STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING ______ B. WING ______	08/14/2009

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CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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L 000	Initial Comments An annual licensure survey was conducted on August 10 through 14, 2009. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 30 residents based on a census of 248 the first day of survey, with 18 supplemental residents. Also investigated were the following complaints and incidents: C-09-113, DC00001830 C-09-114, DC00001831 09-I-4071, DC00001811 09-I-4136, DC00001810 09-I-4374, DC00001809 09-I-5002, DC00001836	L 000	**Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This Plan of Correction (POC) is prepared and/or executed because it is required by the state and federal laws.**	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that one (1) physician failed to maintain a current District of Columbia Controlled Substance License. The findings include: According to 22DCMR 1300.3, "A prescription shall only be issued by a practitioner who holds a valid license issued by the District of Columbia ...to prescribe drugs or medical devices. If the prescription is for a controlled substance, the	L 001		

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L 001	Continued From page 1 practitioner must also have a valid federal Drug Enforcement Agency (DEA) registration number and if applicable, a valid District of Columbia controlled substance registration ... " A review of Physician #1's credentials revealed that the District of Columbia controlled substance registration expired May 31, 2009. The following orders for controlled substances were signed by Physician #1 after his/her District of Columbia Controlled Substance Registration expired: 1. A review of Resident FS1 ' s record revealed that Physician #1 signed the following orders on August 10, 2009: " Fentyl 75 mcg/ hr patch. Apply 1 patch every 3 days & remove old patch for pain ... Lorazepam 0.5 mg tablet -Ativan 0.5 mg QHS (bedtime) for anxiety. " 2. A review of Resident FS2 ' s record revealed that Physician #1 signed the following order on August 7, 2009: " Tylox 1 cap po (by mouth) q (every) 4 hrs prn (as needed) pain. " 3. A review of Resident FS3 ' s record revealed that Physician #1 signed the following order on July 17, 2009: " Tylox 1 cap po q 4 hrs prn mild pain. " 4. A review of Resident FS4 ' s record revealed that Physician #1 signed the following order on August 8 and 10, 2009: " Oxycontin 10 mg po q 12 hrs - pain. " 5. A review of Resident FS5 ' s record revealed that Physician #1 signed the following order on	L 001	**3200.1 Nursing Facilities** **483.75 (b) ADMINISTRATION** 1. Practitioner in question was contacted Immediately. The ability to prescribe Narcotics was immediately suspended by VPMA; Pharmacy Director, MD and Medical Director of Carroll Manor. DEA renewal application was hand delivered to DOH on day expiration identified. The Medical Director at Carroll Manor countersigned all existing narcotic orders for Carroll Manor residents. The Practitioner received renewal within 24 hours of the identification of the issue. 2. The remaining Carroll Manor Practitioner Files were reviewed for compliance, There were no other Practitioners found to be affected. 3. The Medical Affairs will re-educate Practitioners regarding the importance of Ensuring that timely renewal of the controlled Substance registration. A Monitoring system will provide 30 day Notification to Practitioners for pending DEA and other licenses as required. Physicians will be suspended at day 30 for non-compliance. 4. An audit of the Practitioners Licensure and Registration requirements will be conducted Monthly. The results will be reported to the QI committee quarterly.	8/31/09 8/31/09 9/28/09 9/28/09

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L 001	Continued From page 2 August 1, 2009: " Haldol 2.5 mg by mouth every 6 hours as needed. " 6. A review of Resident FS6 ' s record revealed that Physician #1 signed the following order on August 12, 2009: " Tylenol #3 1 po q 4 hrs prn pain. " 7. A review of Resident FS7 ' s record revealed that Physician #1 signed the following order on August 5, 2009: " Tylox 1 tab po every 4 hrs prn pain. Tylox 2 tabs po every 6 hrs prn pain. " A face-to-face interview was conducted with Employee #2 on August 13, 2009 at 1:30 PM. He/she stated, "I just talked to (Physician #1) who said [he/she] forgot to send in the renewal." The records were reviewed August 13 and 14, 2009.	L 001		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;	L 051		

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L 051	Continued From page 3	L 051	**1. 3210.4 Nursing Facilities**	
	(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;		1. Resident #14's care plan was updated to include each episode of wandering.	8/13/09
	(e)Supervising and evaluating each nursing employee on the unit; and		2. All residents with episodes of wandering care plans were reviewed to ensure all episodes were addressed.	9/28/09
	(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:		3. The care plan protocol was reviewed with the licensed staff.	9/28/09
	Based on record review and staff interview for one (1) of 30 sampled residents and one (1) supplemental resident, it was determined that the charge nurse failed to review and revise the care plan for wandering for one (1) resident and for the use of Remeron and Megace for one (1) resident. Residents #14 and JH1.		4. The Nurse Managers will conduct monthly care plan audits to ensure completeness and submit their finding to the DON for presentation at the QA/QI quarterly meeting.	9/28/09
	The findings include:		**2.) 3210.4 Nursing Facilities**	
	1. The charge nurse failed to revise and review Resident #14's wandering care plan.		1. Resident #JH1's care plan was updated For Remeron and Megace usage.	8/13/09
	A review of Resident #14's record revealed that the resident had wandered off the unit on March 6, April 4 and August 6, 2009. The resident did not wander out of the building.		2. All residents on Remeron and Megace care plans were reviewed and update.	9/18/09
	A review of the resident's care plan, last reviewed and revised on May 21, 2009, documented the following: "Wandering - goals - Staff will assist resident by helping to orient to self and current surroundings. Resident's position on unit will be monitored by staff. Resident will be included in activities so that [he/she] can be off nursing unit supervised."		3. The care plan protocol was reviewed with all licensed staff.	9/28/09
	There was no evidence that the care plan was revised or reviewed after the resident's wandering off the unit on August 6, 2009.		4. Nurse Managers will conduct monthly care plan audits to ensure completeness and submit to the DON for presentation at the QA/QI quarterly meeting.	9/28/09

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L 051	Continued From page 4 A face-to-face interview was conducted with Employee #5 on August 12, 2009 at 2:30 PM. He/she stated, "[Resident #14] has a watch mate bracelet on, a picture at the front desk, the safety officer (an appointed Certified Nurse Aide) does hourly checks and activities have engaged Resident #14 in more diversional activities." The record was reviewed August 12, 2009. 2. The charge nurse failed to review and revise Resident JH1's care plan for the use of Remeron and Megace. On August 12, 2009, at approximately 9:00 AM during the reconciliation of the medication pass. The care plan dated April 28, 2009, documented, " Psychotropic Drug Use, " Resident receives Remeron for insomnia and appetite " A review of the physician ' s orders dated and signed on August 7, 2009, directed , " Megace 400 mg po [by mouth] daily for appetite stimulant. " A face-to face interview was conducted at approximately 10:00 AM with Employee # 9 . He/she acknowledged that the careplan was not reviewed or reviewed for Remeron and Megace.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and	L 052		

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L 052	Continued From page 5 contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. 1. Based on observations, staff interview and record review for two (2) of 30 sampled residents	L 052	**1. 3211.1 Nursing Facilities** 1. Neuro checks were initiated on Resident #20 before and after his/her emergency room visit. 2. All residents with R/O Head Trauma were reviewed to ensure neuro checks were done. 3. Neurological assessment/check Competency/in-service will be done on all licensed staff. 4. Nurse Managers will conduct monthly audits to ensure neuro checks were completed on all R/O Head Trauma and submit to DON for presentation at the QA/QI quarterly meeting. **B. 3211.1 Nursing Facilities** 1. Resident #20 was re-weighed on 8/14/09. A dietary consult was done and he/she is currently on weekly weights. 2. All residents weight will be reviewed to Identify any significant weight loss or gain. 3. Staff will be re-in serviced on weight loss/ gain protocol. Nurse Manager and Dieticians will review all residents weights monthly and submit their findings to the Nutrition and Hydration monthly meeting to develop a plan of care. 4. Nurse Managers will conduct monthly weight audits to ensure all variances were addressed and submit their results to the DON for presentation to the quarterly QA/QI meeting.	8/10/09 8/18/09 8/28/09 9/28/09 8/14/09 9/10/09 9/28/09 9/28/09

