

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

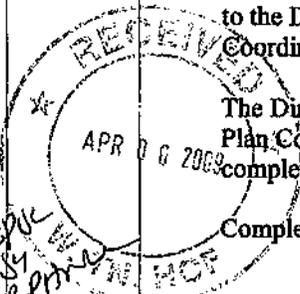
PRINTED: 03/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2009
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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and an interview, it was determined the facility failed to revise the comprehensive care plan to reflect the current status for Foley catheter care or the use of restraints for 2 of 24 (Residents #11 and 13) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #11 documented an admission date of 5/26/99 with diagnoses of Diabetes Mellitus, Cerebral Vascular Accident, Seizures and Hypertension. A</p>	F 280	<p>F-280 Comprehensive Care Plans</p> <p>Americare recognizes that care planning is fundamental to providing necessary care and services to Nursing Home residents. To ensure that other residents are not affected by the care plan issue going forward the following corrective measures will be implemented.</p> <p>The care plans of the residents that were noted during the March 18, 2009 annual survey were revised to reflect their present plan of care.</p> <p>All licensed staff will be inserviced on the care planning process.</p> <p>The Licensed staff will complete the care plan problem intervention list and update care plan daily as needed.</p> <p>The Quality Assurance Nurse will check care plan intervention list and care plan for accuracy daily.</p> <p>The Quality Assurance Nurse will submit the completed care plan intervention list to the Director of Nursing and MDS Coordinator daily.</p> <p>The Director of Nursing and MDS Care Plan Coordinator will randomly audit for completed care plans weekly.</p> <p>Completion date April 15th, 2009</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anna Pearson</i>	TITLE Asst Administrator	(X6) DATE 4-2-09
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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 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 280	<p>Continued From page 1</p> <p>Physician's order dated 2/20/09 documented, "...Insert Foley to promote wound healing..." The comprehensive care plan dated 2/5/09 did not address care of the Foley catheter.</p> <p>Observations in Resident #11's room on 3/16/09 at 10:15 AM, revealed Resident #11 had an indwelling Foley catheter draining yellow urine.</p> <p>2. Medical record review for Resident #13 documented an admission date of 2/23/07 with diagnoses of Senile Dementia with behaviors, Diabetes Mellitus, Seizures, and Hypertension. The the comprehensive care plan dated 1/21/09 documented "...HISTORY OF FALLS... 9. w/c [wheelchair] with lap buddy..."</p> <p>Observations in the Day Room on 3/16/09 at 10:00 AM, revealed Resident #13 in a wheelchair with no lap buddy in place.</p> <p>Observations in the Activity Room on 3/17/09 at 7:45 AM, revealed Resident #13 in a wheelchair with no lap buddy in place.</p> <p>During an interview at the second floor McRee nurses station, on 3/17/09 at 10:00 AM, the Record Review Coordinator (Certified Nursing Assistant (CNA) #1) was asked about Resident #13 using a lap buddy. CNA #1 stated, "...she [Resident #13] has never had a lap buddy since she has been here...not even an alarm...she doesn't try to get out of her wheelchair or elope..."</p>	F 280		
F 328 SS=D	<p>483.25(k) SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;</p>	F 328		

