (beauty parlor, household storage room, in the basement, linen chute discharge room, physical therapy room door leading to the recreation area and social service office) are equipped with dead bolt type locking devices in addition to the conventional door knob type latching devices. These door fastening devices, if engaged, would require more than one door releasing operation from the egress side (the releasing of the dead bolt lock using the thumb twist type releasing device and turning the door knob to release the regular latching device). Also, the thumb twist type dead bolt lock releasing device is not a familiar type device which would be readily operated under all lighting conditions. On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that all double locking devices are being removed from the room</p>	K 038			

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K 038	Continued From page 4 doors.	K 038		
K 076 SS=D	<p>711.2 (a)(1) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that the oxygen cylinders stored within the oxygen storage room off the recreation area, on the first floor, are separated from the combustible material storage (adult briefs, cardboard boxes, miscellaneous packages), as per 8.3.1.11.2, of the NFPA99 - Health Care Facilities.</p> <p>This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy.</p> <p>The findings include: On June 9, 2009, and June 10, 2009, at 10:00 AM to 2:30 PM, it was observed that in oxygen storage room on the first floor, the oxygen</p>	K 076		7/21/09

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K 076	Continued From page 5 cylinders are stored beneath shelves storing packages of residents briefs, boxed supplies and miscellaneous paper packages. The oxygen storage must be separated from the combustible storage, in accordance with NFPA99. On June 10, 2009, at approximately 2:30 PM, the facility director of building services stated that all combustible supplies are being removed from the oxygen storage room. 711.2 (a)(1)	K 076		

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 335723	(Y2) Multiple Construction A. Building B. Wing 01 - EAST HAVEN NURSING HOME	(Y3) Date of Revisit 8/17/2009
Name of Facility EAST HAVEN NURSING AND REHAB C		Street Address, City, State, Zip Code 2323 EASTCHESTER ROAD 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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC <u>K0034</u>	Correction Completed 08/10/2009	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0038</u>	Correction Completed 08/10/2009	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0076</u>	Correction Completed 07/21/2009
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

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

Followup to Survey Completed on: 6/15/2009	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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