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L 052	Continued From page 6	L 052	**2. 3211.1 Nursing Facilities**	
	and five (5) of 18 supplemental residents, it was determined that sufficient nursing time was not given by facility staff to: initiate neurological assessments after one (1) resident hit/her head, follow-up on weight gain for one (1) resident, administer medication in accordance with the physician ' s orders for five (5) residents, write a complete order for medications and differentiate between the use of pain medication for one (1) resident. Residents #20, 28, JH2, S1, S2, SK4, and FS7.		1. Resident #28 was discharged on June 29, 2009.	6/29/09
			2. All residents on PRN pain medications were reviewed to ensure the transcription and dosage administered were given per physician's orders.	9/18/09
			3. Staff will be in-serviced on following Physician's orders when administering Medications.	9/28/09
	The findings include:		4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit to the DON for presentation at the quarterly QA/QI meeting.	9/28/09
	1. Facility staff failed to follow up on neurological checks after Resident #20 sustained a laceration and a raised area to the left outer aspect of his/her eye.		**3. 3211.1 Nursing Facilities**	
	A face-to-face interview was conducted on August 11, 2009 at 9:30 AM with Employee #27. He/she stated, " It was around 6:30 AM ... [Resident #20] said, ' I hit my head. ' [Resident #20] allowed me to check out his/her head. I put a cold compress on his/her head. I went to my charge nurse after the incident around 7:30 AM [to report the incident] ... The CNA [day shift] must have called the day shift nurse to come to the room. The charge nurse came back [to the nurse ' s station] and stated did you see the cut on [Resident #20 ' s] face? I said yes [this was around 7:30 AM]. I filled out the incident report and I tried to make the phone call to the grandson. That was around 8:00 AM. I didn't do any neurochecks; I applied the cold compress to the left temple area."		1. Resident #JH2's medication order was reviewed and she/he was given an additional tablet of calcium carbonate with vitamin D to equal 2 tablets as ordered.	8/13/09
			2. Residents were monitored during medication pass to ensure administration per physician's orders.	9/18/09
			3. Staff will be in-serviced on following physicians orders when administering medications.	9/28/09
			4. Nurse Managers will conduct monthly Medication Pass audits to ensure compliance and submit the results to the DON for presentation to the quarterly QA/QI meeting.	9/28/09
	The Physician's Interim Orders Dated August 10, 2009 at 0830 revealed, " ...Left head trauma Tx [treatment]: give cold compress every 15 minutes			

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L 052	Continued From page 7	L 052	**4. 3211.1 Nursing Facilities**	
	to raised area until transported to [name ER] for evaluation of left temple raised area. "		1. The Nitrodur patch was removed from Resident # S1.	8/13/09
	A review of the progress notes revealed the following: "August 10, 2009 at 0630 ... Resident sustained a cut to left side of forehead. Measures 0.5 cm x 0.1 cm. [Responsible party] made aware via phone ...this AM ... "		2. All residents on Nitrodur patches were assessed to ensure compliance with physicians orders.	9/18/09
	"August 10, 2009 at 0830 ... Writer called to assess resident with small cut about his/her left/side of left eye 0.5 x 1 cm. Resident also has raised area over eye lid ... Resident denies pain, Resident denies discomfort. Area is soft to touch. Small amount of blood from laceration. Resident is being transferred to the ER for evaluation. Will continue to monitor. "		3. Staff will be in serviced on following physicians orders when administering medications.	9/28/09
			4. Nurse Managers will conduct random medication pass audits to ensure physician medication administration compliance and submit the results to the DON for presentation to the QA/QI quarterly meetings.	9/28/09
	The record lacked evidence that neurological assessments were completed after the resident stated he/she hit his/her head and sustained a laceration and a raised area on the left outer aspect of Resident #20 ' s eye from 0630 to 0730.		**5. 3211.1 Nursing Facilities**	
			1. Resident # S2's laxative was administered in the correct amount of water as the next medication administration.	8/14/09
	B. Facility staff failed to follow up on weight gain for Resident #20.		2. All residents receiving medications to be diluted in water was reviewed and staff monitored to ensure accuracy in the preparation.	8/18/09
	A review of the "Monthly Record of V/S [vital signs] and Weights" revealed, "June 1, 2009 weight - 108.60, July 1, 2009 weight - 120.4, and August 1, 2009 weight - 116.8.		3. Staff will be in serviced on following physicians orders when administering medication.	9/28/09
	According to the "Nutrition of Resident" Policy, revised 8/1/09, stipulated, "...2....Weights are re-done if there is a deviation of the last recorded weight...3. The Nursing Department Nutritional Assessment Tool will be completed if triggered for interdisciplinary management of hydration/nutrition when there is any deviation (plus or minus) from the last recorded weight.		4. Nurse managers will conduct monthly med pass audits to ensure compliance and submit their results to the DON for presentation at the QA/QI meeting.	9/28/09

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L 052	Continued From page 8 5% weight loss in 1 month or 10% weight loss in 6 months..." A review of Resident #20's clinical record lacked evidence that facility staff re-weighed and addressed the weight gain after the July 1, 2009 weight of 120.4 pounds. A face-to-face interview was conducted on August 14, 2009 at 2:15 PM with Employee #7. He/she acknowledged that the resident was not re-weighed and that the weight gain was not addressed by the facility staff. The record was reviewed on August 14, 2009. 2. Facility staff failed to administer Oxy IR to Resident #28 in accordance with the physician's order. A review of the physician's orders dated June 15, 2009 directed, "Oxy IR 5 mg 1 tab Q 4 hrs PO prn mild pain; Oxy IR 5 mg 2 tabs Q 4 hrs PO prn mod [moderate]-severe pain " . A review of the MAR June 2009 revealed, " Oxy IR 5 mg; Oxy IR 5 mg two tabs PO Q 4 hrs PRN, mod-severe pain " A review of the " Pain Management " flow sheet revealed, " June 16, 2009 at 0900 Pain location-left hip pain ...Pain Rating-7 [which is severe according to the pain scale used by the facility] ...Intervention-one OXY IR was administered ... " The record lacked evidence that Oxy IR 5 mg 2 tabs Q 4 hrs PO prn for moderate to severe pain was administered to Resident #28 when the pain rating was moderate to severe as directed by the physician.	L 052	**6. 3211.1 Nursing Facilities** 1. Resident #SK4 received the Volturen Cream and it were applied as ordered. 2. All residents with Volturen Cream orders were assessed to ensure the cream was available. 3. Staff was in serviced on the protocol for obtaining medication from the pharmacy. 4. Nurse Managers will conduct monthly med pass audits to ensure compliance and submit their results to the DON for presentation at the monthly QA/QI meeting. **7A. 3211.1 Nursing Facilities** 1. Resident # JH1's medication reconciliation was completed and an order was obtained for nebulizations. 2. All residents were assessed to ensure medication reconciliations were completed. 3. Staff will be in serviced on Medication Reconciliations policy. 4. Nurse Managers will conduct monthly medication reconciliation audits on all residents returning from/or readmitted to the facility to ensure compliance and submit their results to the DON for presentation at the QA/QI meeting.	8/13/09 8/18/09 9/28/09 9/28/09 8.14/09 8/18/09 9/28/09 9/28/09

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L 052	Continued From page 9	L 052	**7B. 3211.1 Nursing Facilities**	
	A face-to-face interview was conducted on August 13, 2009 at 11:15 AM with Employee #7. He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician.		1. Resident # FS7 was discharged.	8/17/09
	A telephone interview was conducted on August 13, 2009 at 3:25 PM with the Consultant Pharmacist. He/she acknowledged that the Oxy IR 5 mg 1 tab prn for mild pain was not entered/transcribed as ordered by the physician. The closed record was reviewed on August 13, 2009.		2. All residents on PRN pain medication reconciliation were reviewed to ensure indication-mild, moderate, severe was noted for number of tablets to be administered.	8/18/09
	3. Facility staff failed to administer medication as per physician's orders for Resident JH2.		3. Pain management competency will be reviewed with all licensed staff.	9/28/09
	A physician's order dated July 13, 2009 directed, "Calcium Carbonate Vitamin D 500 mg/200 mg II (two) tabs daily via G-tube (Gastrostomy)."		4. Nurse managers will conduct monthly audits physicians orders, MAR and med pass to ensure compliance and submit their findings in the QA/QI quarterly meeting.	9/28/09
	During a medication administration observation on August 11, 2009 at approximately 10:30 AM, the nurse administered one (1) Calcium carbonate tablet.		**2. 3211.1 Nursing Facilities**	
	During reconciliation of the medication pass observation with the resident's record, it was determined that two (2) Calcium Carbonate tablets should have been administered, in accordance with physician's orders for August 2009.		1. Resident # 16 was seen by his/her eye doctor in the facility on June 24, 2009 and then again on 9/2/09 in his office.	6/24/09
	A face-to-face interview with Employee #32 was conducted on August 11, 2009 at 1:20 PM. He/she acknowledged that two (2) tablets of Calcium Carbonate should have been administered. The record was reviewed August 11, 2009.		2. All residents medical records will be reviewed to ensure all scheduled appointments are adhered to.	9/18/09
			3. The consult policy will be reviewed with the licensed staff.	9/28/09
			4. Nurse Managers will conduct monthly audits to ensure all consults are follow-up and submit the results to the DON for presentation in the quarterly QA/QI meeting.	9/28/09

