Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0020	A. BUILDING _____ B. WING _____	01/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

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L 000	Initial Comments An annual licensure survey was conducted on January 12 through 16, 2009. The following deficiencies were based on record review, observations, and interviews with residents and the facility staff. The sample included 30 residents based on a census of 349 residents on the first day of survey and 59 supplemental residents.	L 000	The filing of the Plan of Correction does not constitute an admission that the deficiencies actually did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirements of responding to these citations and to continue to provide quality resident care.	
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the physician failed to complete an annual history and physical for Resident #7. The findings include: A review of Resident #7 ' s record revealed that the last history and physical examination was December 12, 2007. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that an annual history and physical examination should have been completed in December 2008. The record was reviewed January 13, 2009.	L 036	**3207.11 Nursing Facilities** Resident #7 1. This resident received her annual H&P. 1/31/09 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were made whenever necessary. 3/31/09 3. The unit clerks will perform monthly quantitative audits noting the date of the last dental screening. Their findings will be communicated to the consultant dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their findings to the DON. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 4/3/09	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051	**3210.4 Nursing Facilities**	

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L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the physician failed to complete an annual history and physical for Resident #7. The findings include: A review of Resident #7 ' s record revealed that the last history and physical examination was December 12, 2007. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that an annual history and physical examination should have been completed in December 2008. The record was reviewed January 13, 2009.	L 036	**3207.11 Nursing Facilities** Resident #7 1. This resident received her annual H&P. 1/31/09 2. An audit was done for all residents of the facility to ensure that an annual dental screen was done. Correction were made whenever necessary. 3/31/09 3. The unit clerks will perform monthly quantitative audits noting the date of the last dental screening. Their findings will be communicated to the consultant dentist. The Clinical Managers will monitor the timeliness of annual dental screens and communicate their findings to the DON. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 4/3/09	
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L 051	Continued From page 1 (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; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (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: Based on observation, record review and staff interview for six (6) of 30 sampled residents, it was determined that the charge nurse failed to initiate care plans with appropriate goals and approaches for: one (1) resident with Anemia and Multiple Sclerosis, two (2) residents for anticoagulant therapy, two (2) residents for the potential adverse interaction for the use of nine (9) or more medications, three (3) resident for incontinence, one (1) resident for the use of side rails and one (1) resident for abusive/aggressive behaviors. Residents # 2, 5, 6, 7, 13 and 15. The findings include: 1. The charge nurse failed to initiate care plans with goals and approaches for Anemia and Multiple Sclerosis for Resident #2.	L 051	**3210.4 Nursing Facilities** (continued) **1. Resident #2Anemia and MS** 1. Resident #2's care plan was amended o include a care plan with goals and approaches for Anemia and Multiple Sclerosis. 2. Care Plans of all residents with the Diagnoses of Anemia and Multiple Sclerosis were reviewed for the same deficient practice and changes made as needed. 3. Appropriate care plans with goals and Approaches for Anemia and Multiple Sclerosis will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/13/09 3/13/09 3/31/09 4/3/09

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L 051	Continued From page 2 According to the admission Minimum Data Set (MDS) assessment completed November 24, 2008, the resident was coded in Section I (Disease Diagnoses) for Anemia and Multiple Sclerosis (MS). A review of the resident's care plans initiated November 24, 2008, revealed that no care plan with appropriate goals and approaches was initiated for Anemia or MS. A face-to-face interview was conducted with the resident at approximately 8:15 AM on January 13, 2009. He/she acknowledged being aware that he/she had a diagnosis of Multiple Sclerosis. The resident stated, " I was diagnosed with MS many years ago [not sure how many]. I used to receive Avonex injections once a week for MS but I have not had any [injections] since I have been here. I didn't ' t get any injections while I was in the other hospital either. I thought I told someone about the injections when I first got here but I am not sure who I told. " A face-to-face interview was conducted with the Employee #9 on January 15, 2009 at approximately 9:00 AM. He/she stated she was not aware of the diagnoses of Anemia and Multiple Sclerosis. He/she added, " I will look into that [the diagnoses]. " In another face-to-face interview conducted with Employee # 9 at approximately 9:30 AM on January 16, 2009 the employee stated, " I have spoken to the physician and the resident will be evaluated for Anemia and MS. " The record was reviewed on January 12, 2009. 2. The charge nurse failed to initiate a care plan for anticoagulant therapy for Resident #5. According to the preprinted "Physician's Orders" signed by the physician on December 23, 2008, the resident was prescribed Plavix 75 mg daily.	L 051	**3210.4 Nursing Facilities** (continued) **2. Resident #5 Anti-coagulant Therapy** 1. Resident #5's care plan was amended to include goals and approaches for a resident receiving anticoagulant therapy. 2. Care Plans of all residents receiving anticoagulant therapy were reviewed for goals and approaches for anticoagulant therapy and amended as needed 3. Appropriate care plans with goals and Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/6/09 3/10/09 3/31/09 4/3/09

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L 051	Continued From page 3 A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of anticoagulant therapy. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed January 3. The charge nurse failed to initiate a care plans with appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications for Resident #6. A review of the clinical record for Resident #6 revealed a Physician ' s Order Sheet (POS) signed on January 6, 2009 with medications which included Colace, Folic Acid, Furosemide, Labetalol, Keppra, Procardia, Coumadin, Dilantin, Senokot, Dulcalox Suppository, Citrate of Magnesia and Tylenol tablets. Further review of the record revealed that no care plan was initiated for the potential adverse interactions for the use of nine or medications. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 11:00 AM. He/she acknowledged that the care plan for the potential interaction of the use of nine or more medications was not on the record. He/she added, " I will put one on right now. " The record was reviewed on January 13, 2009. 4. The charge nurse failed to initiate a care plan for anticoagulant therapy and incontinence for Resident #7. A. Facility staff failed to initiate a care plan for anticoagulant therapy for Resident #7. Review of Resident #7's record revealed a	L 051	**3210.4 Nursing Facilities** (continued) **3. Resident #6 Adverse Reaction** 1.Resident #6's care plan was amended to include appropriate goals and approaches for the potential adverse interactions for the use of 9 or more meds. 2. Medical records of all residents with 9 or more medications were reviewed if a corresponding care plan with appropriate goals and approaches for the potential adverse interactions. 3. Appropriate care plans with goals and Approaches for Adverse Interactions for the Use of 9 or More Meds will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **4A. Resident #7 Anti-coagulant** 1. Resident # 7's care plan was amended to include goals and approaches for a resident receiving anticoagulant therapy. 2. Care Plans of all residents receiving anticoagulant therapy were reviewed for goals and approaches for anticoagulant therapy and amended as needed. 3. Appropriate care plans with goals and Approaches for Anticoagulant Therapy will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation.	3/6/09 3/6/09 3/31/09 4/3/09 3/6/09 3/10/09 3/31/09

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L 051	Continued From page 4 physician's order initiated December 12, 2007 and renewed with each physician ' s visit most recently January 6, 2009, for " Plavix 75 mg q d (once daily) po (by mouth). " A review of the resident ' s care plans revealed that there was no care plan initiated with appropriate goals and approaches for the use of anticoagulant therapy. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that there was no care plan for the use of Plavix. The record was reviewed January 13, 2009. B. The charge nurse failed to initiate a care plan for incontinence. A review of Resident #7's record revealed quarterly MDS assessments completed March 14 and June 9, 2008 and the annual MDS assessment completed September 2, 2008 coded the resident as frequently incontinent of bowel and bladder function in Section H (Continence in last 14 days). The quarterly MDS assessment completed December 2, 2008 coded the resident as totally incontinent of bladder and frequently incontinent of stool in Section H. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for bowel and bladder incontinence. A face-to-face interview was conducted with Employee #6 on January 13, 2009 at 2:25 PM. He/she acknowledged that there was no care	L 051	**3210.4 Nursing Facilities** (continued) **4A. Resident #7 (continued)** 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **4B. Resident #7 Incontinence** 1. Resident # 7s care plan was amended to include goals and approaches for a resident who has incontinence. 2. Care Plans of all residents who has incontinence were reviewed for goals and approaches for incontinence and amended as needed. 3. Appropriate care plans with goals and Approaches for Incontinence will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09 3/6/09 3/31/09 3/31/09 4/3/09