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F 328	<p>Continued From page 2</p> <p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and an interview, it was determined the facility failed to ensure oxygen (O2) therapy was provided as ordered by the physician for 1 of 5 (Resident #14) sampled residents with oxygen.</p> <p>The findings included:</p> <p>Medical record review for Resident #14 documented an admission date of 9/1/06 with diagnoses of Alzheimer's Disease, Neurosyphilis, Cerebral Vascular Accident, and Hypothyroid. The physician's orders dated 1/15/09 documented "...O2 @ [at] 5LBNC [liters binasal cannula per minute] maintain O2 Sat [saturation] > [greater than] 90% [percent]... 12/22/08..." A physician's progress note dated 1/31/09 documented "...continues to require 5L/NC [liters per nasal cannula]..." Nurses' notes dated 3/13/09 documented "...O2 @ 5L BNC in use..." Resident #14's care plan dated 1/9/09 documented "...Potential for SOB [shortness of breath] and decreased O2 saturation r/t [related to] diagnosis of hypoxia...Administer oxygen at 5L per minute BNC..."</p> <p>Observations in Room 410 on 3/16/09 at 9:57 AM, 2:15 PM, and 4:45 PM, on 3/17/09 at 7:50 AM, 10:05 AM and 12:00 PM, and on 3/18/09 at</p>	F 328	<p>F-328 Special Needs</p> <p>Americare strives to ensure that all residents receive special services as ordered by the Physician. Americare upon learning of the oversight, promptly addressed the special needs issue of resident #14 raised during the state survey and found his O2 sat% to be 97 %@ one liter of O2 per min. The facility contacted the physician and the resident's order was modified to (2) two Liters O2 per min.</p> <p>The following measures will be implemented for respiratory therapy paying particular attention to O2 therapy and tracking aggressively to ensure accuracy.</p> <p>All licensed staff will be inserviced on correct O2 administration.</p> <p>An O2 tracking form will be implemented to check oxygen orders and verify flow rates for accuracy.</p> <p>The O2 will be checked daily by the Quality Assurance Nurse utilizing the O2 tracking form.</p> <p>The form will be submitted to the Director of Nursing weekly.</p> <p>The Director of Nursing and Night Nursing Supervisor will randomly audit O2 rate and orders for accuracy.</p> <p>Completion date April 15th, 2009</p>	
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F 328	Continued From page 3 8:38 AM, revealed Resident #14 with O2 being administered between 0.5 and 1 liter per binasal cannula. During an interview in Resident #14's room on 3/18/09 at 8:38 AM, Nurse #5 was asked to verify the amount of oxygen Resident #14 was receiving. Nurse #5 stated, "...It's [oxygen] supposed to be 5 [liters] ...It's on 1 [liter] ..." Nurse #5 increased Resident #14's oxygen to 5 liters per binasal cannula.	F 328		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to ensure 2 of 6 nurses (Nurse #1 and Nurse #2) administered medications without a medication error rate of less than 5 percent (%) for sampled Resident #15 and for Random Resident (RR #1). A total of 3 medication errors were observed out of 43 opportunities for error, resulting in a medication error rate of 6.97%. The findings included: 1. Medical record review for Resident #15 documented an admission dated of 7/3/06 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. A physician's order dated 2/10/09 documented, "B12 2000 mcg [micrograms] PO q [every] day." A physician's order dated 2/26/09	F 332	F-332 Medication Errors Americare recognizes the importance of medication administration for each resident. To ensure that the facility is free of medication error rates of five percent or greater. Americare was found to have an error rate of 6.97% during the March 18, 2009 survey. The nurse(s) involved in medication error was inserviced by the Director of Nursing on administering the correct dosage of medication and giving medication with meals. <i>See Next Page</i>	

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F 332	<p>Continued From page 4</p> <p>documented, "...Start Renvela binder 800 mg [milligrams] ii [two] PO [by mouth] c [with] meals & [and] i PO 800 mg c snacks."</p> <p>Observations in Resident #15's room on 3/18/09 beginning at 8:15 AM, revealed Nurse #2 administered B 12 1000 mcg and Renvela 800 mg by mouth to Resident #15. Administering 1000 mcg of B12 instead of 2000 mcg as ordered resulted in a medication error #1. Administering one Renvela 800 mg instead of two as ordered resulted in medication error #2.</p> <p>During an interview in the hallway of 1st McGoffin on 3/18/09 at 9:50 AM, Nurse #2 stated, "I only gave one [of vitamin B12 and Renvela]. I'm sorry."</p> <p>2. Medical record review for RR #1 documented an admission date of 12/30/08 with diagnoses of Acute Viral Hepatitis C, Chronic Osteomyelitis and Seizures. A physician's order dated 3/2/09 documented, "Iron Sulfate 325 mg PO TID [three times a day] c meals."</p> <p>Observations in RR #1's room on 3/16/09 at 4:28 PM, revealed Nurse #1 administered Iron Sulfate 325 mg with a glass of water. RR #1 did not have his supper tray. Nurse #1 failed to administer the Iron Sulfate with a meal as prescribed by the physician. This resulted in medication error #3.</p> <p>During an interview in the hallway of 2nd McGoffin on 3/16/09 at 4:46 PM, Nurse #1 was asked by the surveyor to verify on the Medication Administration Record what the order was for the Iron Sulfate. Nurse #1 stated, "Order says 325 [mg] ...with meals. Oh."</p>	F 332	<p>All licensed staff to be inserviced on proper medication administration by either the Medical Director, Pharmacy Consultant, Director of Nursing, and /or designee. Going forward, Medication Administration in-services will include expanded training on the proper administration of vitamins and supplements, which reflected the greatest error trend. The medication administration training will include, but is not be limited to the topic of "When to request order clarifications "</p> <p>All licensed staff will be checked off on medication administration, during orientation; weekly for three months; twice monthly for three then monthly thereafter. This will be an on-going process to ensure that medications are administered in the proper dosage and as ordered with meals or snacks.</p> <p>All licensed staff will be given a written competency test during the orientation process and at least every six months.</p> <p>Completion date April 15th, 2009</p>	
F 333	483.25(m)(2) MEDICATION ERRORS	F 333	See Next Page	