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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) COMPLETE DATE
L 052	Continued From page 10	L 052	**3. 3211.1 Nursing Facilities**	
	4. Facility staff failed to remove and apply a Nitrodur Patch as per physician's orders for Resident S1.		1. Resident # SK7's wound care treatment was completed using clean techniques for all subsequence dressing changes.	8/14/09
	During medication pass conducted on August 13, 2009 at 10:00 AM, facility staff was observed administering a Nitrodur Patch. He/she checked to see where best to place the Nitrodur Patch and the old patch from the day before was still on resident's right side of chest. This was removed and the area cleansed with alcohol. The new patch was applied to the left chest area.		2. Observations were done on all residents receiving wound care treatments to ensure a clean technique was adhered to.	8/31/09
	A review of Physician Order Sheet revealed medication order written on March 14, 2007 that reads, " Nitroglycerin 0.2 Milligram/hr daily for Cardiovascular Disease " .		3. Wound Care competencies/inservices will be conducted on all licensed staff by 9/28/09. Annual competencies will be conducted by the Wound Care Specialist.	9/28/09
	A review of the August 2009 Medication Administration Record [MAR] a physician order reads, " Nitroglycerin 0.2 Milligram per hour, apply (1) one patch topically every morning and remove at bedtime for Cardiovascular Disease " .		4. Monthly wound care audits will be done by the Wound Care Specialist and results will be submitted to the DON for presentation at the QA/QI meeting.	9/28/09
	A face-to-face interview was conducted with Employee #7 on August 14, 2009 at 11:20 AM. He/she acknowledged that the Nitrodur Patch was to be removed at 2100 (11:00 PM) as scheduled and voiced that the evening and night shift will be educated on this subject. The record was reviewed on August 14, 2009.		**1. 3211.1 Nursing Facilites**	
			1. Resident # 3's medical record was updated to address the effectiveness of the Ambien and the Mirtazaphine.	8/12/09
			2. All residents' records were reviewed to ensure documentation of the effectiveness of psychotropic and hypnotics after administration.	8/18/09
	5. Facility staff failed to administer a laxative in (8) eight ounces of water to Resident S2		3. Staff will be in serviced on follow up documentation related to anti-hypnotics and psychotropic medication usage.	9/28/09
	During medication pass conducted on August 13, 2009 at 10:30 AM, facility staff was observed administering Polyethylene Glycol 3350 Powder. One scoop was dissolved in (4) four ounces of		4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation to the QA/QI meeting.	9/28/09

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L 052	Continued From page 11 water. A review of Physician Order Sheet revealed medication order on November 11, 2008 that reads, " Miralax (1) One scoop dissolved in (8) eight ounces of water by mouth daily for Constipation " . A review of the August 2009 Medication Administration Record [MAR] a physician order reads, " One scoop dissolved in eight (8) ounces of water by mouth daily for Constipation " . A face-to-face interview was conducted with Employee #7 on August 14, 2009 at 11:20 AM. He/she read the physician's order and voiced that the cups on the medication cart are 4 ounces. He/she acknowledged that the order reads one scoop of Polyethylene Glycol 3350 Powder dissolved in eight (8) ounces of water and that all shifts will be educated. The record was reviewed on August 14, 2009. 6. Facility staff failed to apply an analgesic cream to Resident SK4's knees as per physician's orders. A physician's order dated August 12, 2009 directed, "Volturen 1% to knees QID (four times daily)." The facility identified 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM as the time the Volturen was to be applied to the resident' s knees. During a medication pass observation conducted on August 13, 2009 at 1:20 PM, the Volturen was not administered. Employee #26 stated that the cream was not available, that it had not arrived from the pharmacy. He/she acknowledged that the medication was not available at 9:00 AM either, and thus the resident missed two (2)	L 052	**2. 3211.1 Nursing Facilities** 1. Resident #7's medical record was updated to address the effectiveness of Zolpidem for sleep and Sertraline for depression. 2. All residents' medical records were reviewed to ensure documentation of the effectiveness of hypnotics and psychotropic medication usage. 3. Staff will be in serviced on follow up documentation related to anti-hypnotic and psychotropic medication usage. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit the results to the DON for presentation in the QA/QI meeting. **3. 3211.1 Nursing Facilities** 1. Resident # SK1 was discharged from the facility. 2. All residents medical records were reviewed to ensure allergies were noted and no residents were receiving foods or medication where allergies were noted. 3. Staff will be in serviced on adverse reactions by checking allergies when excepting telephone orders. 4. Nurse Managers will conduct monthly comprehensive medical record audits to ensure compliance and submit results to the DON for presentation in the QA/QI meeting.	8/12/09 8/24/09 9/28/09 9/28/09 7/13/09 9/1/09 9/28/09 9/28/09

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L 052	Continued From page 12 applications. Employee #9 immediately contacted the pharmacy and it was noted that the prescription was entered into the " Treatment " area and thus the medication was not ordered by the pharmacy. A "stat" delivery was requested and the medication arrived within two (2) hours and applied to the resident's knees. 7. Facility staff failed to write a complete order for a nebulizer treatment and differentiate between the use of pain medication for Resident FS7. A. Facility staff failed to write a complete order for a nebulizer treatment. A review of Resident FS7's record revealed a admission orders dated August 4, 2009 and signed by the physician on August 5, 2009 that directed, "Xoponex inhaler 2 puffs q 4 to 6 hours prn sob; Xoponex 1.25 mg plus." A face-to-face interview was conducted with Employee #24 at 7:25 AM on August 14, 2009. He/she stated, "The Xoponex 1.25 is what goes into the inhaler. If the patient has shortness of breath [he/she] can have the inhaler every 4 hours or 6 hours as needed." When queried as who determined the frequency of the inhaler, Employee #24 stated, "The nurse decides if the patient needs the inhaler every 4 hours or every 6 hours." There was no evidence that facility staff clarified that the Xoponex 1.25 mg was to be inserted into the inhaler. Additionally, facility staff failed to clarify the parameters of when to administer the nebulizer every four (4) hours or every six (6)	L 052	**3211.1 Nursing Facilities** 1. Resident #JH 2's medication order was reviewed and he/she was given an additional tablet of calcium carbonate with Vitamin D to equal 2 tablets as ordered. The nitroglycerin patch was removed from Resident #S1. the area was properly cleaned and the nitro patch was properly applied. Resident #S2's laxative was administered in The correct amount of water during the next Medication administration. Resident #SK4 received the Volturem Cream and it was applied as ordered. 2. Residents were monitored during Medication pass to ensure they were administered as per physician's orders. All residents on nitro glycerin patches were assessed to ensure compliance with physician's orders and to ensure proper application. All residents with Volturem cream orders were assessed to ensure the cream was available. 3. The nursing staff will be in-serviced on following physicians orders when administering medications, on proper applications of nitro glycerin patch, and on the protocol for obtaining medication from the pharmacy. 4. The Nurse Managers will conduct monthly audits to ensure physician medication administration compliance and submit the results to the DON for presentation to the QA/QI quarterly meeting.	8/11/09 8/13/09 8/13/09 8/13/09 9/28/09 9/28/09 9/28/09

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hours.

B. Facility staff failed to differentiate between the use of pain medication.

A review of Resident FS7's record revealed an admission order dated August 4, 2009 and signed by the physician August 5, 2009, that directed, "Tylox 1 - 2 tabs po (orally) every 4-6 hours."

A face-to-face interview was conducted with Employee #24 on August 14, 2009 at 7:40 AM. When queried as to who determines how much medication (one (1) or two (2) tabs) and how frequently (every four (4) or six (6) hours) the resident received the medication, he/she replied, "The patient tells us how much medication he wants."

There was no evidence that facility staff clarified the physician's order to differentiate between the levels of severity of pain (mild, moderate or severe) or the amount of medication to be administered for each level of pain. The record was reviewed August 14, 2009. The record was reviewed August 14, 2009.

2. Based on staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to follow up with the physician's order for an eye appointment follow-up for one resident. Resident #16

The findings include:

Facility staff follow up with the physician's order for an eye appointment follow-up due in June 2009 for Resident # 16.