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L 051	Continued From page 5 plan for incontinence. The record was reviewed January 13, 2009. 5. The charge nurse failed to initiate care plans for Resident #13 for incontinence and aggressive/ abusive behaviors. A. Facility staff failed to initiate a care plan for incontinence for Resident #13. Review of Resident #13's record revealed the admission MDS completed May 21, 2008 coded the resident as usually incontinent of bowel and totally incontinent of bladder. The quarterly MDS assessments completed July 24 and October 16, 2008 and January 21, 2009 coded the resident in Section H as usually incontinent of bowel and bladder. A review of the resident's care plans revealed that there was no care plan initiated with appropriate goals and approaches for bowel and bladder incontinence. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that there was no care plan for incontinence. The record was reviewed January 13, 2009. B. The charge nurse failed to initiate a care plan for aggressive/abusive behaviors for Resident #13. According to a review of Resident #13's of the "Initial Psychiatric Evaluation" dated October 9, 2008, " ...[Resident] admits to being verbally abusive to other patients at times and physically assaultive off and on ... " The resident was prescribed Seroquel 50 mg orally twice daily and	L 051	**3210.4 Nursing Facilities** (continued) **5A. Resident #13 Incontinence** 1. Resident # 3s care plan was amended to include goals and approaches for a resident who has incontinence. 2. Care Plans of all residents who has incontinence were reviewed for goals and approaches for incontinence and amended as needed. 3. Appropriate care plans with goals and Approaches for Incontinence will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **5B. Resident #13 Behaviors** 1. The care plan was amended to include goals and approaches for a resident exhibiting both aggressive/ abusive behaviors. 2. Medical records of all residents who exhibit aggressive/abusive behaviors were reviewed for corresponding goals and amended as needed. 3. Appropriate care plans with goals and Approaches for aggressive/abusive behaviors will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement	3/6/09 3/31/09 3/31/09 4/3/09 3/6/09 3/6/09 3/31/09

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L 051	Continued From page 6 Klonopin 1 gm orally daily for agitated behaviors. According to a quarterly MDS assessment completed July 24, 2008, the resident was coded in Section E (Mood and Behaviors) for verbal abuse. A review of the " Psychoactive Medication Monthly Flow Sheet " which monitored target behaviors and medication side effects were blank for October, November, December 2008 and January 2009. A review of the resident ' s care plans revealed that there was no care plan initiated with appropriate goals and approaches for abusive/aggressive behaviors. A face-to-face interview was conducted with Employee #5 on January 13, 2009 at 11:00 AM. He/she acknowledged that there was no care plan for incontinence and aggressive/abusive behaviors. The record was reviewed January 13, 2009. 5. The charge nurse failed to initiate a care plans with appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications and for the use of full side rails for Resident #15. A. Review of the clinical record for Resident #15 revealed a Physician ' s Order Sheet (POS) signed on January 6, 2009 with medications which included Aspirin, Coreg, Lasix, Glipizide, Keppra, Synthroid, Simvastatin, Prednisone, Zantac, Zaroxylin and Tylenol tablets. Further review of the record revealed that no care plan was initiated for the use of nine or more medications for Resident #15. A face-to-face interview was conducted with	L 051	**3210.4 Nursing Facilities** (continued) **5B. Resident #13 Behaviors (continued)** Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **5A. Resident #15 Adverse Reaction** A. Adverse Interactions for 9+ medications 1.Resident #15's care plan was amended to include appropriate goals and approaches for the potential adverse interactions for the use of 9 or more meds. 2. Medical records of all residents with 9 or more medications were reviewed if a corresponding care plan with appropriate goals and approaches for the potential adverse interactions. 3. Appropriate care plans with goals and Approaches for Adverse Interactions for the Use of 9 or More Meds will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	4/3/09 3/6/09 3/31/09 3/6/09 3/31/09 4/3/09

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L 051	Continued From page 7 Employee #6 on January 14, 2009 at approximately 3:00PM. He/she acknowledged that the care plan for potential adverse interaction for the use of nine or more medications was not on the record. He/she added, " I will put one on right now. " The record was reviewed on January 13, 2009. B. The charge nurse failed to initiate a care plan for the use of full side rails for Resident # 15. Resident #15 was observed lying in bed with full side rails up on January 13, 2009 at approximately 12:30PM and 4:10PM on January 14, 2009. The resident was asked why the side rails were up and she responded, " They keep me from falling out of the bed. " The resident was then asked whether she could release the side rails. She responded, " No. " According to the facility ' s policy entitled " Nursing Physical Restraints: Policy # 1404399A.000 " Page 1 of 2 under the heading of " Definition " it is stated "Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body. " In addition, on Page 2 of 2 of the aforementioned policy under the heading of " Examples of Restraining Devices " the following examples are listed: " 1. Merry Walker 2. Velcro seat belt 3. Soft waist belt 4. Clip belt 5. Lap buddy 6. Lap Tray 7. Reverse Seat belt 8. Reclining Geri-chair without tray 9. Straight back Geri-chair with tray 10. Bed rails not requested by the resident	L 051	**3210.4 Nursing Facilities** (continued) **5B. Resident #15 Full Side Rail** 1. Resident care plan was amended to include a care plan for the use of full side rails. 2. Medical records of all residents using full side rails were reviewed for a corresponding care plan for the use of side rails and care plan amended as needed. 3. Appropriate care plans with goals and Approaches the use of Full Side Rails will be evaluated using the "Care Plan Audit" of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	3/6/09 3/6/09 3/31/09 4/3/09

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L 051	Continued From page 8 11. Bed against the wall. " A review of the clinical record revealed a Side Rail Assessment Form dated December 5, 2008 which documented the following; " Recommendation: Full side rails indicated to serve as enabler to promote independence. " There was no evidence in the record that the side rails were requested by the resident. A face-to-face interview was conducted with Employee #6 on January 14, 2009 at approximately 3:00 PM. He/she acknowledged that there was no care plan on the record for the use of side rails and stated, " I will add the care plan to the record. " The record was reviewed on January 13, 2009.	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 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;	L 052	**3211.1 Nursing Facilities**	

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L 052	Continued From page 9 (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. Based on observation, record review and staff interview, for 10 of 30 sampled residents and six (6) supplemental residents, it was determined that sufficient nursing time was not given to each resident as evidenced by failing to: stop wound care treatments to re-assess the residents for complaints of pain for three (3) residents, follow an order for administration of topical antifungal cream for three (3) residents, follow the physician's order to treat with skin cream for one (1) resident, follow up with a physician's order for a cardiology consult for one (1) resident, administer dilantin as per physician's order for one (1) resident, obtain a physician's order to discontinue a foley catheter for one (1) resident,	L 052		

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	HFD02-0020	A. BUILDING _____ B. WING _____	01/16/2009

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L 052	Continued From page 10 obtain a physician's order for use of full side rails for one (1) resident, obtain an order for velcro seat belt for one (1) resident, follow a wound care order to fluff gauze for one (1) resident, failed to follow the physician's order for administration of medication for two (2) residents, obtain the physician's order prior to medication administration for three (3) residents, inaccurate staging of a pressure sore for one (1) resident and follow clean technique for a pressure sore dressing for two (2) residents. Residents #11, 20, 27, 1, 2, 8, 11, 14, 15, 19, JH1, JH2, JH8, JH 9, JH10, and S2. The findings include: 1. Sufficient nursing time was not given to Residents #11, 20 and 27 as evidence by facility staff failing to re-assess residents for complaints of pain during pressure ulcer dressing changes. A. Facility staff failed to stop and re-assess Resident #11 for a complaint of pain during a wound care treatment. A wound care treatment observation was conducted on January 14, 2009 at approximately 11:30 AM for Resident #11 who had left lower lateral leg wound. The resident was pre-medicated on January 14, 2009 with Tylenol 325 mg two (2) tablets at 11:00 AM, as per physician's orders dated December 15, 2008. A review of the resident's clinical record revealed a physician's order signed and dated December 15, 2008 that directed "...Cleanse left lower lateral leg with NS [normal sterile saline]. Apply thin layer of silvadene cream, cover with dry gauze	L 052	**3211.1 Nursing Facilities** **1A. Resident #11** 1. Staff where resident resides were given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 2. Facility staff on all units were given inservice training on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment. 3. Observation of wound treatments will be done by Nursing Supervisors to ensure compliance with the facility's pain management protocols.. Wound care will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/18/09 1/18/09 3/31/09 4/3/09

