

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

PRINTED: 03/18/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335199	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/15/2008
NAME OF PROVIDER OR SUPPLIER RESORT NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BEACH 68TH STREET ARVERNE, NY 11692	
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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225		1/12/09

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.

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F 225	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, record review, staff and resident interviews during the recertification survey, the facility did not ensure that an incident during a resident transfer, which was the result of a Certified Nursing Assistant (CNA) not following the resident's plan of care, was reported to the administration for investigation. Specifically, 1 resident (#11) in a total sample of 30 residents reviewed for abuse was lowered from the wheelchair to the floor during a 1 person assist. The resident's plan of care documented the resident requiring a 2 person transfer. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.</p> <p>The finding is:</p> <p>Resident #11 has diagnoses which include Osteoarthritis, End Stage Renal Disease, Diabetes Mellitus and Chronic Obstructive Pulmonary Disease.</p> <p>The resident 's cognition was documented as moderately impaired on the Quarterly Minimum Data Set (MDS) Assessment dated 11/11/08. The MDS further documented that the resident required total assist of 2 people for transfer and that the resident was not ambulatory.</p> <p>The Physician's Order dated 11/18/08 documented that the resident was to get out of bed to a reclining back wheelchair with assist of 2 people.</p> <p>During a tour of the resident's room on 12/12/08 at 8:45 AM, the resident's roommate told the surveyor that her roommate "fell" last night</p>	F 225			

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F 225	<p>Continued From page 2 (12/11/08). There was a 7AM-3PM shift CNA in the room at that time who confirmed what the resident's roommate stated to the surveyor.</p> <p>Resident #11 was interviewed on 12/12/08 at 9:00 AM. She was alert and able to converse with the surveyor appropriately. When asked "how was your night?" she stated "when I returned from dialysis last night the CNA was putting me to bed and she couldn't hold me because my knees got weak and I fell".</p> <p>The CNA Accountability record documented that the resident required "constant" 2 person assist for transfer. The 3-11 PM accountability was signed as completed on 12/11/08.</p> <p>A interview on 12/15/08 at 3:15 PM with the CNA who was assigned to the resident on 12/11/08 on the 3-11 PM shift. The CNA revealed that she was unaware that the resident was a 2 person transfer.</p> <p>Medical record review revealed no documentation of a fall on 12/11/08. In an interview on 12/12/08 at 9:10AM with the Registered Nurse (RN)/Manager and RN/Charge Nurse, both stated that they were unaware of any incident related to Resident #11 the evening of 12/11/08.</p> <p>A review of the 12/11/08 Daily Report Sheet revealed that no incident for Resident #11 was documented.</p> <p>An interview was conducted with the RN/Risk Manager on 12/12/08 at 9:00 AM. The RN stated that the incident had not been reported to her and that she would start the investigation immediately.</p>	F 225			

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F 225	Continued From page 3 The Facility Investigation Summary dated 12/12/08 was reviewed. The Investigation Summary documented that the 3:00PM-11:00PM RN/Supervisor covering the unit where the 12/11/08 incident occurred had yet to be investigated, as there was no report of the incident. The 12/12/08 report also included that the assigned CNA should not have transferred the resident by herself and should have followed the plan of care.	F 225			
F 281 SS=D	415.4 (b)(2) 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews during the recertification survey it was determined that the facility did not ensure that services provided met professional standards of practice for one of thirty sampled residents. Specifically, the facility did not ensure that Resident # 22 received medication as ordered by the physician in a timely manner. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The finding is: Resident # 22 has diagnoses that include Chronic Obstructive Pulmonary Disease (COPD) and history of Psychotic Disorder. The Minimum Data Set (MDS) Assessment dated 10/16/08 documented that the resident's cognition	F 281		1/14/09	