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L 052	Continued From page 14 According to a Consultation Record in the resident ' s clinical record, the resident was seen for an eye examination on June 19, 2008 with recommendations that included follow up in one year. A review of the resident ' s clinical record revealed a Physician ' s Order Sheet dated October 7, 2008 and renewed December 11, 2008, and June 2, 2009 that directed " To obtain new glasses and follow up with Dr ...in one year. Follow up due June 2009. " A further review of the resident ' s clinical record lacked evidence that facility staff followed up with the physician ' s order for a follow-up eye appointment. A face-to-face interview was conducted on August 13, 2009 at approximately 1:40 PM with Employee # 5. He/she acknowledged the aforementioned findings. The record was reviewed August 13, 2009. 3. Based on observations for one (1) of four (4) wound care treatments, it was determined that facility staff failed to maintain clean technique for Resident SK7 ' s sacral and shoulder wound. The findings include: A wound treatment observation was conducted on August 14, 2009 at 10:05 AM to Resident SK7's sacrum and right shoulder. Employee #21 placed a towel under the resident's sacrum and removed the soiled dressing. A Certified Nurse Aide (CNA) was assisting the resident to remain on his/her left side. The rectal area was soiled with stool, which was cleaned by	L 052		

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Remeron 7.5mg by mouth Q HS x7 days for depression, appetite and sleep. "

According to the Medication Administration Record (MAR) for the months for June 2009 through August 9, 2009, Resident #3 was administered " Ambien 5 mg P.O. QHS for sleep " , and Remeron 7.5mg for depression, appetite and sleep as evidenced by the initials on the MAR on the aforementioned dates. The Remeron was increased to 15mg on June 5, 2009.

A further review of the resident's "Interdisciplinary Progress Notes" lacked consistent documented evidence for monitoring for the use of Ambien for sleep and Remeron for sleep and depression.

A face-to-face interview was conducted with Employee #8 on August 11, 2009 at approximately 10:30 AM. He/She acknowledged that the resident's clinical record including the progress notes lacked consistent documented evidence of monitoring for the use of Ambien for insomnia and Remeron for depression and sleep. Employee # 8, further stated " We monitor weekly on the flow sheet and document only when the resident have sleep problem. " The record was reviewed August 12, 2009.

2. Facility staff failed to document evidence and consistently monitor for the use of Zolpidem for insomnia and Sertraline for depression for Resident #7.

A physician's order signed and dated August 10, 2009 directed, "Zolpidem 10mg PO Q HS for insomnia and Sertraline 100mg PO every morning for depression. "

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According to the Medication Administration Record (MAR) for the months of July 1, 2009 through August 9, 2009, Resident #3 was administered " Zolpidem 10mg P.O. QHS for insomnia " and was administered Sertraline 50mg PO every morning for depression. July 1, to July 21, 2009. The Sertraline was increased to 100mg every morning on July 22, 2009. as evidenced by the initials on the MAR on the aforementioned dates.

A further review of the resident's "Interdisciplinary Progress Notes" lacked documented evidence for monitoring for the use of Zolpidem and Setraline.

A face-to-face interview was conducted with Employee #6 on August 12, 2009, at approximately 12:15 PM. He/She acknowledged that the resident's clinical record including the " Interdisciplinary Progress Notes " lacked documented evidence of monitoring for the use of Ambien for sleep. Employee # 8 further stated: " We document only if there is problem including sleep problem. We do weekly flow sheet that is used to monitor the sleep. " The record was reviewed August 12, 2009.

3. Facility staff administered Amoxicillin to Resident SK1 who had an allergy to Penicillin.

A telephone order dated July 2, 2009 at 2:30 PM, signed by the physician the same day, and directed, " Amoxicillin 500 mg po q 8 hours x 2 weeks for Otitis of R (right) ear ... "

A review of Resident SK1 ' s record documented on the " Admission & Annual Physical Exam Form " completed by the physician on July 13, 2009, under " Allergies - Penicillin (PCN). "

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L 052	Continued From page 18 Hand written on each " Physician ' s Interim Orders " (telephone order sheets) at the bottom of the sheet was, " Allergies: PCN. " " PCN " was identified as an allergy on the June and July 2009 Medication Administration Record. A 24 hour chart check was completed on July 3, 2009. The nurse failed to identify that the resident was allergic to Amoxicillin. According to the manufacturer, " Amoxicillin belongs to a group of antibiotics called Penicillins. " (www.dsm.com <http://www.dsm.com>). The resident received 32 doses while in the facility. The resident was discharged home on July 13, 2009 with directions to complete the antibiotic. There was no evidence in the record that the resident had any untoward effects from the Amoxicillin. A face-to-face interview was conducted on August 13, 2009 at 2:30 PM, with Employee #27, who processed the Amoxicillin order. He/she stated, " The pharmacy will alert us if the resident has an allergy and then we call the doctor. I don't know why they didn't let us know that the resident was getting the wrong medication. I don ' t know how the resident got the wrong medication. " The record was reviewed August 13, 2009. 5. Based on observation, record review and staff interview, it was determined that the medication error rate was 7.35 % with five (5) non-significant errors in 68 opportunities. The findings include:	L 052		

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Employee #21 with a wet towel. Employee #21 directed the CNA the leave the resident and dispose of the soiled towel.

When the CNA left the resident, he/she rolled onto his/her back with the exposed sacral wound resting on the towel. Employee #21 cleansed the wound and the resident again rolled back on the towel. The towel had areas of bloody drainage on it from the sacral wound. The treatment was completed as per physician's orders.

Employee #21 completed the wound treatment to the right shoulder as per physician's orders.

A face-to-face interview was conducted with Employee #21 at the time of the wound treatment observation. He/she acknowledged that the sacral wound was re-contaminated when it came into contact with the towel. Employee #21 re-cleaned the wound and completed the wound treatment.

4. Based on record review and staff interview for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to: monitor the effects of an antipsychotic medication for two (2) residents and administered Amoxicillin to a one (1) resident with an allergy to Penicillin. Residents #3, 7 and SK1.

The findings include:

1. Facility staff failed to document evidence and consistently monitor for the use of Ambien for insomnia, Mirtazapine for depression and sleep, Resident #3.

A physician's order signed and dated June 3, 2009 directed, "Ambien 5 mg PO Q HS " and "

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L 052	Continued From page 19 On August 10, 11 and 13, 2009, medication pass was observed on five (5) of five (5) nursing units. 68 opportunities were observed with five (5) non-significant errors. The non-significant errors were as follows: 1. Facility staff failed to administer medication as per physician's orders for Resident JH2. A physician's order dated July 13, 2009 directed, "Calcium Carbonate Vitamin D 500 mg/200 mg II (two) tabs daily via G-tube (Gastrostomy)." During a medication administration observation on August 11, 2009 at approximately 10:30 AM, the nurse administered one (1) Calcium carbonate tablet. During reconciliation of the medication pass observation with the resident's record, it was determined that two (2) Calcium Carbonate tablets should have been administered. A face-to-face interview with Employee #32 was conducted on August 11, 2009 at 1:20 PM. He/she acknowledged that two (2) tablets of Calcium Carbonate should have been administered. The record was reviewed August 11, 2009. 2. Facility staff failed to remove a nitroglycerin patch (nitro patch) as per physician's orders. Resident S1. A physician's order dated October 10, 2007 directed, "Nitroglycerin 0.2 MG/HR Patch, Apply 1 (one) patch topically every morning and remove at bedtime." According to the August 2009 Medication Administration Record, the facility	L 052		

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L 052	Continued From page 20 identified 2100 (9:00 PM) as the time the nitro patch was to be removed During a medication pass observation conducted on August 13, 2009 at 10:20 AM, the nurse administering the nitro patch found that the resident had a nitro patch on the right side of his/her chest dated August 12, 2009. The nitro patch was not removed as per the physician's orders. Employee #20 acknowledged that the patch dated August 12, 2009 should have been removed by the evening nurse at 2100 PM. The nurse immediately removed the Nitro patch. A face-to-face interview was conducted at the time of the observation with Employees #7 and 20. They acknowledged that the nitro patch was not removed as order per physician's order. The record was reviewed August 13, 2009. 3. Facility staff failed to appropriately apply a nitroglycerin patch (nitro patch) to Resident S1. A physician's order dated October 10, 2007 directed, "Nitroglycerin 0.2 MG/HR Patch, Apply 1 (one) patch topically every morning and remove at bedtime." The facility identified 9: 00 AM as the time the Nitro patch was to be applied. During a medication pass observation conducted on August 13, 2009 at 1020 AM, the nurse administering the nitro patch did not apply the patch evenly. The middle portion of the patch was stuck together, causing a crease in the patch. The entire surface of the patch was not applied to the resident's chest. Employee # 20 acknowledged that the nitro patch	L 052		

scoop was provided.

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was not applied patch evenly on left side of resident chest.

According to the manufacturer's recommendations, the patch must be smoothly placed on the designated area to ensure proper absorption of the medication (www.herconlabs.com).

A face-to-face interview was conducted at the time of the observation with Employees #7 and 20. They acknowledged that the nitro patch was not applied patch evenly on left side of resident's chest. The record was reviewed August 13, 2009.

4. Facility staff failed to administer laxative as per physician's orders. Resident S2

The physician's orders dated November 11, 2008, directed, "Miralax 1 (one) scoop dissolved in 8 (eight) ounces of water by mouth daily for Constipation".