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L 052	Continued From page 11 and change daily." Employee #26 introduced self to the resident and explained what he/she intended to do. Resident #11 was positioned on his/her right side, pulled up the pant leg on the left lower leg to expose the wound to be dressed. As Employee #26 cleansed the left lower lateral leg wound, the resident grimaced and said, "That's sore" Employee #26 responded, "I am sorry." Employee #26 continued to wipe the area with 4x4 gauze pads moistened with normal sterile saline, applied Silvadene with 4x4 gauze pads, wrapped the dressing and secured the dressing with a tape. Employee #26 failed to stop the wound care treatment to re-assess the resident's pain. A face-to-face interview was conducted with Employee #26 on January 15, 2009 at approximately 2:45 PM. He/she acknowledged that he/she did not stop the wound care treatment to re-assess the resident's complaint of pain. The record was reviewed on January 15, 2009. B. Facility staff failed to reassess Resident #20 for pain during a wound treatment and follow the physician's order to fluff the wound treatment gauze and failed to maintain clean technique during the dressing change. A. The wound treatment observation was conducted on January 14, 2009 at 12:00 PM for Resident #20 who had sacral and ischial wounds. The resident was pre-medicated on January 14, 2009 with Percocet two (2) tablets at 11:00 AM, as per physician's orders dated November 8, 2008. According to the physician's telephone order	L 052	**3211.1 Nursing Facilities** **1B. Resident #20** 1. Staff where resident resides were given inservice on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the wound treatment gauze per MD order and the specifics of clean technique. 2. Facility staff on all units were given inservice training on facility policy on Pain Management focusing on pain assessment and intervention during wound treatment including fluffing the wound treatment gauze per MD order. 3. Observation of wound treatments will be done by Nursing Supervisors to ensure compliance with the facility's pain management protocols including following the physician's wound treatment order. Wound care will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI team will collect date on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator.	1/18/09 1/18/09 3/31/09 4/3/09

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L 052	Continued From page 12 dated December 22, 2008 and unsigned, "(1) Cleanse left ischium with normal sterile saline (NSS). Pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze) and Coversite BID and PRN (twice daily and as needed ... (4) Cleanse sacral wound with NSS and pat dry. Pack with fluffy gauze and Santyl ointment. Cover with 4 x 4 (gauze pads) and ABD (abdominal pad) then tape until healed BID and PRN." The resident was positioned on his/her left side, exposing both wounds. The nurse cleaned the left ischial wound. Employee #23 cleansed the interior of the wound twice and the exterior of the wound twice. Each time Employee #23 cleansed the wound, the resident moaned loudly. Employee #23 applied the 4 x 4 gauze pads and Santyl ointment and failed to fluff the gauze to pack the wound as per the physician's order. Employee #23 failed to stop the wound treatment and reassess the resident's pain. After completing the treatment on the left ischial wound, Employee #23 began treatment on the sacral wound. Employee #23 cleansed the interior of the sacral wound twice and the exterior of the wound three times. Each time Employee #23 cleansed the wound, the resident moaned. After cleansing the sacral wound the first time Employee #23 stated to the resident, "I know it hurts. I'm sorry but we are almost done." Employee #23 applied the 4 x 4 gauze pads with Santyl ointment and failed to fluff the gauze to pack the wound as per physician's orders. Employee #23 then applied the Coversite. The resident moaned during the application of the dressing. The wound treatments were completed at 12:30 PM.	L 052	**3211.1 Nursing Facilities**	

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L 052	Continued From page 13 B. Sufficient nursing time was not given to Resident #20 as evidenced by facility staff failing to follow clean technique during a wound treatment. A wound treatment observation was conducted on January 14, 2009 at 12:00 PM. The resident had an ischial and sacral wound. Employee #23 completed the ischial wound treatment and failed to wash hands and change gloves before beginning the treatment on the sacral wound. After completing the sacral wound treatment, Employee #23 failed to clean the resident ' s bedside table that was used to house wound treatment equipment. C. Facility staff failed to stop and re-assess Resident #27 for complaint of pain during a wound care treatment and failed to accurately stage a pressure sore. 1. A wound care treatment observation was conducted on January 15, 2009 at approximately 1:15 PM for Resident #27 who had a sacral pressure ulcer. The resident was pre-medicated on January 15, 2009 with one (1) tablet of Tylenol #3 at 12:30 AM, as per an unsigned physician ' s telephone orders of December 16, 2008. A review of the resident's clinical record dated December 16, 2008, revealed an unsigned physician's telephone order that directed "...Cleanse sacral area Stage III with NSS, pat dry, apply Santyl, pack with fluffy gauze daily, cover with 4 x 4, tape till healed ... " The resident was positioned on his/her left side,	L 052	**3211.1 Nursing Facilities** (continued) **C. Resident #27** 1. Staff where resident resides was given inservice on facility policy on Pressure Ulcer staging. 3/31/09 2. Facility staff on all units were given Inservice training on facility policy on Pressure Ulcer Staging. 3/31/09 3. Observations of pressure ulcer staging will be done by Nursing Supervisors To ensure compliance with the facility's pain management protocols. Pressure Ulcer Staging will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4/3/09	

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L 052	Continued From page 14 soiled with contents of the resident's ostomy bag, exposing the sacral pressure ulcer. Employee # 27 cleansed the sacral ulcer. As the Employee #27 cleansed the ulcer, the resident moaned and grimaced. Employee #27 continued with the wound care treatment. Employee #27 applied Santyl on fluffy 4 x 4 gauze pads, packed the wound and secured the dressing with pre-labeled tape. Employee #27 failed to stop the wound treatment to re-assess the resident's complaint of pain. 2. Sufficient nursing time was not given to Resident #27 to accurately stage a pressure sore. A " Weekly Wound Progress Report " dated July 29, 2008 coded an initial observation of a Stage III sacral pressure sore 1.5 cm x 4 cm x 0.1cm. According to "Pressure Ulcers in Adults: Prediction and Prevention" by the U.S. Department of Health and Human Services, page 1, "Stage II: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater. Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue." There was no evidence in the record that documented damage or necrosis of subcutaneous tissue. The resident was observed on January 15, 2009 at approximately 1:15 PM during a wound treatment to the sacral pressure ulcer by	L 052	**3211.1 Nursing Facilities** (continued) **2. Resident #27** 1. Staff where resident resides was given inservice on facility policy on Pressure Ulcer staging. 3/31/09 2. Facility staff on all units were given Inservice training on facility policy on Pressure Ulcer Staging. 3/31/09 3. Observations of pressure ulcer staging will be done by Nursing Supervisors To ensure compliance with the facility's pain management protocols. Pressure Ulcer Staging will be evaluated using the "Treatment Observation" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4/3/09	

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L 052	Continued From page 15 Employee #27. A face-to-face interview was conducted with Employee #9 on January 15, 2009 at approximately 4:20 PM. He/she acknowledged that the pressure should have been identified as a Stage II. The record was reviewed January 15, 2009. 2. Facility staff failed to follow-up with and clarify the podiatrist's plan of care for use of over the counter (OTC) topical anti-fungal medication for Residents # 1 and 11. A. Facility staff failed to clarify an order for an anti-fungal medication for Resident #1. Resident #1 was seen by the podiatrist on November 25, 2008. The podiatrist's plan of care included the following: "All mycotic nails were debrided ...The patient is not a candidate for oral antifungal. OTC topical may be used. Tinactin anti-fungal medication was recommended." Use of a topical antifungal was included in the podiatrist's plan of care for Resident #1 on June 30, 2008. There was no evidence in the record that facility staff clarified the podiatrist's recommendation for the use of anti-fungal medication with the resident's primary physician. A review of the resident's Medication Administration Record (MAR) for July 2008 through January 2009 lacked evidence that the resident was administered any topical antifungal medication for the feet. A face-to-face interview was conducted with Employee #6 on January 16, 2009, at	L 052	**3211.1 Nursing Facilities** (continued) **2A. Resident #1** 1. Podiatrist order for antifungal medication was clarified . PMD notified. 2. Medical records of all residents seen by the podiatrist with an order for an anti-fungal medication were reviewed to ensure that the order was clarified if necessary. 3. Routine review of medical records of residents seen by the podiatrist will be reviewed if orders for antifungal medication and other orders were clarified whenever necessary. Clinical Mangers will report the results of this review and data collection to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	3/6/09 3/13/09 3/31/09 4/3/09