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F 281	<p>Continued From page 4 was modified independence.</p> <p>During an interview on 12/12/08 at 10:00AM Resident # 22 informed the surveyor that she had not received her Lipitor (medication for high cholesterol) for the past nine days.</p> <p>The Physician's Orders Form signed 12/2/08 documented an order for Lipitor 20 milligrams (mg) one tablet at bedtime.</p> <p>Review of the Medication Administration Record (MAR) dated 12/2008 documented that the Lipitor had been signed as given from 12/3/08 through 12/14/08. The blisterpack for Lipitor was requested and there was no Lipitor available for Resident # 22.</p> <p>Resident # 22 was interviewed on 12/15/08 at 11:00 AM. The Resident was asked if she had received her Lipitor last evening. The Resident stated that she had not received Lipitor for over one week.</p> <p>The providing Pharmacist was interviewed on 12/15/08 at 11:30 AM. The Pharmacist stated that there was an insurance issue with the Lipitor for Resident # 22. The Pharmacist further stated that a 30 day supply of Lipitor was last sent to the facility on 11/5/08 for Resident # 22. The Pharmacist stated that a Medicare Part D-Action Required Form was faxed to the facility that addressed Lipitor as a non-formulary medication. The resident's physician was expected to change the Lipitor to another formulary cholesterol medication. This form was re-faxed to the pharmacy on 12/2/08. The physician had changed the medication to Simvastatin (Zocor) 30 tablets once a day.</p>	F 281			

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F 281	<p>Continued From page 5</p> <p>There was no documentation in the record that the Lipitor had been discontinued and no order for the Simvastatin to be administered to Resident # 22.</p> <p>The Director of Nursing Services (DNS) was interviewed on 12/15/08 at 12:10 PM. The DNS was unaware that that a Medicare Part D Action form had been faxed to the facility for Resident #22.</p> <p>The DNS was also unaware of any concerns about Lipitor for Resident # 22.</p> <p>The DNS was again interviewed on 12/15/08 at 1:30 PM. The DNS stated that the Medicare Part D Action Form would have been kept in the nursing office for the Supervisor to address. The form would be kept on a "to do clip board." The DNS further stated that no one recalled giving the form to the physician. He also stated that the Supervisor would have been responsible to contact the Physician for an Interim Order and to discontinue the Lipitor.</p> <p>On 12/15/08 the DNS interviewed the medication nurses that had signed for the Lipitor for Resident # 22. The 3:00 - 11:00 PM nurse who worked on 12/11/08 acknowledged to the DNS that while she had signed for the medication she had not administered Lipitor.</p> <p>The medication nurse that worked 12/14/08 stated that she had administered the last Lipitor tablet to the resident and had faxed a request to the pharmacy for another supply.</p> <p>The Registered Nurse (RN) Supervisor who worked 7:00 AM to 7:00 PM on 12/2/08 was</p>	F 281			

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F 281	Continued From page 6 interviewed on 12/15/08 at 3:40 PM. The Supervisor stated that she saw the form and should have obtained a telephone order for the Simvastatin. She was unable to explain why this had not been completed. The RN Supervisor who worked 7:00 AM to 7:00 PM on 12/6/08 was interviewed on 12/15/08 at 3:45 PM. The RN stated that she had not seen the Medicare Part D Action Form.	F 281			
F 314 SS=D	415 .11 (c)(3)(i) 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews during the recertification survey, the facility did not ensure that a resident received necessary services to promote healing and prevent the deterioration of a sacral pressure ulcer. Specifically, 1 resident (#12) of 14 residents reviewed for Pressure Ulcers, had an existing pressure ulcer which deteriorated from a Stage II to a Stage IV. A timely assessment was not completed resulting in delayed nutritional interventions and the ischial pressure ulcer deteriorated from a Stage II to a Stage IV. This	F 314		1/12/09	