During a medication pass observation conducted on August 13, 2009 at 10:00 AM, the nurse administered Miralax 1 (one) scoop dissolved in 4 (four) ounces of water instead of 8 (eight) ounces of water.

A face-to-face interview was conduct on August 13, 2009 at approximately 10:25 AM with Employees #7 and 20. He/she acknowledged that the Miralax should have been mixed 1 (one) scoop dissolved in 8 (eight) ounces of water instead of 4 (four) ounces of water. The record was reviewed August 13, 2009.

5. Facility staff failed to apply an analgesic cream to Resident SK4's knees as per physician's

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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) COMPLETE DATE
L 052	Continued From page 22 orders. A physician's order dated August 12, 2009 directed, "Volturen 1% to knees QID (four times daily)." The facility identified 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM as the time the Volturen was to be applied to the resident' s knees. During a medication pass observation conducted on August 13, 2009 at 1:20 PM, the Volturen was not administered. Employee #26 stated that the cream was not available, that it had not arrived from the pharmacy. He/she acknowledged that the medication was not available at 9:00 AM either, and thus the resident missed two (2) applications. Employee #9 immediately contacted the pharmacy and it was noted that the prescription was entered into the " Treatment " area and thus the medication was not ordered by the pharmacy. A "stat" delivery was requested and the medication arrived within two (2) hours and applied to the resident's knees.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on the tour of the main kitchen and pantries on each floor, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: one (1) of one (1) ice scoop and one (1) of one (1) paddle for the ice machine stored uncovered, one (1) of one (1) observation of	L 099		

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	HFD02-0027	A. BUILDING ______ B. WING ______	08/14/2009

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L 099	Continued From page 23 chicken being thawed in standing water, soiled floor and grout, two (2) of two (2) soiled deep fryers, one (1) of one (1) observation of water leaking behind the steamer and combo ovens, 17 of 17 hotel pans store wet and ready for reuse, one (1) of one (1) soiled tilt grill, two (2) of two (2) soiled convection ovens, two (2) of two (2) leaking hand sinks, one (1) of one (1) hand sink without paper towels, one (1) of one (1) back splash to the pot and pan sink area soiled, 10 of 14 soiled cooking hood filters, one (1) of one (1) floor to walk-in refrigerator and freezer slippery, items unlabeled and undated in the walk-in refrigerator, food and paper/plastic trash in the same container, no air gap for one (1) of one (1) back flow pipe, one (1) of one (1) soiled air vent in pot and pan wash area, no sanitizer available during the food preparation time, one (1) of one (1) rusty can opener, and two (2) of two (2) vegetable mixtures and one (1) of one (1) batch of mashed potatoes prepared without recipes. The following observations were made in the facility ' s pantries: 1st floor Pantry: Wrong scoop size for pureed turkey plated for the lunch meal for August 10, 2009, one (1) of one (1) damaged area behind spray nozzle, one (1) of one (1) damaged counter, damaged cove base, and one (1) of one (1) soiled transport cart. 2nd floor Pantry: Wrong scoop size for turkey and squash plated for the lunch meal for August 10, 2009, one (1) of one (1) damaged dining room threshold, one (1) of one (1) piece of side cabinet missing, one (1) of one (1) soiled transport cart with damaged gasket, two (2) of two (2) blue drain tube and copper pipe from ice machine secured into drain with no air gap to	L 099	**3219.1 Nursing Facilities** **1.** 1.The ice scoop was cleaned immediately and placed in the proper holder. 2.The Chicken parts were removed immediately. 3.The floor in the main kitchen was cleaned. 4. The two deep fryers and gas and electrical equipment underneath were cleaned. 5. A corrective water was generated and Issued for water leaking behind the steamer this was corrected prior to the date in the completion date. 6. The wet pans were re-cleaned and re-stored after drying. 7. The interior and exterior of the convection and tilt oven was cleaned. 8. The leaking hand sinks were repaired. 9. The back splash to the pot and pan wash sink was cleaned. 10. The two cans propping the storage door Were removed immediately 11.The hood filters were taken down and cleaned. 12. The walk in refrigerator and freezer floors were cleaned. 13. All food items placed in the refrigerator And freezer were labeled and dated. Items identified to have any soft areas or changes in color were discarded. 14. All food items in the freezer were labeled and dated. 15. The lettuce and chicken parts were sorted and disposed of separately. 16. A corrective work order was generated for the backflow prevention pipe, and will be corrected by the plan of correction date. 17. A corrective work order was generated for the three compartment sink and will be corrected by the plan of correction date.	

Health Regulation Administration

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L 099	Continued From page 24 prevent backflow, one (1) of one (1) soiled cup low rater and bent front, one (2) of one (1) soiled floor in pantry, one (1) of one (1) soiled back splash by sink, two (2) of two (2) ceiling tiles soiled, and one (1) of one (1) rusty air vent. 3rd floor Pantry: Wrong scoop size for stuffing, pureed turkey and squash, and no purred potatoes for lunch meal for August 10, 2009, damaged cove base, one (1) of one (1) backflow drain from ice machine in dining room positioned so that water hit side of drain and not centered over drain, one (1) of one (1) marred chair rail, one (1) of one (1) refrigerator with soiled interior and exterior, one (1) of one (1) outside of sanitizer container soiled with built-up thick white substance, and one (1) of one (1) back splash soiled with caulking above sink noted with black spots. 4th floor Pantry: Corners at entrance to dining room by nurse ' s station soiled, one (1) of one (1) ceiling tile falling out of ceiling over resident ' s table, one (1) of one (1) broken handle on palate and dish low rater, one (1) of one (1) soiled fan in the refrigerator, and one (1) of one (1) soiled interior and exterior of the refrigerator. 5th floor Pantry: Wrong scoop size for squash and pureed turkey for lunch meal of August 10, 2009, three (3) of five (5) rusty air vents in dining room, one (1) of one (1) soiled exterior transport cart, one (1) of one (1) cabinet door off track, soiled corners, one (1) of one (1) damaged electric plug, and one (1) of one (1) soiled interior and exterior refrigerator. The following observations were made in the kitchen on 5E of the main hospital: One (1) of five	L 099	**3219.1 Nursing Facilities continued** **#1 continued** 18. Sanitizer solution was make available. 19. The can opener was replaced. 20. The cooks were instructed to follow recipes as directed on the package/Geri menu recipes.	9/28/09
			2. A comprehensive inspection was conducted in the main kitchen. This included ensuring items correctly stored such as ice scoops and pans. The items were also checked for cleanliness. The environmental checks included all equipment, wall and floor surfaces, appliances and supplies. All food items stored in the refrigerators and freezers were inspected thoroughly for spoilage and expiration dates. All food items that showed signs of spoilage were discarded. Recipes were posted and staff were instructed to use recipes.	9/28/09
			3. The Food Service staff will be re-educated on The storage, preparation and distribution of Food. The Sanitation Check list was revised to include items identified in survey. The supervisors were re-educated on the sanitation of the kitchen. The Maintenance staff have modified preventive maintenance program to include the main kitchen.	9/28/09