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L 052	Continued From page 16 approximately 11:30 AM. He/she acknowledged that facility staff failed to follow-up with and clarify the podiatrist's plan of care for the use of topical antifungal medication on the resident's feet. The record was reviewed January 16, 2009. B. Resident #11 was seen by the podiatrist on April 15, June 17, August 26, and November 11, 2008. The Podiatrist's plan of care included the following: "...All mycotic nails were debrided today ...Topical antifungals may be used as needed." There was no evidence in the record that facility staff clarified the podiatrist's recommendation for the use of anti-fungal medication with the resident's primary physician. A review of the resident's MAR for July 2008 through January 2009 lacked evidence that the resident was administered any topical antifungal medication. A face-to-face interview was conducted with Employee #8 on January 16, 2009, at approximately 11:30 AM. He/she acknowledged that facility staff failed to follow-up with and clarify the podiatrist's plan of care for the use of topical antifungal medication on the resident's feet. The record was reviewed January 16, 2009. 3. Sufficient nursing time was not given to Resident #2 as evidenced by facility staff failing to follow the physician's order to apply Kenalog Cream in a timely manner. A review of Resident # 2's clinical record revealed a telephone order dated January 12, 2009 which stated, "Kenalog Cream to incision site on chest tid [three times a day] for two (2) weeks for itching."	L 052	**3211.1 Nursing Facilities** (continued) **2B. Resident #11** 1. Podiatrist order for antifungal medication was clarified . PMD notified. 2. Medical records of all residents seen by the podiatrist with an order for an anti-fungal medication were reviewed to ensure that the order was clarified if necessary. 3. Routine review of medical records of residents seen by the podiatrist will be reviewed if orders for antifungal medication and other orders were clarified whenever necessary. Clinical Mangers will report the results of this review and data collection to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **3. Resident #2** 1. Incident report completed. Pharmacy was notified. Discovered that the Kenalog Cream was placed in the treatment cart instead of the Medication cart. 2. MARs were audited to review that meds ordered were administered in a timely manner for all residents. 3. Facility staff were given an inservice training on Medication Administration placing special emphasis on calling pharmacy for meds. Telephone Orders will be evaluated using the "Telephone/Verbal Orders" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation.	3/6/09 3/13/09 3/31/09 4/3/09 1/15/09 3/31/09 3/31/09

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L 052	Continued From page 17 Daily review of the MAR on January 12, 13 and 14, 2009, revealed that the medication was not administered. According to the January 2009 MAR, the medication was administered on January 15, 2009. A face-to-face interview was conducted with Employee #9 at approximately 3:00 PM on January 14, 2009. He/she stated, "I did not know [he/she] was not getting the cream. I will check on it." The record was reviewed on January 12, 2009. 4. Sufficient nursing time was not given to Resident #8 as evidenced by facility staff failing to follow up with a physician's order for a cardiology consult. A review of the resident's clinical record revealed an "Interim Order Form" dated and signed November 27, 2008 that directed "Cardiology consult: confirm need of anticoagulation." A review of the resident's record lacked evidence that facility staff followed up with the physician's order for a cardiologist consult. A face-to-face interview was conducted with Employee #12 on January 16, 2009 at approximately 11:00 AM. He/she acknowledged that Resident #8's clinical record lacked evidence that facility staff followed up with the physician's order for a cardiologist consult. The record was reviewed January 16, 2009. 5. Sufficient nursing time was not given to Resident #14 as evidenced by facility staff failing to obtain a physician's order to discontinue a foley catheter. According to an admission Minimum Data Set (MDS) completed September 22, 2008 Resident	L 052	**3211.1 Nursing Facilities** (continued) **3. Resident #2** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator **4. Resident #8** 1. Physician reviewed the total plan of care on this resident to provide evidence of the resident's cardiology consult. 2. All the medial records of this physician were reviewed to provide evidence of other residents who have had orders for cardiology consults . 3. Physician Services meeting was held to review the physicians' responsibility in addressing specific resident issues. Monitoring of inclusion of these issues in the physician progress notes will be done by the Clinical Managers who will forward any concerns to the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **5. Resident #14** 1. MD notified and order carried out. 2. Medical records of all residents with discontinued foley catheters were audited to ensure the presence of a physician's order prior to discontinuing the catheter.	4/3/09 3/31/09 3/31/09 3/31/09 4/3/09 1/16/09 3/31/09

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L 052	Continued From page 18 # 14 was admitted to the facility on September 17, 2008. Section H3 "Continence/Appliances and Program " coded the resident as having an indwelling catheter. A review of the resident's clinical record revealed a "Admission Order Sheet and Physician Plan of Care sheet " that "Foley Catheter ...16FR [French], until seen by MD [Medical Doctor] ... " routine care ...change cath. [Catheter] Q. month ... " The following order, on the October 2008 MAR, "Foley cath. [Catheter] care Q.S. [Every Shift] and Foley cath Fr. 16 change Q month" was discontinued on October 8, 2008. A review of the resident ' s clinical record lacked evidence that facility staff obtained a physician ' s order to discontinue the foley. A face-to-face interview was conducted with Employee #9 on January 15, 2009 at approximately 12:45 PM. He/she acknowledged that the resident's clinical record lacked evidence of that facility staff obtained a physician's order to discontinue Resident #14's foley catheter. The record was reviewed January 15, 2009. 6. Sufficient nursing time was not given to Resident #11 as evidenced by facility staff failing to administered Dilantin as per the physician's order. A physician's order dated November 20, 2008 and signed by the physician on December 13, 2008, directed, "Phenytoin ...100mg ...Dilantin ...2 capsules (200mg) by mouth twice daily for seizures."	L 052	**3211.1 Nursing Facilities** (continued) **5. Resident #14** (continued) 3. Facility staff were given an inservice on the facility protocol for Insertion and removal of a foley catheter. Discontinued catheter orders will be evaluated using the "urethral Catheter" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **6. Resident #11** 1. Involved nursing staff was counseled for not administering/not documenting Dilantin 100 mg (2capsules 200mg) by mouth twice daily for seizures. PMD was notified of the lack of evidence that the Dilantin was administered. 2. MARs were audited for similar over-sight of documentation. Non-compliance with the facility's policy for MAR documentation will result in the employee being subjected to the facility's disciplinary process. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation.	3/31/09 4/3/09 3/6/09 3/31/09 3/31/09

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L 052	Continued From page 19 A review of the resident's MAR for the month of August 2008 lacked evidence that the resident was administered Dilantin at 8:00 PM on August 26 and 29, 2008 as evidenced by absence of initials for Dilantin during the aforementioned dates indicating Dilantin was not administered. The resident's clinical record lacked documentation as to why Dilantin was not administered. There was no evidence in the record that the resident experienced untoward effects from the omitted Dilantin doses. A face-to-face interview was conducted with Employee #8 on January 14, 2009 at approximately 11:30 AM. He/She acknowledged that the resident's MAR lacked evidence that facility staff administered Resident #11 Dilantin as per the physician 's order. The record was reviewed January 14, 2009. 7. Sufficient nursing time was not given to Resident #15 as evidenced by facility staff failing to obtain a physician's order for the use of full side rails. On January 12, 2009 at approximately 4:00 PM, January 13 at 12:30 PM and 4:10 PM on January 14, 2009, Resident #15 was observed lying in bed with full side rails up. In a face-to-face interview with the resident on January 13, 2009 at approximately 12:30 PM he/she was asked why the side rails were up and he/she responded, "They keep me from falling out of the bed." The resident was then asked whether he/she could release the side rails. The resident responded, "No.'" A review of the clinical record revealed that there was no physician's order for the use of full side rails for Resident # 15. A face-to-face interview was conducted with Employee # 6 at approximately 4:00 PM on	L 052	**3211.1 Nursing Facilities** (continued) **6. Resident #11** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 7. Resident #15 1. Physician's order obtained for use of full side rails for resident. 2. Medical records of all residents using full side rails were reviewed to ensure the presence of a physician's order. 3. Inservice training was given to facility staff on the facility protocol for use of full side rails. Restraint documentation will be evaluated using the "Physical Restraint" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09 1/16/09 1/16/09 3/31/09 4/3/09