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F 314	<p>Continued From page 7</p> <p>resulted in no actual harm with the potential for more than minimal harm which is not immediate jeopardy.</p> <p>The finding is:</p> <p>Resident #12 has diagnoses which included Osteoporosis and Parkinson's Disease.</p> <p>The facility's Assessment of Pressure Ulcer Potential dated 8/18/08 documented the resident at high risk for the development of pressure ulcers.</p> <p>The Quarterly Minimum Data (MDS) Set dated 9/24/08 documented the resident with modified independent cognitive skills for daily decision making. The MDS also documented that the resident was dependent on staff for all activities of daily living.</p> <p>A weekly Skin Assessment Flow Sheet dated 10/2/08 documented a Stage II Pressure Ulcer on the right ischium.</p> <p>A Physician's Order dated 10/02/08 documented a treatment to the right ischium Stage II.</p> <p>A Quarterly Nutritional Review was completed on 9/16/08 . The resident's skin was documented as "intact" at that time. There were no further documented dietary assessments in the clinical record until 11/13/08.</p> <p>On 10/11/08 the Weekly Skin Assessment Flow Sheet documented that the right ischium ulcer was assessed at a Stage III with increase in size and a serous exudate.</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>Physician's Order dated 10/11/08 documented a change in treatment for the Stage III pressure ulcer.</p> <p>There was no documented evidence that the resident's nutritional needs were assessed addressing the deterioration of the pressure ulcer.</p> <p>The Pressure Ulcer Flow Sheet dated 10/17/08 documented that the ischial Pressure Ulcer had deteriorated to a Stage IV. There was no dietary assessment addressing the deterioration of the wound to a Stage IV.</p> <p>The Registered Dietitian (RD) was interviewed on 12/15/08 at 1:30 PM. The RD stated that the resident's protein needs were based on the resident's ideal body weight of 125 to 153 pounds and not on the the resident's actual weight of 213 pounds. She stated that the resident was receiving 2200 calories with 110 grams of protein based on 100% intake. It was further stated that she was unaware of Resident #12's Pressure ulcers and that if she had been aware, the protein needs would have been assessed at the current body weight and in accordance with the undated Facility Nutritional Pressure Ulcer Guidelines.</p> <p>During the interview, the RD calculated that the resident's protein needs with a Stage II pressure ulcer would have been 116 grams (gm) based on her actual body weight of 213 pounds. Additionally, the RD calculated that a Stage III pressure ulcer would require 135 gm of protein and at Stage IV pressure ulcer would require 145 gm of protein. The RD further explained that presently there is no formal system of informing the RD of skin changes and a protein supplement should have been automatically ordered when the</p>	F 314			

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F 314	Continued From page 9 pressure ulcer was first identified, even without the RD's Assessment. As of 12/15/08 the resident's current intake of daily protein was 155 gm. The right ischium pressure ulcer was documented as a Stage IV on the 10/17/08 Weekly Skin Assessment Flow Sheet. The Physician Orders dated 10/17/08 documented a change in treatment of the Stage IV pressure ulcer. The Physician's orders from 10/17/08 also included Vitamin C, Zinc, Multivitamin, and Prostat 101 (a protein supplement). This was the first time that nutritional supplements were documented as ordered for the right ischium pressure ulcer which was first identified as a Stage II. The RN/Wound Care Nurse was interviewed on 12/15/08 at 9:15 AM. The RN stated that when a Physician's Order is written a copy should also be sent to the Dietary Office. He further stated that the Wound Treatment Protocol Physician's Interim Order Sheet should have been completed by the Physician when the pressure ulcer was first identified. There was no documented evidence that the form had been completed.	F 314			
F 322 SS=D	415.12(c)(1) 483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		1/12/09	