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L 099	Continued From page 26 rounds on July 13, 2009 and August 3, 2009 and was not repaired at time of observation. The hand sink in dish room leaked from underneath the bowel. 9. The back splash to pot and pan wash sink soiled with grease and debris. 10. The dry storage fire door was propped open with two (2) cans. 11. 10 of 14 cooking hood filters were soiled with grease and debris. The filters were cleaned on June 6, 2009. 12. The walk in refrigerator and freezer floors were slippery. Employee #11 stated that there were rubber mats to place on the floor which is made of aluminum. 13. Items not dated or labeled in walk-in refrigerator: Yellow and green jello in a hotel pan 32 of 32 containers of pudding 10 of 10 containers of applesauce Three (3) packages of open American cheese One (1) package tortilla wraps One (1) container sliced tomatoes not wrapped securely One (1) package broccoli parts Two (2) plastic bags of radishes One (1) plastic bag of lettuce Four (4) heads of wilted lettuce Two (2) of four (4) tomatoes with brown spots and soft 12 cherry tomatoes in large bin of cherry tomatoes with soft and brown spots One (1) of three (3) watermelons split and brown 14. Items not dated in the freezer: One (1) of one (1) package of bagels One (1) of one (1) loaf of French bread One (1) of one (1) package of waffles One (1) of one (1) package of muffins 15. Lettuce and chicken parts in the same trash can with paper.	L 099	**3219.1 Nursing Facilities** **2nd Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the threshold, blue drain tube with air gap, ceiling tiles and air vents. These areas will be corrected as indicated in the completion date. The transport cart exterior cleaned. The cup lower rater was cleaned and a work order was created for the bent front panel. The floor in the pantry and the back splash were cleaned. 2. A comprehensive review of the second Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed. Drainage tubes, air vents and low raters Were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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L 099	Continued From page 27 16. A backflow prevention pipe was observed in the drain with no air gap by the three (3) compartment sink. 17. One (1) of one (1) air vent soiled above three (3) compartment sink. 18. No sanitizer was available during food preparation time. 19. One (1) of one (1) can opener with rusty surfaces. 20. Employee #13 stated that he/she did not use a recipe to make the vegetable mixture for the lunch meal. He/she stated, "I just put it in the steamer and add butter and salt." Employee #14 stated that he/she did not use a recipe for the winter vegetable mixture being prepared for the dinner meal. He/she stated, "The veggies are steamed and I add butter and salt. We don't have a recipe." Employee #14 stated, "We make the mashed potatoes in the big silver bowel. I use 7 gallons of boiling water, six packages of mashed potato mix, three sticks of butter and one quart of milk." Directions on the back of the package of potato mix directed to mix one gallon of water with the contents of the package. An interview was conducted with Employee #4 on August 10, 2009 at 3:30 PM. He/she stated, "We are trying to enhance the food and use less supplements. We are just starting this and haven't really discussed or documented this information about the potatoes." 1st floor Pantry 1. Observation of the lunch meal for August 10, 2009 included the wrong scoop size was used for the pureed turkey.	L 099	**3219.1 Nursing Facilities** **3rd Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the cove base, drainage pipe, and chair rail These items will be corrected by the completion date. The interior and exterior surfaces of the refrigerator, sanitizer and back splash were cleaned. 2. A comprehensive review of the third Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters, appliances and equipments. The use of appropriate scoop size was also reviewed. Drainage tubes, air vents and chair rails were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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L 099	Continued From page 25 (5) knobs missing off the stove, one (1) on one (1) bag of unlabeled and undated food items, one (1) of one (1) vegetable platter with "Best used by" date of August 8, 2009, one (1) of one (1) bag of Kentucky Fried Chicken undated and unlabeled, two (2) of two (2) plastic containers undated and unlabeled, and one (1) of one (1) package of bagels with expiration date of June 13, 2009.	L 099	**3219.1 Nursing Facilities continued** **4.** The Dietary manager and/or designee will increase the Monitoring and surveillance of the kitchen. This surveillance will be included on a Dietary sanitation audit tool. This tool will be completed monthly and reported to the QA/QI committee quarterly.	9/28/09
	The tour of the main kitchen and pantries was conducted on August 8, 2009 from 8:40 AM through 3:45 PM in the presence of Employees #11 and 12. The findings include: 1. One (1) of one (1) ice scoop and one (1) of one (1) paddle used for the ice machine was stored on top of the ice machine uncovered. 2. Chicken parts were being thawed in standing water in the cook ' s preparation area. 3. The floor of the main kitchen was observed soiled and the grout between the tiles of the main kitchen floor was observed discolored.		**3219.1 Nursing Facilities** **1ST Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the area behind the spray nozzle, The counter pulled away from the wall, and the cove base. These areas will be corrected as indicated in the completion date. The transport cart exterior was cleaned.	9/28/09
	4. Two (2) of two (2) deep fryers and gas and electrical equipment underneath observed soiled with grease and other debris. 5. Water was leaking behind the steamer and combo ovens.		2. A comprehensive review of the first floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed.	9/28/09
	6. 17 of 17 hotel pans were stored wet and ready for reuse: four (4) of four (4) one quarter inch hotel pan, seven (7) of seven (7) one-half hotel pan and six 9^) of six (6) one quarter hotel pans. 7. The interior and exterior of one (1) of one (1) tilt grill and one (1) of one (1) convection ovens were observed soiled with grease and debris.		3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance.	9/28/09
	8. The hand sink by the pot and pan wash area leaked from underneath the bowel when the water was turned on. This was identified during		4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09

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L 099	Continued From page 28 2. A 4 oz (ounce) scoop was used and according to the meal ticket the serving portion was 3 oz. 3. Plaster was damaged behind spray nozzle on the sink. 4. The counter was observed with the back of counter pulled away from wall. This was identified on round on February 18, 2009 and not repaired at time of observation. 5. Cove base was observed soiled and damaged in the pantry. 6. The transport cart exterior was soiled. 2nd floor Pantry 1. Observation of the lunch meal for August 10, 2009 included the wrong scoop size for stuffing. A 3 oz scoop was used and according to the meal ticket the serving should have been ½ cup and for the squash, a 6 oz scoop was used and the serving size should have been ½ cup. 2. The threshold to the dining room was damaged. 3. The exterior of the transport cart was soiled with a damaged gasket. 4. A blue drain tube and a copper pipe from ice machine were secured into a drain with no air gap to prevent backflow. 5. The cup low rater was soiled with a bent front panel. 6. The floor in the pantry was soiled. 7. The back splash by the sink was soiled. 8. Two (2) ceiling tiles were soiled above the sink with one (1) tile bowing downward over the sink area. 9. One (1) of one (1) air vent was rusty. 3rd floor Pantry 1. Observation of the lunch meal for August 10, 2009, included the wrong scoop size for the	L 099	**3219.1 Nursing Facilities** **4th Floor Pantry** 1. The corners and entrances to the dining Room nurse station was cleaned. A corrective work order was ceiling tile. These areas will be corrected as indicated in the completion date. The broken handle was removed. The fan in the refrigerator and the interior and exterior surfaces of the refrigerator were cleaned. 2. A comprehensive review of the fourth Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The refrigerators were also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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L 099	Continued From page 29 stuffing. A 3 oz scoop was used and the meal ticket directed the portion should have been ½ cup; 4 oz scoop was used for the pureed turkey and should have been 3 oz; a 2 oz scoop was used for the pureed squash and it should have been ½ cup. There were no pureed potatoes for 3 pureed diets on the 3rd floor. 2. The cove base behind the equipment in the dining room was damaged. 3. The drainage pipe from the ice machine in the dining room was not centered over the drain and caused water to pool behind the equipment. 4. The chair rail in the back of the dining room was marred with chipped paint. 5. The interior and exterior surfaces of the refrigerator were soiled with accumulated debris. 6. The outside of the sanitizer container was soiled with a thick white substance. 7. The back splash of the sink was soiled with debris and the caulking above sink was noted with black spots. 4th floor Pantry 1. The corners at entrance to dining room by nurse ' s station were soiled. 2. One (1) ceiling tile was falling out of the ceiling over a resident ' s table. 3. A broken handle was observed on the palate and dish low rater. 4. The fan in the refrigerator was soiled with accumulated debris. 5. The interior and exterior of the refrigerator was soiled. 5th floor 1. Observation of the lunch meal on August 10, 2009 included the wrong scoop size was used for the squash. A 6oz scoop was used and the meal	L 099	**3219.1 Nursing Facilities continued** **5th Floor Pantry** 1. The proper scoops were provide for the Meal service and staff instructed which Scoop to use. A corrective work order was issued for the air vents, cabinet doors, and plugs were completed. These areas will be corrected as indicated in the completion date. The exterior transport cart, corners and the interior and exterior of the refrigerator were cleaned. 2. A comprehensive review of the fifth Floor Pantry was conducted. This included reviewing wall and floor surfaces and counters and equipments. The use of appropriate scoop size was also reviewed. Cabinets, air vents and electrical plugs were Also checked. 3. The supervisory staff were re-educated on The expectation of the pantry areas. The supervisory staff have also been instructed to be more vigilant in walk throughs to ensure compliance. 4. The Dietary Manager and/or designee will audit the pantries monthly and report the findings to the QA/QI Committee Quarterly.	9/28/09 9/28/09 9/28/09 9/28/09

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L 099	Continued From page 30 ticket noted the serving should have been ½ cup and a 4 oz scoop was used for pureed turkey and should and have been 3 oz. 2. Three (3) of five (5) air vents in the dining room were rusty. 3. The exterior transport cart was soiled. 4. The cabinet door was off track in the dining room. 5. Corners were soiled in the dining room. 6. An electric plug where the palate and plate warmer plugged into was damaged. 7. The interior and exterior of the refrigerator was soiled. The following observations were made in the kitchen on 5E of the main hospital: One (1) of five (5) knobs missing off the stove. One (1) on one (1) bag of unlabeled and undated food items in the refrigerator. One (1) of one (1) vegetable platter with "Best used by" date of August 8, 2009 in the refrigerator. One (1) of one (1) bag of Kentucky Fried Chicken undated and unlabeled in the refrigerator. Two (2) of two (2) plastic containers filled with food undated and unlabeled in the refrigerator. One (1) of one (1) package of bagels in the refrigerator with "Sell by" date of June 13, 2009. Employees #11 and 12 acknowledged the findings at the time of the observations.	L 099	**3219.1 Nursing Facilities continued** **5 East** 1. The knobs missing off the stove were Replaced. The undated and unlabeled food Items were discarded. 2. All areas in the Center that have stoves Were checked, and those areas that needed Replacement were replaced. All refrigerators were checked for undated and unlabeled food items. 3. Staff was in serviced on the importance of Appliances being properly maintained and on refrigerator log protocol for checking for undated and unlabeled food items. 4. The Dietary Manager and/or designee will Monitor the stoves on a monthly basis. The night charge nurse will conduct refrigerator audits daily and complete refrigerator cleaning log to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting.	8/10/09 8/10/09 9/28/09 9/28/09
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation and staff interview it was determined that in one (1)) of seven (7) medication carts observed, the facility staff to	L 161		