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L 052	Continued From page 20 January 14, 2009. He/she acknowledged that there was no order for the use of full side rails for Resident #15. The employee added, "I will call the physician for an order for the use of the side rails." The record was reviewed on January 13, 2009. 8. Sufficient nursing time was not given to Resident #19 as evidenced by facility staff failing to follow physician's orders to use a Velcro seat belt. A review of Resident #19's record revealed a telephone order dated December 18, 2008 at 4:00 PM, signed by the physician on the same date that directed, "Obtain consent for seat belt (self release) from guardian. Resident to have self release seat belt on while sitting up in w/c (wheelchair)." "Consent for the Use of a Physical Restraint" for a seat belt (Velcro) was signed by the responsible party on December 22, 2008. Care plan #7, "Restraint device ..." was updated on December 22, 2008 when the Velcro seat belt was applied to Resident #19. An observation of Resident #19 was conducted in the presence of Employee #13 on January 15, 2009 at 2:15 PM. Resident #19 was observed with a clamp type seat belt and was unable to open the belt when asked. Employee #13 acknowledged that the resident was wearing a clamp type seat belt and was unable to open the belt. The record was reviewed January 15, 2009. 9. Sufficient nursing time was not given to Residents JH1 and JH2 as evidenced by facility staff failing to follow the physician's orders for administration of medication. A. Sufficient nursing time was not given to	L 052	**3211.1 Nursing Facilities** (continued) 8. Resident #19 1. The clamp style seat belt was discontinued, and replaced with the Velcro seat belt per physician's order. RP was notified and consent obtained. 2. Medical records of all residents using a clamp style seat belt were audited to ensure a corresponding physician order. Changes were made whenever necessary. 3. Inservice was given to facility staff re' the difference between a Velcro self release seat belt that a resident can self release and a clamp style seat belt that a resident is unable to self release(Physical Restraint) Restraint documentation will be evaluated using the "Physical Restraint" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/15/09 3/13/09 3/31/09 4/3/09

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L 052	Continued From page 21 Resident JH1 as evidenced by facility staff failing to follow the physician's orders for medication administration. On January 13, 2009, at approximately 11:40 AM , during the medication pass, Employee #22 administered Multivitamin, Plavix 75mg, Glipizide 2.5mg, Ranitidine 150mg, Amlodipine 5mg, Geodon 80mg and Divalproex EC 500mg to Resident JH1. After reconciling the Physicians Orders Sheet (POS) signed and dated on January 10, 2009 with the Medication Administration Record (MAR) for January 2009, it was discovered that Simvastin 20 mg was omitted during the medication pass. A face-to-face interview was conducted on January 16, 2009, at approximately 1:05 PM, Employee #22 stated, "I gave the medication during the medication pass that morning." the medication was not observed as being administered during the morning medication pass. B. Sufficient nursing time was not given to Resident JH2 as evidenced by facility staff failing to follow the physician's orders for medication administration. On January 13, 2009, at approximately 9:50 AM, during the medication pass, Employee #40 administered Multivitamin, Amlodipine 10mg, Isoniazid 300mg, ASA 325 mg, Vitamin B-6 50 mg, Lisinopril 20 mg, and Haloperidol 1 mg to Resident JH2. After reconciling the Physicians Orders Sheet (POS) signed and dated on December 18 2008	L 052	**3211.1 Nursing Facilities** (continued) 9A. Resident JH1 1. The involved staff member was counseled with inservice given. 2. Subsequent observations have been done on all nurses to ensure their ability to pass medications as ordered. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator 9B. Resident #JH2 1. The involved staff member was counseled with inservice given. 2. Subsequent observations have been done on all nurses to ensure their ability to pass medications as ordered. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/16/09 3/31/09 3/31/09 4/3/09 1/16/09 3/31/09 3/31/09 4/3/09

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L 052	Continued From page 22 and an Interim order signed and dated December 16, 2008 with the MAR for January 2009, it was discovered that Alphagan 0.15% ophthalmic drops, Cospt ophthalmic drops, Cardiazem ER180mg and Ranitidine 150 mg tablets were omitted during the medication pass. A face-to-face interview was conducted on January 16, 2009, at approximately 1:15 PM, Employee #40 stated, "I am not familiar with this floor. I looked and asked someone to help me find it. I administered the all medication before 12:00 PM." 10. Failed to obtain the physician's order prior to medication administration. Residents JH8, JH9, and JH10. A. Review of the physician ' s order for Resident JH8, signed and dated June 23, 2008, directed, " D/C [Discontinue] Percocet ii [two] tabs 5/325 mg q [every] Monday before tx [treatment] and qd [daily] before tx [treatment]. " 30 tablets were dispensed. On January 15, 2009, at approximately 12:00 PM during the inspection of the medication carts for 1 South, a blister package containing 10 tables of Oxycodone/APAP 5/325mg (Percocet) tablets were observed stored in the medication cart. A review of the Controlled Drug Record documented that medication was removed on July 7, 8, 19 and 20, 2008 and August 24, 2008. This medication was dispensed after the physician had discontinued the order. Oxycodone/APAP 5/325mg was not transcribed onto the MAR for July and August 2008 because it was discontinued. There was no evidence that	L 052	**3211.1 Nursing Facilities** (continued) **10A. Resident #JH8** 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	1/31/09 1/31/09 3/31/09 4/3/09

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L 052	Continued From page 23 the resident received the medication on the above cited days. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employee #53. He/ she acknowledged the above stated findings. B1. A review of the physician ' s order signed for Resident JH9 and dated July 11, 2008, directed , " Tylenol #3, two tabs stat, i [one] q4h [every 4 hours] prn [as needed] pain for five days for dental extraction " 30 tablets were dispensed. On January 16, 2009, at approximately 10:00 AM during the inspection of the medication carts for 2 South, a blister package containing 22 tablets of APAP/Codeine 300 mg/ 15mg (Tylenol #3) tablets were observed stored in the medication cart. A review of the Controlled Drug Record documented that tablets of Oxycodone/APAP 5/325mg was removed on September 16, October 11 and 16, and November 13, 2008, for a total of eight (8) tablets removed after the medication was discontinued. There was no evidence on the September, October and November 2008 MAR that the medication was administered to the resident. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employees #8 and 54. They acknowledged the above stated findings. B2. A physician's order dated April 15, 2008 directed, "APAP W/codeine #3 (Tylenol #3) two (2) tablets po every 6 hours as needed for pain."	L 052	**3211.1 Nursing Facilities** (continued) **10B1. Resident # JH9** 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **B2. Resident #JH9** 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/31/09 1/31/09 3/31/09 4/3/09 1/31/09 1/31/09 3/31/09 4/3/09

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L 052	Continued From page 24 30 tablets were dispensed for Resident JH9. The physician did not renew the above cited order when orders were signed on August 21, September 22, and November 24, 2008. According to the Controlled Drug Record Tylenol #3, two (2) tablets were removed on August 24, September 1 (twice), October 17, October 22, November 22, November 24 and November 28, 2008. There was no evidence on the August, September, October and November 2008 MARs that the resident received the medication. A face-to-face interview was conducted on January 15, 2009 at approximately 12:15 PM with Employees #8 and 54. They acknowledged the above stated findings. C. Review of the physician ' s order for Resident JH10, signed and dated October 2, 2008, directed, " Tylenol #3 q6h [every 6 hours] prn [as needed] pain for 4 (four) days, dental extractions. " 16 tablets were dispensed. On January 14, 2009, at approximately 3: 30 PM during the inspection of the medication carts on the 3 North unit, a blister package containing seven (7) APAP/Codeine 300 mg/ 15mg (Tylenol #3) tablets was observed stored in the medication cart. According to the Controlled Drug Record, one (1) tablet was removed on October 7 and one (1) tablet was removed on October 8, 2008, after the mediation was discontinued by the physician. There was no evidence on the MAR for October	L 052	**3211.1 Nursing Facilities** (continued) **C. Resident #JH10** 1. Employee involved was counseled and received education regarding the facility's Pharmacy policies and procedures. 2. MARs and Controlled Substance sign-Out sheets for all residents were reviewed to ensure compliance. 3. MAR documentation will be evaluated using the "Medication Pass" tool of the Nursing Quality Improvement Program. The members of the Nursing QI Team will collect data on this issue and forward that information to the DON for review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	1/31/09 1/31/09 3/31/09 4/3/09