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F 322	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review during a recertification survey the facility did not ensure that a resident who is fed by a Gastrostomy Tube (GT) received appropriate treatment and services to prevent complications including metabolic abnormalities. This was noted for one of 11 Gastrostomy Tube fed residents reviewed in a total sample of 30 residents. Specifically, Resident #26, whose nutrition and hydration needs were met through GT, received protein from 6/17/08 to 9/9/08 in an amount that was approximately double the required amount and three times the required amount from 9/9/08 to 12/15/08. This resulted in Azotemia (higher than normal blood levels of protein metabolites-Blood Urea Nitrogen (BUN) and Creatinine). The over load of protein put unnecessary strain on the liver and kidneys. This resulted in no actual harm to the resident with a potential for more than minimal harm.</p> <p>The finding is:</p> <p>Resident #26 has diagnoses including Hypertension, Dementia and Dysphagia. A GT for feeding was inserted on 6/17/08.</p> <p>The Registered Dietitian (RD) was interviewed on 12/15/08 at 11:15 AM. The Dietary regimen and documentation including the laboratory values, comprehensive care plan, and Physician's orders were reviewed with her for the period between June 2008 through December 2008. The following was concluded:</p> <p>The RD stated that the resident's GT feeding</p>	F 322			

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F 322	<p>Continued From page 11</p> <p>consisted of 100 grams (gm) of protein and 1404 calories from 6/17/08 until 9/9/08, the breakdown was 1000 cubic centimeters (cc) of Nutren Pulmonary (1000 calories, 40 gm protein) and 60 cc's of Prostat (Protein supplement- 404 calories and 60 gm protein) daily. The initial Nutritional Assessment dated 6/17/08 documented the protein need (based on 1-1.2 gm per kilogram, (kg) body weight) to be 39-47 gm per day. It documented that the resident was noted with multiple decubitus ulcers and that her need for at least 1.2 gm protein per kg were being met.</p> <p>The resident was actually receiving protein at the rate of 2.55 gm/kg. The Dietitian stated that the resident was readmitted from the hospital with multiple decubitus ulcers. The nursing progress notes documented that the decubitus ulcers healed shortly after admission.</p> <p>A Tube Feeding Nutritional Analysis dated 9/9/08 documented that the GT formula and volume were changed and the resident now received 1500 cc's of Replete with fiber with no change in the Prostat order. This provided 154 gm protein and 1500 calories daily. A dietary progress note dated 9/9/08 documented that the new tube feeding order would promote weight gain and that it provided protein at the rate of 3.9 gms/kg of body weight.</p> <p>The Tube Feeding Nutritional Analysis dated 9/9/08 documented the resident's ideal body weight range to be 115-141 pounds (lbs).</p> <p>According to the monthly weight tracking sheet, the resident's weight remained at 86 lbs from 6/08 until 9/08, and improved to 97 lbs in 10/08 and 11/08 and to 102 lbs in 12/08.</p>	F 322			

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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 322	<p>Continued From page 12</p> <p>The normal laboratory values are as follows: BUN (normal values 8-20 milligrams/deciliter (mg/dl)) and Creatinine (normal values 0.6-0.9 mg/dl), BUN/creatinine ratio (normal values 6-22), Sodium (normal values 135-145 milliequivalent/liter (mEq/L)) and Potassium (normal values 3.8-5.5 mEq/L)</p> <p>The resident laboratory values were noted to be as follows: 6/9/08: BUN 25, Creatinine 0.5, BUN/Creatinine ratio 49.9, Sodium 142, Potassium, 4.5. 6/25/08: BUN 47, Creatinine 0.7, BUN/Creatinine Ratio 66.8. 11/10/08: BUN 63, Creatinine 0.7, BUN/Creatinine Ratio 90.4, Sodium 140, Potassium 5.5. 11/13/08: BUN 63, Creatinine 0.7, BUN/Creatinine Ratio 89.2, Sodium 143, Potassium 5.3. 11/17/08: BUN 51, Creatinine 0.9, BUN/Creatinine Ratio 56. 12/12/08: BUN 78, Creatinine 1, BUN/Creatinine Ratio 78.3, Sodium 139, Potassium 5.4.</p> <p>A Nutritional Assessment for Enteral Feeding form dated 6/17/08 and a Tube Feeding Nutritional Analysis dated 9/9/08 documented that the resident received 2050 cc fluids daily from 6/17/08 until 9/9/08, and 2324 cc of fluids daily from 9/9/08 until 11/9/08. The Physician ordered on 11/9/08 to give an extra 300 cc of water for three days and one dose of Kayexalate (a medication to address elevated Potassium). On 11/11/08 the Physician ordered extra fluids through IV (intravenous) (fluids administered through a catheter placed in a vein) at 75 cc an hour for 48 hours for Azotemia.</p>	F 322			