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F 333 SS=D	<p>Continued From page 5</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of "Nursing 2008 Drug Handbook", medical record review, observations and interviews, it was determined the facility failed to ensure 1 of 8 (Resident #15) residents observed during the medication administration pass was free of a significant medication error for the administration of Renvela (a phosphorus binder).</p> <p>The findings included:</p> <p>Review of the the "Nursing 2008 Drug Handbook", page 1266 and 1267, documented, "...sevelamer... To control phosphorus level in chronic kidney disease patients on dialysis... A phosphate binder that inhibits intestinal phosphate absorption and decrease phosphorus levels... Drug may bind to other drugs and decrease their bioavailability. Give other drugs 1 hour before or 3 hours after this drug ...take with meals..."</p> <p>Medical record review for Resident #15 documented an admission dated of 7/3/06 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. A physician's order dated 2/26/09 documented, "...Start Renvela binder 800 mg [milligrams] ii [two] PO [by mouth] c [with] meals & [and] i PO 800 mg c snacks."</p> <p>During an interview in Resident #15's room on</p>	F 333	<p>F-333 Medication Errors</p> <p>Americare recognizes the importance of medication administration for each resident ,to ensure that the facility is free of medication error rates of five percent or greater. Americare was found to have an error rate of 6.97% during the March 18, 2009 survey.</p> <p>The nurse(s) involved in medication error was inserviced by the Director of Nursing on administering the correct dosage of medication and giving medication with meals.</p> <p>All licensed staff to be inserviced on proper medication administration by either the Medical Director, Pharmacy Consultant, Director of Nursing, and /or designee. Going forward , Medication Administration in-services will include expanded training on the proper administration of vitamins and supplements, which reflected the greatest error trend. The medication administration training will include, but is not be limited to the topic of "When to request order clarifications "</p> <p>See Next Page</p>	

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F 333	<p>Continued From page 6</p> <p>3/18/09 at 8:00 AM, Resident #15 stated he had already eaten his breakfast and had not taken his medications yet.</p> <p>Observations in Resident #15's room on 3/18/09 beginning at 8:15 AM, revealed Nurse #2 administered eleven (11) medications including Renvela 800 mg to Resident #15. Nurse #2 failed to administer Resident #15's Renvela along with a meal as ordered, resulted in a significant medication error.</p> <p>During an interview in the hallway of 1st McGoffin on 3/18/09 at 9:50 AM, Nurse #2 stated, "I only gave one [Renvela]. I'm sorry." The surveyor asked the nurse if she was aware that the medication was supposed to be given with food to be effective. Nurse #2 acknowledged she did not know that.</p> <p>During a telephone interview on 3/18/09 at 9:40 AM, the surveyor talked with Registered Nurse (RN) at the dialysis clinic who was caring for Resident #15. The dialysis clinic RN stated, "Renvela is a phosphate binder and must be given with meals or immediately before the meals or it is not effective. It has to be in the stomach with food to bind with the phosphorus. It is useless [if administered] 30 to 40 minutes before or after meals."</p>	F 333	<p>All licensed staff will be checked off on medication administration, during orientation; weekly for three months; twice monthly for three then monthly thereafter. This will be an on-going process to ensure that medications are administered in the proper dosage and as ordered with meals or snacks.</p> <p>All licensed staff will be given a written competency test during the orientation process and at least every six months.</p> <p>Completion date April 15th, 2009</p>	
F 502 SS=D	<p>483.75(j)(1) LABORATORY SERVICES</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 502	<p>See Next Page</p>	