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L 161	Continued From page 31 removed expired medication from currently date medication. The findings include: On August 10, 2009, between 12:00 PM and 3:30 PM, during the inspection of the medication carts on the 3rd, 4th, and 5th the following medications were observed expired. 3rd Floor (19) Clonidine 0.1 mg tab - expired September 18, 2008 (9) Clonidine 0.1 mg tab - expired August 10, 2008 (22) Clonidine 0.1 mg tab - expired December 5, 2008 A face-to-face interview was conducted at the time of the observation. Employee #7 acknowledged that the medications were expired.	L 161	**3227.12 Nursing Facilities** 1. 5th Floor Xalatan was discarded; a new bottle was ordered and obtained from the pharmacy. 3rd Floor Lidocaine, Tuberculin, Pneumococcal vials and Clonidine tablets were all discarded. New vials and tablets were ordered and received from the pharmacy. 2. All residents medications were reviewed to ensure no expired. medications were being administered. 3. Staff will be in serviced on pharmacy policies on dating and discarding expired medications. 4. Nurse Managers will conduct monthly audits on pharmaceutical services to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting.	8/10/09 8/10/09 9/28/09 9/28/09
L 162	3227.13 Nursing Facilities Each medication that is no longer in use shall be destroyed or returned to the in-house pharmacy. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined during the inspection of the medications storage areas that the facility staff failed in three (3) of nine (9) medication carts to remove discontinued medication from the medication carts. The findings include: On August 12, 2009, between 12: 00 PM and 3:30 PM, discontinued (patient no longer using medication) medication was observed stored in the medication carts on the 3rd and 5th floors:	L 162		

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L 162	Continued From page 32 Discontinued medication Ciprofloxacin 250 mg tablet, discontinued July 24, 2009 Robitussin DM cough syrup (generic brand), discontinued July 7, 2009 Pred Forte 1% Ophthalmic drops, discontinued July 30, 2009 Robitussin cough syrup (generic brand) , discontinued August 1, 2009 Diabetic Tussin syrup, discontinued July 24, 2009 Robitussin cough syrup (generic brand), discontinued July 9, 2009 Pepto Bismol (generic brand), discontinued April 20, 2009 A face-to-face interview was conducted at the same time of the observation with Employees #7 and 9. They acknowledged that the medications should have been removed from the medication carts.	L 162	**3227.13 Nursing Facilities** 1. All discontinued and unlabeled medications were removed from the medication carts on the 3rd and 5th floors. 2. All medication carts were inspected and all discontinued and unlabeled medications were removed. 3. Staff will be in serviced on the facility policy on labeling and discontinued medications. 4. Nurse Managers will conduct monthly audits on pharmaceutical services to ensure compliance and submit the results to the DON for presentation at the quarterly QA/QI meeting.	8/12/09 8/13/09 9/28/09 9/28/09
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and staff interview during the environmental tour and the tour of the main kitchen , it was determined that facility staff failed to maintain an accident free environment as evidence by: four (4) of six (6) oxygen tank stored without a holder, one (1) of one (1) fan in the wash area of the main laundry with an extension cord stretched among chemical barrels, one (1) of one (1) frayed cord to the tilt grill and screws protruding from the base of the entrance door to	L 214		

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L 214	Continued From page 33 the dining room. The environmental tour was conducted on August 10, 2009 from 10:30 AM through 3:45 PM and on August 11, 2009 from 8:40 AM through 3:00 PM in the presence of Employees #5, 6, 7, 8, 9, 11, 15, and 16. The tour of the main kitchen and pantries was conducted on August 8, 2009 from 8:40 AM through 3:45 PM in the presence of Employees #11 and 12. The findings include: 1. Oxygen tanks were not secured in holders to prevent accidental tip over in the following areas: 4 East storage room, four (4) of six (6) oxygen containers stored on the floor without a holder. 3 North supply room, two (2) of five (5) containers stored on the counter without a holder. 2. One (1) of one (1) fan with soiled interior and exterior surfaces was observed with an extension cord stretched among chemical barrels. 3. The cord to one (1) of one (1) tilt grill was frayed. This was identified on weekly rounds on August 3, 2009 and not repaired at time of this observation. 4. Screws were protruding from the door to the dining room at the base of the door on the first floor. A metal cover was missing over the screws.	L 214	**3234.1 Nursing Facilities** 1. All oxygen tanks identified in item #1 were secured immediately. A corrective work order was generated and issued for the extension cord stretched among the chemical barrels, frayed cord on the tilt grill, and the screws protruding from the door. All items will be corrected as indicated in the Completion date. 2. Environmental Rounds were conducted on all floors and all rooms to ensure there were no further oxygen tanks without holders. Additionally, an environmental tour was conducted to review for any safety related concerns, no other areas were identified. 3. The staff will be re-inserviced regarding Accidents and supervision particularly as it pertains oxygen tanks, fans, extension cords, chemical barrels and the frayed cords and screws. 4. The nursing management team will conduct monthly audits as it pertains to the oxygen tanks. Environemental rounds/audits will be conducted to review safety concerns. Both audits will be reported to the QA/QI Committee quarterly.	9/28/09 9/28/09 9/28/09 9/28/09
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe,	L 410		

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L 410	Continued From page 34 sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: During the environmental tour, it was determined that facility staff failed to maintain housekeeping and maintenance services to maintain an sanitary, orderly and comfortable environment as evidenced by: 30 of 70 dusty beds, 28 of 70 dusty blinds, 35 of 70 dusty window sills, 23 of 70 dust over bed shelves, 31 of 35 soiled accordion doors to the bathroom, 15 of 35 soiled Heating Ventilation Air Conditioning (HVAC) units on the interior of the perimeter of the unit, nine (9) of 70 rooms with damaged cove base, six (6) of 35 resident bathroom air vents not functioning, and five (5) of 35 slow draining sinks. The main laundry and the personal laundries on each floor were also included in the environmental tour. The following was observed: items stored in the lint compartment room, one (1) of one (1) ceiling tile was missing over the sheet folder, 19 of 24 interior of lights soiled with debris, one (1) of one (1) laminate wall disattached from the wall, cove base damaged by the sheet folder, one (1) of one (1) door jam to lint collector room damaged, two (2) of four (4) air vents without covers, one (1) of one (1) drain from lint compressor not positioned over drain, four (4) of four (4) dryer exteriors soiled, floor damaged in front of dryer, four (4) of four (4) washers with rusted bolts, and water leaking between washer #1 and #2 and by washer #4. 5th floor Laundry room: One (1) of one (1) light cover missing above the hand wash sink, the interior of two (2) of three (3) lights with debris, two (2) of two (2) soiled air vents and one (1) of one (1) soiled exterior of the washer.	L 410	**1. 3256.1 Nursing Facilities (Section A)** 1. The soiled beds identified in item #1 have been cleaned. The soiled blinds identified in item #2 were cleaned with a power wash. Each slat of the blinds were then wiped to ensure compliance. The soiled window sills observed in item #3 have been cleaned. The soiled over bed shelves observed in item #4 have been cleaned. The Accordian doors to the bathrooms observed it item #5 have been cleaned. A corrective work order for the soiled interior perimeter of the HVAC units in item #6 was generated and all will be completed by completion date. A corrective work order was submitted for the cove base identified in item #7 and will be completed by completion date. A corrective work order was submitted for the bathroom air vents identified in item #8 and all will be corrected by completion date. A corrective work order was submitted for the slow draining sinks identified in item #9 and all will be corrected by completion date. 2. The bed frames in the facility were checked to ensure cleanliness. The bed frames will be cleaned and inspected on a daily basis. All blinds and window sills were inspected. All over bed shelves were inspected. All accordion doors were inspected. Additionally, an inspection of the HVAC units, cove base and sinks was conducted. Areas of concern were corrected. 3. The housekeeping staff will be inserviced on housekeeping services including the cleaning of bed frames, blinds, window sills over bed shelves, and accordion doors. The maintenance department was inserviced on cleaning the interior perimeter of the HVAC	9/28/09 9/28/09