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F 322	Continued From page 13 The facility's current, undated Nutrition Policy documented the following guidelines for the protein need calculation: For normal (3.5 gm/dl) protein status, calculate at the rate of 0.8 gm per kg of body weight, per day For severe (2.1 gm/dl) protein depletion, calculate at the rate of 1.5/2.0 gm/kg body weight, per day. The RD stated that she did not know the rationale for giving the resident high rates of protein (2.5 gm/kg) and (3.9 gm/kg). She stated that the resident had pressure ulcers upon admission and that she did not think that the resident was receiving excessive amount of protein. In an interview with the unit Charge Registered Nurse on 12/15/08 at 11:45 AM she stated that the resident had multiple stage one pressure ulcers upon admission but has had no pressure ulcers since August 2008. In an interview with the resident's attending Physician on 12/15/08 at 10:30 AM he stated that the resident previously had no renal issue, and that he had discussed the resident's elevated BUN with the renal Specialists. He was concerned about the elevated BUN and did not understand what might be causing its elevation. He had increased the fluids and despite the resident now receiving 3 liter of fluid, the BUN was still high. He stated that the resident is in an excessive catabolic state. He added that it was possibly related to nutrition or feeding. The Physician ordered to discontinue Prostat on 12/15/08. 415.12 (g)(2)	F 322			

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F 325 SS=G	<p>483.25(i) NUTRITION</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews and record reviews during a recertification survey 1) the facility did not ensure that the resident's maintain acceptable parameters of nutritional status such as body weight. This was noted for one resident of 11 Gastrostomy Tube (GT) fed resident's reviewed in a total sample of 30 residents. Specifically, Resident #16 whose nutritional needs were met through GT feeding did not receive an adequate amount of calories to maintain the body weight from 9/08 to 11/08. In addition the facility did not address resident weight loss in a timely manner for four (Resident #5, #7, #15 and # 23) of 22 residents reviewed for weight issues in a total sample of thirty residents. This resulted in actual harm that is not immediate jeopardy for Resident #16 and no actual harm for Residents #5, #7, # 15 and # 23.</p> <p>The findings include but are not limited to:</p> <p>1) Resident #16 has diagnoses including Pleural Effusion, Hypertension, Dementia, Diabetes</p>	F 325		1/21/09	

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F 325	<p>Continued From page 15 Mellitus.</p> <p>The resident's Minimum Data Set assessment dated 9/08 documented that the resident had impaired memory and cognition.</p> <p>The nursing Progress notes documented that the resident was hospitalized from 8/18/08 until 9/9/08 with Atrial Fibrillation and Pleural Effusion and returned with a Gastrostomy Tube for feeding.</p> <p>The monthly tracking weight sheet from August 2008 to December 2008 documented that the resident weighed 200 lbs prior to his hospitalization in August 2008. Upon return from the hospital on 9/9/08 he was documented to be 172 lbs. The subsequent weekly weights for October 2008 documented a progressive weight loss: 169 lbs, 165 lbs, and 162 lbs. The November 2008 weight was documented to be 157 lbs. This represents a 15 lb weight loss in 2 months.</p> <p>The Dietary progress note upon 9/9/08 re-admission documented that the resident had lost 30 lbs during hospitalization, and was tolerating the GT feeding well. The note documented that the resident was noted to be on Lasix (a diuretic), that could cause fluid shifts and also that the current weight may not be a true weight.</p> <p>A Tube Feeding Nutritional Analyses Sheet dated 9/9/08 documented to give 1500 cubic centimeters (cc) of formula (Replete with Fiber), to provide 1500 calories. The Analyses Sheet documented the estimated caloric needs based on 30 calories per kilogram (kg) body weight to be</p>	F 325			