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F 502	<p>Continued From page 7</p> <p>by: Based on medical record review and interviews, it was determined the facility failed to obtain laboratory tests timely and as ordered by the physician for 3 of 24 (Residents #2, 14, and 17) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #2 documented an admission date of 5/3/01 with diagnoses of Seizures, Hypertension, Anemia, Cardiovascular Accident, Cerebrovascular Insufficiency. Review of physician orders for 4/1/08 to 4/30/08 revealed a change laboratory order to do a Depakote and Keppra level every 3 months. Review of Resident #2's laboratory test results revealed the Depakote level was done on 4/17/08 and on 5/1/08. There was no documentation that the Depakote level was done again until 10/30/08. The Keppra level was done on 4/17/08 and on 6/19/08. There was no documentation the Keppra level was done again until 10/30/08. 2. Medical record review for Resident #14 documented an admission date of 9/1/06 with diagnoses of Alzheimer's Disease, Neurosyphilis, Cerebral Vascular Accident, and Hypothyroid. Review of Resident #14's laboratory (lab) test results of a Valproic Acid level dated 12/23/08 documented to repeat the lab work in 2 weeks. A physician's order dated 12/23/08 documented to 	F 502	<p>F-502 Laboratory Services</p> <p>Americare recognizes the importance of obtaining laboratory services to meet the needs of each resident. To ensure that laboratory services are obtained in a timely manner the following will be implemented to correct this deficiency.</p> <p>A tracking form will be completed by all disciplines involved in writing orders-MD, Dietician, Nurses and Consultants. (See Attachment B). This tracking tool will be forwarded to the Records Review Coordinator, Quality Assurance Nurse, Director of Nursing, Assistant Administrator, and 11-7 shift Supervisor daily.</p> <p>The Quality Assurance Nurse, the Records Review Coordinator and the 11-7 shift Supervisor will check the orders from the tracking tool daily to assure that all orders are carried out.</p> <p>The Assistant Administrator and the Director of Nursing will conduct random chart audits to assure that orders are completed.</p> <p>The 11-7 Charge Nurses will continue to do twenty four hour chart checks.</p> <p>Completion date April 15th, 2009</p>	
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F 502 Continued From page 8

repeat the Valproic Acid level on 1/15/09. The facility was unable to provide documentation that a Valproic Acid level was drawn on 1/15/09.

During an interview at First McRee nurses station on 3/17/09 at 10:05 AM, Nurse #5 called the lab to get the results of the test due 1/15/09. Nurse #5 stated, "...It [Valporic Acid level] wasn't drawn ... they [laboratory] have just what we have..."

3. Medical record review for Resident #17 documented an admission date of 11/25/08 with diagnoses of Peripheral Vascular Disease, Hypertension, Osteoarthritis, Nocturnal Asthma, and Morbid Obesity. Review of the physician's admission orders dated 11/25/08 documented "...BMP [basic metabolic panel] every 6 months - June/ [and] Dec [December]..." The facility was unable to provide documentation that the BMP was obtained in December 2008.

During an interview in the conference room on 3/18/09 at 10:45 AM, the Director of Nurses (DON) stated, "...[named Certified Nursing Assistant #1] called the lab ...it [BMP] wasn't done..."

4. During an interview in the conference room on 3/18/09 at 10:50 AM, the DON was asked how orders for diagnostics were communicated. The DON stated, "...every floor has a diagnostics book...the nurses are supposed to write it [the order] in that book on the flow sheet...and on that month [the month the test is due]..." The DON was asked if routine labs were supposed to be documented on the re-certification orders. The DON stated, "...yes...supposed to be...when they [nurses] check the orders...supposed to check that they are on the book [diagnostics book]..."