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L 052	Continued From page 25 2008 that the medication was administered to the resident, as evidenced by no initials were recorded in the allotted area. A face-to-face interview was conducted on January 15, 2009 at approximately 3: 45 PM with Employee #52. He/ she acknowledged the above stated findings. 11. Sufficient nursing time was not given to Resident S2 as evidenced by facility staff failed to follow clean technique during a wound treatment. A wound treatment observation was conducted on January 15, 2009 at 11:45 AM. Employee #22 placed a package of 4 x 4 gauze pads, bottle of Isagel (hand cleanser) and bottle of normal sterile saline on a non-permeable barrier on top of the resident ' s bedside stand. After completion of the wound treatment, Employee #22 removed the soiled dressing and the non-permeable barrier, placing the package of 4 x 4 gauze, the bottle of normal sterile saline and the bottle of Isagel directly on the top of the bedside stand. Employee #22 disposed of the wound treatment waste, returned to the resident ' s room and placed the package of 4 x 4 gauze sponges, the bottle of Isagel and the bottle of normal sterile saline in the treatment cart. Additionally, Employee #22 failed to wash the beside table after all items were removed.	L 052	**3211.1 Nursing Facilities** (continued) **11. Resident # S2** 1. The staff involved was counseled and given a 1:1 inservice. 2. Nursing staff from other units were given inservice training in proper wound techniques before and after each wound treatment. 3. Wound treatments will be observed by ADONs, Clinical Mgrs, & Nursing supervisors to ensure that proper techniques were used during the treatment. Data collected through the Nursing Quality Improvement Program's Treatment Observation Tool Will be forwarded to the Director of Nurses and her QI team for evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	1/31/09 3/31/09 3/31/09 4/3/09
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with	L 091	**3217.6 Nursing Facilities**	

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L 091	Continued From page 26 the requirements of this chapter. This Statute is not met as evidenced by: Based on observation and record review for two (2) of 30 sampled residents, it was determined that facility staff failed to: wash hands after reaching into a pocket before proceeding with a wound care treatment for one (1) resident, and clean a soiled mattress for one (1) resident. Residents #11 and 27. The findings include: 1. Facility staff failed to wash his/her hands after reaching into his/her pocket and before proceeding with a wound care treatment for Resident #11. Employee #26 was observed during a wound care treatment to Resident #11 on January 14, 2009 at approximately 11:30 AM. He/she introduced self to the resident and explained what he/she was going to do. He/she washed hands, cleaned the table and covered with a barrier before putting the treatment supplies on the table. Employee #11 reached into his/her pant's pocket, took out keys and locked the treatment cart. He/she failed to wash his/her hands before proceeding with the wound care treatment procedure after locking the treatment cart. A-face-to-face interview was conducted with Employee# 26 on January 16, 2009 at approximately 10:30 AM. He/she acknowledged that he/she failed to wash his/her hands after taking the keys from his/her pocket to lock the treatment cart. 2. Facility staff failed to clean Resident # 27's soiled mattress after removing bed linen soiled	L 091	**3217.6 Nursing Facilities** (continued) 1. Resident #11 1. Employee involved was counseled and provided inservice with return demonstration to ensure competency. 2. Wound treatment observation was done with nursing staff to ensure their competency with infection control and wound care. 3. Inservice training regarding proper handwashing while in the process of doing wound care treatments was provided to the staff. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Infection Control." The Nursing QI Team will forward their findings to the Director of Nursing for her evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 2. Resident #27 1. Employee involved was counseled and provided inservice. 2. There are no other residents in the facility with both a colostomy and who require wound care. 3. Inservice training regarding proper Infection Control under the cited circumstances was provided to the staff. This practice will be monitored through the Nursing Services Quality Improvement Program's tool for "Infection Control." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation.	3/6/09 3/31/09 3/31/09 4/3/09 3/6/09 3/6/09. 3/31/09

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L 091	Continued From page 27 and soaked with the contents of the resident's colostomy bag and before making the bed with clean linens. Resident # 27 was observed during a wound treatment on January 15, 2009 at 1:15 AM by Employee #27. The resident's body and bed linens were observed soiled and soaked with the contents of the resident's colostomy bag. After Employee #27 completed the resident's wound care treatment, Employee #29 took over from Employee #27 to clean the resident. Employee #29 stripped the bed of a fitted and flat sheets, picked up some crumbs on the mattress and applied clean linens (a fitted and flat sheets) to make the bed. Employee #29 failed to clean the stained mattress before applying clean bed linens to make the bed. A face-to-face interview was conducted with Employee #29 on January 15, 2009 at approximately 2:35 PM. He/she acknowledged that the stained mattress was not cleaned after stripping the soiled linens from the bed and before making the bed with clean linens.	L 091	**3217.6 Nursing Facilities** **2. Resident #27** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator.	4/3/09
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 observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were served in a safe and sanitary manner as evidenced by: foods observed undated in the walk-in refrigerator, reach-in refrigerator and the dry storage area;	L 099	**3219.1 Nursing Facilities**	

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L 099	Continued From page 28 soiled dome covers, ice machine, ceiling tiles, spice rack and food carts; damaged ceiling tile in the dry storage area; and serving utensils were observed wet; foods were observed being plated with the incorrect ladle [scoop size] during the tray line service; a pan of vegetables placed on the floor tray line service and use gloved hands to place noodles on resident plates when plating food; failed to use gloves when checking ladles sizes; and consistently used gloves when testing food temperature . These findings were acknowledged by Employees #14 and 41 at the time of the observations. The findings include: A. The following foods were observed undated in the walk-in refrigerator, reach-in refrigerator and the dry storage area: Two (2) bundles of withered lettuce One (1) box of withered kale One (1) case of strawberries with a green and white substance on the berries and side of the cartons One (1) pan of lemon pudding undated Two (2) of four (4) cartons of packed parmesan cheese undated Three (3) of three (3) cans of gelatin undated Two (2) of seven (7) containers of pudding were unclearly dated [January 2009], facility staff unable to determine if the date was January 9, 2009 or January 2009 B. The following were observed soiled and/or damaged in the main kitchen: One (1) of one (1) ice machine interior surface was observed soiled in the main kitchen Ceiling tiles were soiled in the chemical room	L 099	**3219.1 Nursing Facilities** (continued) **A. Undated Food in the Refrigerators and Dry Storage Areas** 1. Food found undated was taken out of storage and discarded. 1/16/09 2. All food in the walk-in and reach-in refrigerators and the dry storage areas were reviewed to ensure proper dating. 1/16/09 3. Nutritional Services staff was inserviced regarding the need to date all perishable and canned goods upon delivery to the facility. Monitoring of this practice will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09 **B. Ice machine Interior** 1. The interior of the ice machine was cleaned upon discovery. 1/16/09 2. There are no other ice machines in the kitchen area. 1/16/09 3. Nutritional Services staff was inserviced regarding the need to routinely clean the interior of the ice machine. Monitoring of this practice will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 3/31/09 4. The Department Head will present	

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L 099	Continued From page 29 One (1) damaged ceiling tile in the dry storage area One (1) of one (1) spice rack was soiled 24 of 51 food carts were observed soiled One (1) full size pan of serving utensils were observed wet and was stored for reuse Seven (7) of 41 dome covers were observe soiled and were store for reuse C. During tray line observations on January 12, 2009 at 1:40 PM on the 1st floor dining room and during the tray line service on January 13, 2009 at 12:40 PM on the 3rd floor, dietary staff was observed plating the following foods for residents with the incorrect ladle [scoop size]: Season spinach, mechanical soft pork and rice The ladle sizes were verified with Employee #14 on January 14, 2009 at approximately 4:00 PM. D. During the tray line observation on January 12, 2009 at 1:44 PM on the 1st floor dining room, Employee #40 was observed removing a loaf pan of vegetables [covered with foil] from the warmer and placing it on the floor and then putting it back into the food warmer. At the time of the finding Employee #40 acknowledged what happened and stated that the pan was hot and he/she had to put it down. Approximately five minutes later the pan was removed from the warmer by Employee #41. E. During tray line observations on January 12, 2009 at 1:40 PM in the 1st floor dining room, the following was observed: 1. Employee #42 was observed placing loose noodles on resident plates with gloved hand not a utensil. 2. Dietary staff was observed checking the ladle sizes with ungloved hands.	L 099	**3219.1 Nursing Facilities** (continued) 4. (continued) a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator . **C. Ladle Size** 1. The employee involved with the use of the wrong sized ladle was counseled and inserviced. 2. All servers were inserviced on the size of ladles. 3. . Monitoring of the ladles will be done by the members of the Nutritional Services Quality Improvement Committee. who will collect data on this criteria and forward their information recommendations to the Director of Nutritional Services for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator E1. The Noodle 1. The employee was corrected and the plate was discarded. 2. All servers were monitored to ensure proper serving and infection control technique. 3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his	4/3/09 1/16/09 3/31/09 3/31/09 4/3/09 1/13/09 1/16/09 3/31/09