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F 325	<p>Continued From page 16</p> <p>2280 per day. It documented that the resident's Recommended Dietary Allowances were being met.</p> <p>A Dietary progress note dated 10/8/08 documented that the resident weighed 166 lbs, had lost 6 lbs in one month, and had a significant weigh loss in 6 months and was at a high nutritional risk. It further documented that the need of at least 30 calories and 1.2 gm per kg body weight was being met. The note documented that the diuretic was likely contributing to weight fluctuations and fluid shifts. It further documented that weekly weights were being monitored and to continue the plan of care.</p> <p>The resident's caloric requirement was calculated along with the Registered Dietician (RD) using 30 calories per kg body weight (a standard universal guideline for weight maintenance). With the resident's reduced weight of 166 lbs, the calculated requirement was noted to be 2250 calories. Therefore the documentation by the RD on 10/8/08, that the 1500 calories that the resident received were adequate, did not reflect that the resident was receiving 750 calories less than the required 2250 calories daily.</p> <p>The Dietary progress note dated 11/9/08 documented the resident's weight to be 161 lbs, a 5 lb loss in 1 month, a 30 lb loss in 6 months, significant weight loss in 6 months and at high nutritional risk. It was further documented that the 9/08 albumin (2.9 g/dl) was low, Prostat (protein supplement), will be provided to aid protein store repletion. The Nutrition care plan documented that Prostat 101, 60 cc twice a day was started on 11/9/08. This would provide an additional 400 calories and 60 gms of protein.</p>	F 325			

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F 325	Continued From page 17 The resident's caloric requirement were calculated with the RD (based on a standard calculation of 30 calories per kg body weight) at the resident's reduced weight of 161 lbs, is 2190 calories. With the additional 400 calories from Prostat the resident received 1900 calories daily, below the requirement by 290 calories daily. A Nutritional Quarterly Review dated 11/30/08 documented that the resident was at a high nutritional risk due to significant weight loss in one month and six months, the potential weight fluctuations were expected due to diuretic therapy. The RD added that the current weight may not be a true weight. It was also documented that no further weight loss was anticipated as the GT feeding and Prostat met the need of at least 30 calories per kg body weight. A Physician's referral dated 12/1/08 requested a Dietary consult to Evaluate Meal Plan/Supplements due to weight loss. The form's findings section documented, "Refer to Dietary", the remaining sections including the diagnoses, recommendations, signatures etc were blank. The RD was interviewed on 12/12/08 at 10 AM, regarding the resident's weight loss. The interview revealed the following: The RD stated that despite the weight loss the resident was still well above the lower end of his ideal body weight range (139-169 lbs). She stated that the weight loss was most likely and expected due to the diuretic therapy. She stated that the standard volume of formula that is routinely provided to the tube fed residents in this facility is 1500 cc. She stated that she did not want to run the feeding for a longer time as it was a quality of	F 325			

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F 325	<p>Continued From page 18</p> <p>life consideration. She stated that she had expected the resident's weight to be stabilized in a few months. She further stated that the Prostat 60 cc twice daily (primarily a protein supplement) was added on 11/9/08 to provide added 400 calories and 60 gm protein. She stated that the Prostat was added for additional calories instead of additional feeding formula as she did not want to increase the volume of the feeding. She stated that she did not consider other GT formula as the resident was also a diabetic.</p> <p>The Physician's progress notes for August, September, and October 2008 did not document any edema present. In the note dated 11/29/08 the Physician documented that the resident did not have edema and a GI (Gastro Intestinal) consult was to be ordered for failure to thrive. The GI Consult was subsequently requested by the Physician on 12/1/08 due to weight loss. The Consult was completed by the GI specialist on 12/9/08. It documented a progressive weight loss from 195 lbs in July (2008) to 169 lbs in September (2008) to 157 lbs in December (2008). The recommendation was to increase calories to 1800/day.</p> <p>The Physician ordered to increase calories to 1800/day on 12/10/08.</p> <p>The Physician was interviewed on 12/12/08 at 11:15 AM and stated that he had been concerned about the resident progressive weight loss and failure to thrive. He further stated that he wanted to rule out any GI pathology or malignancy so he asked for a GI consult who recommended an increase in calories. He stated that he was not aware that the resident was receiving inadequate calories to maintain weight.</p>	F 325			