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118
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F 508 SS=D	<p>483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES</p> <p>The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews, it was determined the facility failed to obtain radiology tests timely and as ordered by the physician for 2 of 24 (Residents #10, and 17) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #10 documented an admission date of 11/17/08 with diagnoses of Human Immunodeficiency Virus, Vitamin B12 Deficiency, Peripheral Neuropathy, Neurogenic Bladder, history of Cerebral Vascular Accident, and Failure to Thrive. Review of the nurses' notes dated 2/2/09 documented "...Resident c/o [complained of] Lt. [left] foot pain, after examination 2+ [plus] edema c [with] tenderness to touch noted...new order for x-ray obtained..." Review of a physician's order dated 2/2/09 documented "...X-ray of Lt. foot R/o [rule out] fx [fracture]...Doppler Studie [study] of Lt. foot to R/o DVT [Deep Vein Thrombosis] & [and] Lt. lower leg..." A nurses' note dated 2/13/09 documented "...c/o pain Lt ankle..." The nurses' note dated 2/23/09 documented "...Resident encouraged to remain in bed QO [every other] day c [with] lower extremities elevated to promote [decrease] edema to Lt. foot..." There was no documentation in the medical record that the left</p>	F 508	<p>F-508 Radiology and Other Diagnostic Services</p> <p>Americare recognizes the importance of obtaining radiology and other diagnostic procedures for the residents as ordered by the physician .</p> <p>Upon learning of these missed orders, Americare promptly scheduled resident #10 and #17 for the ordered diagnostic service . Both residents X-Rays came back negative.</p> <p>To ensure that all procedures are obtained in a timely manner going forward, the following process has been implemented.</p> <p>A tracking form will be completed by all disciplines involved in writing orders- MD, Dietician, Nurses and Consultants. (See Attachment "(A)")</p> <p>This tracking tool will be forwarded to the Records Review Coordinator, Quality Assurance Nurse, Director of Nursing, Assistant Administrator, and 11-7 shift Supervisor daily.</p>	

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

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118	
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F 508	<p>Continued From page 10</p> <p>foot x-ray or the doppler study were obtained as ordered.</p> <p>During an interview at First McRee nurses' station on 3/17/09 at 10:05 AM, Certified Nursing Assistant (CNA) #1 who is the Record Review Coordinator, was asked for the x-ray and doppler results.</p> <p>During an interview at First McRee nurses' station on 3/17/09 at 12:02 PM, the Director of Nurses (DON) was asked for the results of the x-ray and doppler study. The DON stated, "...couldn't find it [x-ray and doppler study results] ...she [Resident #10] didn't go get it [x-ray and doppler] ...it was scheduled, but she didn't go...trying to reschedule it..."</p> <p>During an interview in the conference room on 3/17/09 at 3:40 PM, the DON stated, "...she [Resident #10] has an appointment at 8:30 in the morning..."</p> <p>2. Medical record review for Resident #17 documented an admission date of 11/25/08 with diagnoses of Peripheral Vascular Disease, Hypertension, Osteoarthritis, Nocturnal Asthma, and Morbid Obesity. Review of the physician's admission orders dated 11/25/08 documented "...Chest xray yearly (Jan) [January]..." The facility was unable to provide documentation that the chest x-ray was obtained in January 2009.</p> <p>During an interview in the conference room on 3/18/09 at 10:45 AM, the DON stated, "...[named CNA #1] called x-ray ...it [chest x-ray] wasn't done..."</p> <p>3. During an interview in the conference room on</p>	F 508	<p>The Quality Assurance Nurse, the Records Review Coordinator and the 11-7 shift Supervisor will check the orders from the tracking tool daily to assure that all orders are carried out and results and reported to the physician and properly charted.</p> <p>The Assistant Administrator and the Director of Nursing will conduct random chart audits to assure that all orders are being carried out in a timely fashion.</p> <p>The 11-7 Charge Nurses will continue to do twenty four hour chart checks.</p> <p>Completion date April 15th, 2009</p>	

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F 508	<p>Continued From page 11</p> <p>3/18/09 at 10:50 AM, the DON was asked how orders for diagnostics were communicated. The DON stated, "...every floor has a diagnostics book...the nurses are supposed to write it [the order] in that book on the flow sheet...and on that month [the month the test is due]..." The DON was asked if routine labs were supposed to be documented on the re-certification orders. The DON stated, "...yes...supposed to be...when they [nurses] check the orders...supposed to check that they are on the book [diagnostics book]..."</p>	F 508		
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