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L 410	Continued From page 35 4th floor Laundry room: two (2) of four (4) air vents with missing covers, exterior surface and the exterior surface of one (1) washer and one (1) dryer soiled. Observations of the Rehabilitation Department, 3rd floor, included the following: One (1) of two (2) dusty air vents, two (2) of two skid strips on the shoulder flexion machine were worn, and one (1) 6-inch by 8-inch hole under the hand wash sink. Observations of the Rehabilitation Department on 5E in the main hospital, included the following: one (1) of one (1) standing table with one (1) loose right bar. The environmental tour was conducted on August 10, 2009 from 10:30 AM through 3:45 PM and on August 11, 2009 from 8:40 AM through 3:00 PM in the presence of Employees #5, 6, 7, 8, 9, 11, 15, and 16. The findings include: A. The following observations were made during the environmental tour: 1. Soiled beds were observed in the following rooms: 551, 545, 530, 456, 438, 410, 411, 407, 341, 345, 346, 341, 321, 313, 248, 246, 245, 241, 232, 230, 222, 203, 156, 142, 134, 111, 110, 109, 108 and 106. 2. Soiled blinds were observed in the following rooms: 514, 512, 509, 453, 446, 438, 432, 431, 407, 405, 347, 345, 321, 326, 313, 311, 246, 241, 232, 230, 222, 203, 156, 134, 111, 110, 108 and 106.	L 410	**3256.1 Nursing Facilities Section A continued)** #3 continued. units, repairs to the cove base, bathroom air vents and draining sinks. Daily rounds will be conducted by the house keeping manager to include a review of the beds, blinds, window sills, over bed shelves, and accordion doors. Additionally, environmental rounds will be conducted on the HVAC units, cove base, bathroom air vents and slow draining sinks. 4. The housekeeping manager will conduct daily room inspections. These inspections will include a review of the beds, blinds, win-dow sills, overbed shelves, and accordion doors. The environmental team will also monitor the HVACs, cove base, bathroom air vents and drains on the sink. This information will be a component of the audit tool that is compiled on a monthly basis. This informa-tion will be reported to the QI Committee on a quarterly basis. **3256.1 Nursing Facilities (Section B)** 1. All items stored in the lint collector room In item #1 were removed. The ceiling tile Identified in item #2 was replaced. The interior ceiling lights identified in item#3 were cleaned. Corrective work orders were generated for the detached laminate and wall in item #4, this will be corrected by the completion date. Corrective work orders were also generated for the base board, door jam to the lint collector room and drain in the lint room which were identified in items # 5, 6 and 7, these areas will be corrected by the completion date.	9/28/09 9/28/09

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L 410	Continued From page 36 3. Soiled window sills were observed in the following rooms: 527, 512, 456, 455, 453, 445, 438, 432, 431, 410, 407, 405, 346, 345, 333, 331, 326, 313, 311, 246, 241, 232, 230, 226, 222, 203, 156, 155, 142, 141, 138, 111, 110, 108 and 106. 4. Soiled over bed shelves were observed in the following rooms: 533, 514, 509, 456, 453, 438, 432, 411, 341, 313, 248, 246, 241, 232, 230, 222, 203, 156, 134, 111, 110, 108 and 106. 5. Accordion doors to bathrooms were observed soiled in the following rooms: 551, 545, 533, 530, 522, 509, 512, 456, 446, 445, 443, 431, 410, 346, 345, 326, 321, 313, 304, 245, 241, 226, 222, 203, 154, 143, 136, 133, 127, 110 and 103. 6. Soiled interior perimeter of the HVAC units in the following rooms: 551, 544, 530, 527, 522, 514, 446, 431, 429, 345, 326, 246, 155, 154 and 153. 7. Damaged cove base in the following areas: 552, 533, 530, 509, 429, 346, 326, 248, and 232. 8. Bathroom air vents not drawing air in the following rooms: 552, 544, 456, 453, 304 and 302. 9. Slow draining sinks in the following rooms: 552, 527, 210, 207 and 154. B. The following was observed in the main laundry and the unit laundry rooms:	L 410	**3256.1 Nursing Facilities (Section B continued)** #1 continued The exterior surfaces of the dryers were cleaned. Air vents in the main laundry room has been ordered as indicated in item #9. Corrective work orders were generated for floor damaged in front of the dryers, and bolts holding down the washer as indicated in items #10 and #11, these areas will be corrected by the completion date. Paper towels were placed by the hand washing sink as indicated in item #12. Corrective work orders were issued for the water accumulated between washers #1 and #2, light covers, and interior of lights as indicated in item#13 and #15. This will be completed by completion date. There were no air vents in the 5th floor laundry as indicated in item #15. There are no air vents in the 4th floor laundry room as indicated in item #16. The exterior surfaces of the washer and dryer were cleaned as indicated in item #16. 2. A detailed environmental review was Conducted in the main laundry and unit Laundry rooms. This review included: lint collection areas, lights and light fixtures, ceiling tiles, and wall surfaces. This review also include the floor surfaces, cove base, sinks and exterior surfaces of washers and dryers. There were no other areas found to be deficient. 3. The Environmental staff including, Housekeeping, laundry and maintenance have been re-educated on the cleaning and maintenance of the main laundry and unit laundry rooms.	9/28/09 9/28/09 9/28/09

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L 410	Continued From page 37	L 410	**3256.1 Nursing Facilities (Section B continued)**	
	follows: one (1) mop and bucket, two (2) ladders, one (1) package of florescent light bulbs; box of metal parts, miscellaneous machine parts, one (1) bucket of paint, one (1) gallon of motor oil stored next to the compressor, and one (1) piece of wood beam. It was noted that the handles of the mop and broom was warm to touch.		4. A review/audit of the main laundry and the Unit laundry rooms will be completed monthly This information will be reported to the QA Committee quarterly.	9/28/09
	2. One (1) of one (1) ceiling tile was missing above sheet folder.		**3256.1 Nursing Facilities (Section C)**	
	3. 19 of 24 interior ceiling lights were observed with accumulated debris in the folding and drying area.		1. A corrective order was issued for the air vents, skid strips and hand wash sink, These items will be corrected by the completion date.	9/28/09
	4. The wall by the sheet folder had protective laminate that was disattached from the dry wall.		2. A detailed review of the environment in The rehabilitation department no other Deficient practices were noted.	9/28/09
	5. The base board by the disattached wall was damaged.		3. The Environmental staff including, Housekeeping and maintenance have been re-educated on the cleaning and repair needs of the rehabilitation department.	9/28/09
	6. One (1) of one (1) door jam to lint collector room was damaged.		4. An audit of the rehabilitation department Will be completed and reported to the QA Committee quarterly.	9/28/09
	7. One (1) of one (1) drain in lint collector room was lying on its side and failed to completely empty into the floor drain causing water to accumulate on floor seeping through to sheet folding side of wall.		**3256.1 Nursing Facilities (Section D)**	
	8. The exterior surfaces of four (4) of four (4) dryers were soiled.		1. A corrective order was issued for the For the 5 East standing table loose bar. This will be corrected by the completion date.	9/28/09
	9. Two (2) of four (4) air vents were observed without covers above dryers.		2. A detailed review of the environment in The rehabilitation department on 5E, no Other deficient practices were noted.	9/28/09
	10. The floor was damaged in front of the dryers.			
	11. Bolts holding down four (4) of four (4) washers were observed with accumulated debris			

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L 410	Continued From page 38 on sides of washers, and with rusted bolts. 12. One (1) of one (1) hand wash sink by the washing machines had no paper towels. 13. Water was observed accumulating between washers #1 and #2, and towards the back of #2. A puddle of water was observed to side of washer #4. 15. 5th floor Laundry room: One (1) of one (1) light cover missing above the hand wash sink. The interior of two (2) of three (3) lights soiled with debris. Two (2) of two (2) air vents were soiled with dust. The exterior of one (1) of one (1) washer was soiled with debris. 16. 4th floor Laundry room: Two (2) of four (4) air vents were observed with missing covers. The exterior surface of one (1) washer and one (1) dryer soiled were soiled with debris C. Observations of the Rehabilitation Department, 3rd floor, included the following: One (1) of two (2) air vents was dusty. Two (2) of two skid strips on the shoulder flexion machine were worn. One (1) 6-inch by 8-inch hole was observed under the hand wash sink around the pipe. D. Observations of the Rehabilitation Department on 5E of the main hospital included the following: One (1) of one (1) standing table with one (1) loose right bar. Employees #5, 6, 7, 8, 9, 11, 15, and 16 acknowledged these findings at the time of the	L 410	**3256.1 Nursing Facilities (Section D continued)** 3. The Environmental staff including, Housekeeping and maintenance have been re-educated on the cleaning and repair needs of the rehabilitation department. 4. An audit of the rehabilitation department Will be completed and reported to the QA Committee quarterly.	9/28/09 9/28/09

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L 410	Continued From page 39 observations.	L 410		