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F 325	<p>Continued From page 19</p> <p>2) Resident #7 has diagnoses that include Dysphagia and Dementia.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 11/26/08 documented that the resident was severely impaired in cognition and decision making and had a swallowing problem and had a GT for nutrition.</p> <p>The Comprehensive Care Plan (CCP) developed for nutrition dated 10/27/08 documented that the resident's weight was 128.8 pounds (lbs). The resident received a tube feeding formula at 1000 cubic centimeter (cc) to be administered at 99 cubic centimeter per hour (cc/hr). The CCP also documented to monitor the resident's weight weekly.</p> <p>The Nursing Admission Record dated 11/20/08 and the Initial Nutrition Assessment documented the resident's weight at 135.8 lbs and the ideal body weight (IBW) was between 99-121 lbs.</p> <p>The resident's weight flow sheet documented the following: 11/26/08 - 121.6 lbs 12/03/08 - 130.9 lbs 12/10/08 - 128.2 lbs</p> <p>Nurses notes reviewed from 11/26/08 through 12/03/08 contained no documented evidence that the resident was re-weighed to validate that the weights taken on 11/26/08 and 12/03/08 were accurate. There was also no documented evidence that the dietitian and physician had been informed of the resident's documented weight loss.</p>	F 325			

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F 325	<p>Continued From page 20</p> <p>The Unit's 24-Hour Report dated 11/26/08 revealed no documented evidence that the weight obtained on 11/26/08 was addressed.</p> <p>The nutrition CCP was updated on 12/1/08. There was no documented evidence that the weights obtained on 11/26/08 was addressed.</p> <p>The Unit RN Supervisor was interviewed on 12/15/08 at 9:00 AM. The RN stated that there was no re-weigh done to validate the resident's weight taken on 11/26/08. The RN also stated that the Weight Book served as a communication book for the Unit Dietitian. The Certified Nursing Assistant (CNA) who took the resident's weight that day was not available for interview.</p> <p>The Unit Dietitian was interviewed on 12/15/08 at 9:30 AM. The Dietitian stated that the change of the resident's weight on 11/26/08 was not communicated to her and that she might have missed or presumed that it was just an error when she reviewed the Weight Book. The Dietician stated that she did not request for a reweigh of the resident to verify its accuracy.</p> <p>3) Resident #15 has diagnoses including Schizoaffective Disorder, Parkinsons Disease and Benign Prostate Hypertrophy.</p> <p>A Nursing Assessment Record dated 11/11/08 documented that the resident was readmitted from the hospital. The assessment also documented that the resident was 168 centimeters (cm) tall and the space for the resident's weight was blank.</p> <p>A Nursing Note titled Weekly Weights dated 11/12/08 recorded that Resident #15 weighed</p>	F 325			

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F 325	<p>Continued From page 21</p> <p>224 lbs.</p> <p>A Dietary Progress Note and a Comprehensive Care Plan Evaluation dated 11/12/08 documented that the resident's readmission weight was pending.</p> <p>A Monthly Weight Sheet dated July 2008 to December 2008 documented that the resident lost 21.2 lbs (approximately 12% of body weight) between 7/2008 (173 lbs) and 12/2008 (151.8 lbs).</p> <p>An interview was conducted with the Registered Nurse (RN) Unit Manager on 12/10/08 at 1:45 PM. The RN stated that the resident should have been reweighed by the next day and she would notify the Registered Dietitian (RD) after the reweigh was completed. The RN further stated that she assigns the Certified Nursing Assistant (CNA) to obtain a reweigh when needed.</p> <p>An interview was conducted with the resident's RD on 12/10/08 at 1:50 PM. The RD stated that she was aware of the residents weight of 224 lbs taken on 11/12/08 and verbally requested a reweigh to the RN Unit Manager. The RD further stated that she reviews the weekly weights on a weekly basis. The RD also stated that a reweigh should have been obtained within 24 hours and verified by a nursing supervisor.</p> <p>An interview was conducted with the Director of Nursing Services (DNS) on 12/10/08 at 2:35 PM. The DNS stated that reweighs should be done the same day that the resident's weight is lower or higher than the previous weight. The DNS further stated that a nursing supervisor should be present and sign off to verify that the reweigh is</p>	F 325			