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L 099	Continued From page 30 F. During tray line observations on January 13, 2009 at 12:40 PM the 3rd floor dining services staff was observed using one (1) gloved hand when testing the temperatures for the mechanical soft Salisbury steak, mechanical soft chicken, gravy, carrots, mashed potatoes and baked potatoes. Employee #42 inserted the thermometer with the gloved hand and cleaned the thermometer with the ungloved hand. The above mentioned findings were acknowledged by Employee #14 and 41.	L 099	**3219.1 Nursing Facilities** (continued) A. The Noodle (continued) review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator. E2. 1. The ladle was taken out of service upon discovery. 2. All servers were monitored to ensure proper serving and infection control technique. 3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator F. 1. The thermometer in question was cleaned using an alcohol pad and a gloved hand. 2. All servers were monitored to ensure proper serving and infection control technique. 3. Inservice was done on the proper use of gloves and serving utensils when handling food and taking temperatures. Compliance will be monitored through the Nutritional Services Quality Improvement	3/31/09 4/3/09 1/12/09 1/16/09 3/31/09 4/3/09 1/13/09
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and	L 128		

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L 128	Continued From page 31 that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents, it was determined that the pharmacist failed to: recommend attempting a dose reduction for antipsychotics for two (2) residents, and review one (1) resident's medication monthly. Residents #5 and 13. The findings include: 1. The pharmacist failed to recommend attempting a dose reduction for Resident #5 who was prescribed Seroquel for five (5) months and complete a review of the Drug Regimen for one (1) month. A. The pharmacist failed to review Resident #5's medications for November 2008. A review of Resident #5's record revealed that the pharmacist reviewed the resident's medications on July 29, August 28, September 29, October 27 and December 24, 2008. There was no evidence that the pharmacist reviewed the resident's medications for November 2008. A face-to-face interview with Employee #5 was conducted on January 12, 2009 at 3:45 PM. He/she acknowledged that the pharmacist did not review the resident's medications for November 2008. The record was reviewed January 12, 2009. B. Review of Resident #5 ' s record revealed that admission orders, signed by the physician on July 4, 2008, directed, " Seroquel 25 mg twice daily; Seroquel 400 mg at bedtime. "	L 128	**3219.1 Nursing Facilities** (continued) F. Continued Program's tool for "Infection Control." The QI team will forward their findings to the Director of Nutritional Services for his 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which Is chaired by the Administrator. **3224.3 Nursing Facilities** **1A. Resident #5** 1. Consultant Pharmacist was made of the oversight. 2. Other charts were checked to ensure the monthly Drug Regimen Review was completed. No further notification to the Consultant Pharmacist was necessary. 3. Monitoring of the Consultant Pharmacists notes will be added to the monthly audit tool completed by the Unit Clerks. Discrepancies will be brought to the attention of the Consultant Pharmacist immediately upon discovery. by the Director of Nurses. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **1B. Resident #5** 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for a gradual dose reduction of her Seroquel.	3/31/09 4/3/09 3/6/09 3/9/09 4/1/09 4/3/09 3/31/09

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L 128	Continued From page 32 A review of the " Chronological Record of Medication Regimen Review " revealed that the pharmacist reviewed the resident ' s medication on July 29, August 28, September 29, October 27 and December 24, 2008. The pharmacist did not review the resident ' s medication in November 2008. There was no evidence that the pharmacist recommended attempting a gradual dose reduction for Resident #5 ' s Seroquel. A face-to-face interview was conducted with Employee #5 on January 12, 2009 at 3:45 PM. He/she acknowledged that the pharmacist failed to recommend attempting a gradual dose reduction for Resident #5 ' s Seroquel. The record was reviewed January 12, 2009. 2. The pharmacist failed to recommend a gradual dose reduction for Resident #13 who was prescribed Seroquel for three (3) months. A review of Resident #13's record revealed the psychiatrist's order dated October 9, 2008, "Seroquel 50 mg po twice daily for agitated behaviors, Klonopin 1 mg po daily for agitation." There was no Behavior Flow Sheet located by Employee #5 at the time of this review for October and December 2008. The November 2008 Behavior Flow Sheet was blank. The pharmacist reviewed the resident's medications on October 19, November 19, and December 18, 2008. The pharmacist failed to recommend a gradual dose reduction for the use of Klonopin and Seroquel for Resident #13. A face-to-face interview with Employee #5 was	L 128	**3224.3 Nursing Facilities** **1B. Resident #5** (continued) 2. For any other resident on Seroquel who has not been evaluated for a gradual dose reduction, staff will request a consultation from the Psychiatrist. 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **2. Resident #13** 1. Psychiatrist consult will be ordered for this resident requesting to evaluate the resident for a gradual dose reduction of her Seroquel. 2. For any other resident on Seroquel who has not been evaluated for a gradual dose reduction, staff will request a consultation from the Psychiatrist. 3. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Psychoactive Drug Review." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator,	3/31/09 3/31/09 4/3/09 3/31/09 3/31/09 4/3/09

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L 128	Continued From page 33 conducted on January 13, 2009 at 3:45 PM. He/she acknowledged that the a gradual dose reduction was not recommended by the pharmacist. The record was reviewed January 13, 2009.	L 128		
L 157	3227.8 Nursing Facilities Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility staff failed to properly store medication under proper temperature controls for one (1) of six (6) unit refrigerators and stored Xalatan unopened in the medication cart for one (1) of six (6) medication carts observed. The findings include: 1. Facility staff failed to properly store medication under proper temperature controls. On January 15, 2009, at approximately 10:20 AM, during the inspection of the medication refrigerators, the 3 North medication refrigerator ' s temperature read 24 F. According to the monthly unit pharmacy inspection reports for 2008 , the temperature of the 3 North refrigerator in November was 28 F	L 157	**3227.8 Nursing Facilities** **1. Medication Refrigerators** 1. Noted refrigerator temperatures were retaken at the time of the survey and found to be in range. 1/16/09 2. All medication refrigerators were checked for the correct temperature and no corrections were needed. 1/16/09 3. Medication refrigerators are checked monthly by the Consultant Pharmacist, monthly by the Maintenance QI Team and routinely by the nursing staff. Fluctuations in temperature are brought to the attention of the Director of Maintenance for review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. 4/3/09 2. 1. Xalatan eye drops found improperly stored at the time of the survey were discarded upon discovery. 1/16/09 2. All medication carts were checked for the improper storage of Xalatan eye drops and no corrections were necessary. 1/16/09	

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L 157	Continued From page 34 and December 35 F. A face-to-face interview was conducted at the time of the observation with Employee #29. He/she acknowledge that the refrigerator was out of range and immediately adjusted the refrigerator to the correct temperature. 2. Xalatan was observed stored in the medication cart on 2 South. The vials were unopened. Two (2) unopened vials of Xalatan were observed on January 16, 2009 at 9:00 AM stored in the medication cart on 2 North. According to the manufacturer's recommendation, "Store unopened bottle (s) under refrigeration at 36 F to 46 F." A face-to-face interview was conducted at the time of the observation with Employees #8 and 54. Both acknowledged that the unopened Xalatan should have been stored in the refrigerator.	L 157	**3227.8 Nursing Facilities** (continued) **2. (continued)** 3. Inservice training regarding proper storage of Xalatan eye drops was provided to the staff. Compliance will be monitored through the Nursing Services Quality Improvement Program's tool for "Med Pass." The Nursing QI Team will forward their findings to the Director of Nursing for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator. **3227.12 Nursing Facilities** 1. Expired medication found in the medication area of 3 North and 2 South at the time of the survey were disposed of per policy 2. All medication areas were inspected for the presence of expired meds and no further issues were found. 3. Expired medication disposition will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator	3/31/09 4/3/09 1/31/09 1/31/09 3/31/09 4/3/09
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility staff failed to remove expired medications from the medication cart in two (2) of six (6) medication storage areas. The findings include: According to the manufacturer's specifications, "A vial of Tuberculin PPD which has been entered and in use for 30 days must be discarded."	L 161		

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L 161	Continued From page 35 On January 14, 2008 at approximately 3:30 PM during the inspection of the medication area on 3 North the following medications were found expired in the medication cart and refrigerator. Buspirone 10 mg, 30 tablets, expiation date 5/28/2008 Risperdal 1 mg, 50 tablets, 2/15/2008 Multivitamin, 50 tablets, 2/15/2008 Loperamide 2 mg, 5 capsules, 9/13/2008 Alprazolam 0.25 mg, 25 tablets, 12/28/2008 Tylenol #3, 12 tablets, 8/6/2008 Clonazepam 0.5 mg, 9 tablets, 5/30/2008 Fluvirin 5 ml injection, 1 vial, 6/30/2008 Tubersol 5 TU vial - opened, 1 vial, 1/3/2009 2 South observed on January 16, 2009 at 9:00 AM Diphenhydramine 25 mg capsules, 10/08 Loperamide 2 mg capsules, 12/28/08 Tylenol 325 mg tablets, 10/07 A face-to-face interview was conduct with Employee #8 and 54 on January 14, 2008, after the carts were inspected. He/she acknowledge that the above findings at the time of the inspection.	L 161		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility staff failed to	L 168	**3227.19 Nursing Facilities**	