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F 325	Continued From page 22 correct. Additionally, the DNS stated that the RD should be informed verbally by the nursing staff when any weight discrepancy is identified. The facility policy dated 5/2002 titled Weight Taking documents the following: Weights will be taken on the day of admission and will be monitored for all newly and readmitted residents; Physician orders weekly weights times four for new and readmitted residents; Nursing will reweigh residents immediately for 3 lbs increase or decrease in weight to ensure accuracy; and the Interdisciplinary Team should be informed immediately for any significant change in weight. 415.12(i)(1)	F 325			

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 335199	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/13/2009
Name of Facility RESORT NURSING HOME	Street Address, City, State, Zip Code 430 BEACH 68TH STREET ARVERNE, NY 11692	

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>F0225</u>	Correction Completed 01/21/2009	ID Prefix <u>F0281</u>	Correction Completed 01/21/2009	ID Prefix <u>F0314</u>	Correction Completed 01/21/2009
Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</u>		Reg. # <u>483.20(k)(3)(i)</u>		Reg. # <u>483.25(c)</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix <u>F0322</u>	Correction Completed 01/21/2009	ID Prefix <u>F0325</u>	Correction Completed 01/21/2009	ID Prefix _____	Correction Completed
Reg. # <u>483.25(g)(2)</u>		Reg. # <u>483.25(i)</u>		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: 12/15/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
	YES NO

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NAME OF PROVIDER OR SUPPLIER RESORT NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BEACH 68TH STREET ARVERNE, NY 11692
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: 2000 NFPA 101 LSC Chapter 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.2 Supervision. 9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of	K 061		1/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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: 335199	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/15/2008
NAME OF PROVIDER OR SUPPLIER RESORT NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BEACH 68TH STREET ARVERNE, NY 11692		
(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 061	<p>Continued From page 1</p> <p>control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p> <p>Based on observation and staff interview, the facility did not ensure that all sprinkler control valves were electronically supervised to sound an alarm at a continuously monitored location in that control valves in the 1st floor Clean Linen Room and 2nd floor landings in Stairs A & B were not provided with electronic supervisory devices; and one of four control valves on the fire pump for the sprinkler system, provided with an electronic supervisory device, did not alarm when tested. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>The findings are:</p> <p>On 12/11/08 between 11:00am- 12:30pm during the annual survey, one control valve in the 1st floor Clean Linen Room and control valves at each 2nd floor landing in Stairs A & B were not provided with electronic supervisory devices and one of four control valves on the fire pump for the sprinkler system, provided with an electronic supervisory device, did not alarm when tested.</p> <p>In an interview on 12/11/08 at approximately 11:30am, the Director of Maintenance stated that he does not know why the electronic supervisory devices were not installed in the first place and</p>	K 061			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335199	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/15/2008
NAME OF PROVIDER OR SUPPLIER RESORT NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BEACH 68TH STREET ARVERNE, NY 11692		
(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 061	Continued From page 2 that he would call the company to install the devices immediately. He further stated that the device that did not alarm when tested was adjusted and functional now. 711.2(a)(1)	K 061			

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 335199	(Y2) Multiple Construction A. Building B. Wing 01 - RESORT NURSING HOME	(Y3) Date of Revisit 2/17/2009
Name of Facility RESORT NURSING HOME		Street Address, City, State, Zip Code 430 BEACH 68TH STREET ARVERNE, NY 11692

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 K0061	Correction Completed 01/21/2009	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

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: 12/15/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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