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L 168	Continued From page 36 date and initial opened multi-dose vials in two (2) of six (6) medication storage areas. The findings include: On January 14, 2008 between during the inspection of two (2) of six (6) the medication storage areas, it was determined that multi-dose vials were not dated and initialed when first opened. 1 North (2) Lantus 10 ml vial Novolog 10 ml vial (2) Pneumococcal vaccine 1 ml vials Heparin 10,000 unit, 10 ml vial 3 North Lorazepam Injection mg ml 10 ml vial	L 168	**3227.19 Nursing Facilities** (continue) 1. Opened Multi-dose vials found not to be dated or initialed at the time of the survey were destroyed upon discovery. 2. All multi-dose vials were inspected to insure proper documentation if opened. No other issues were found. 3. Multi-dose vial documentation will be monitored by the Clinical Manger throughout the month. The results of their monitoring will be given to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly QI Committee which is chaired by the Administrator **3234.1 Nursing Facilities** **1. Extension Cords** 1. Extension cords were removed upon discovery and replaced with a surge protector. 2. All residents' rooms were searched for the use of extension cords. No other instances were found. 3. Extension cord use will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **2. Wall Outlet Cover** 1. Wall outlet cover were replaced upon discovery. 2. All residents' rooms were searched	1/16/09 1/16/09 3/31/09 4/3/09 1/16/09 1/16/09 4/3/09 1/16/09
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 observation, staff interview and record review, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: extension cords in residents' rooms, a missing electrical socket face plate, a non-skid backed rug in a resident's room, four (4) treatment carts left unlocked and unattended, Resident #19's foot stuck in a side rail and medication left unattended on one (1) medication cart. The findings include:	L 214		

2. Outlet Covers (continued)
for the missing outlet covers. No other instances were found. 1/16/09
3. Missing outlet covers will be monitored by the Maintenance Quality Improvement Team. Any data collected on this issue will be forwarded to the Director of Maintenance for his review and evaluation.
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

3. Rug
1. The throw rug was removed by the resident upon discovery. 1/16/09
2. All resident rooms were evaluated for the presence of a throw rug without a non-skid backing. No other issues were uncovered. 1/31/09
3. Housekeeping staff were inserviced on the need to report the presence of a throw rug without a non-skid backing to the nursing staff and the housekeeping supervisor. Monitoring of this issue will be done by the Housekeeping Quality Improvement Team as they collect data on the issues which may be present in the resident rooms. The data collected with be brought to the Director of housekeeping for her review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

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L 214	Continued From page 37 1. Extension cords were observed in the following residents' rooms: Room 233 plugged into a multiple plug device at approximately 2:25 PM on January 13, 2009. Room 205 plugged into a radio at approximately 2:50 PM on January 13, 2009. 2. A wall outlet cover was observed missing in the first floor dining room January 14, 2009 at 10:50 AM. 3. A rug with a non-skid backing was observed in room 357 on January 13, 2009 at 11:05 AM. These findings were acknowledged by Employees #11 and 29, 30 at the time of the observations. 4. Facility staff failed to lock four (4) treatment carts that were left unattended. A. During a wound treatment observation on January 14, 2009 at 12:00 PM on unit 3 South, Employee #23 removed wound treatment items from the treatment cart and placed them in the resident ' s room. Employee #23 positioned the treatment cart against the wall in the hallway by the resident ' s room and closed the door. The treatment cart was left unlocked and unattended. When the wound treatment was completed, the resident ' s door was opened and two (2) residents were observed in the hallway in close proximity to the treatment cart. Items contained in the top drawer of the treatment cart included tubes of Santyl ointment, Bacitracin ointment, Urea 40% cream, Collagen hydrogel wound dressing ointment and Hydrocortisone Valerate 0.2% ointment. The treatment cart was observed unlocked in the presence of Employee #23 immediately after the	L 214	**3234.1 Nursing Facilities** (continued) **A. Unlocked Med Cart** 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **B. Unlocked Med Cart** 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found	1/16/09 1/31/09 3/31/09 4/3/09 1/16/09 1/31/09

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	HFD02-0020	A. BUILDING _____ B. WING _____	01/16/2009

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L 214	Continued From page 38 wound treatment was completed. B. During a wound treatment observation on January 15, 2009 at 11:45 AM. Employee #22 removed wound treatment items from the treatment cart. Employee #22 turned the cart drawers towards the wall by the resident ' s room in the hallway on 1 North and closed the resident ' s door. The treatment cart was left unlocked and unattended. After the wound treatment was completed, the resident ' s door was opened. One (1) resident was sitting in a wheelchair next to the treatment cart. The top drawer of the treatment cart contained tubes of Collagen hydrogel wound dressing ointment. The treatment cart was observed in the presence of Employee #22 immediately after the wound treatment was completed. C. During a wound treatment observation on January 15, 2009 at 1:15 PM, Employee #27 removed wound treatment items from the treatment cart. Employee # 27 turned the cart ' s drawers towards the door of the resident ' s room in the hallway on 3 North. The resident ' s door was left opened. Resident # 27 ' s bed was by the window away from the entry door and the privacy curtain was pulled. The treatment cart was left unlocked and unattended. Several residents were observed walking up and down the hallway returning from the dinning room. The contents of the top drawer included the following wound dressing ointments: Accuzyme, Bacitracin, Collagen hydrogel Santyl, and Urea 40% cream.	L 214	**3234.1 Nursing Facilities** (continued) **B. Unlocked Med Cart** 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **C. Unlocked Med Cart** 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation.	3/31/09 4/3/09 1/16/09 1/31/09 3/31/09

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L 214	Continued From page 39 The treatment cart was observed unlocked and unattended in the presence of Employee #27 immediately after the wound treatment was completed. Employee #27 eventually secured the treatment cart in the clean utility room. A-face-to-face interview was conducted with Employee# 27 on January 15, 2009 at approximately 2:45 PM. He/she acknowledged that the treatment cart was not locked. D. During a tour of the facility on January 16, 2009 at approximately 10:35 AM, Employee #30 was in Resident A2 ' s room. In the presence of Employee #10, it was observed that Employee #30 left the treatment cart unlocked and unattended in the hallway on 3 South. Several residents were observed walking up and down the hallway returning from the dinning room and other activities around the facility. The contents of the top drawer included the following wound dressing ointments: Ammonium lactate, Ketoconazole shampoo, Hydrocortisone, Accuzyme, Bacitracin, Collagen hydrogel, Santyl, Urea 40% cream and plastic bags. A face-to-face interview was conducted with Employees #10 and 30. They both acknowledged that the treatment cart was unlocked and unattended with the aforementioned contents. 5. Facility staff failed to provide adequate supervision for Resident #19 who's foot was stuck in a side rail. A review of Resident #19's record revealed a nurse's note dated December 24, 2008 at 12:00 AM, "Resident's foot stocked [stuck] in the bedside rail..."	L 214	**3234.1 Nursing Facilities** (continued) C. (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **D. Unlocked Med Cart** 1. Treatment carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All treatment carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that treatment carts are locked when not in use for safety reasons. Monitoring of the locking of treatment carts will be done through the Nursing Quality Improvement Team and their "Treatment Observation" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **5. Resident #19** 1. The resident is currently using a low bed with half rails. 2. Other residents who may have an order for half rails were evaluated. No other issues were found.	4/3/09 1/16/09 1/31/09 3/31/09 4/3/09 3/20/09 3/31/09

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L 214	Continued From page 40 The resident was hospitalized from December 25, 2008 through January 6, 2009 for a deep vein thrombosis. A telephone order dated January 14, 2009 at 6:50 PM, unsigned by the physician noted, "Needs order for 1/2 side rails to aid in bed mobility for resident." Resident #19 was observed on January 15, 2009 at 7:45 AM in bed with the top side rails in the up position. A face-to-face interview was conducted with the resident at the time of the observation. When asked if he/she remembered getting his/her leg stuck in the side rails, the resident replied, "I don't remember." The record was reviewed January 15, 2009. 6. Facility staff left medication unattended on the medication cart . On January 12, 2009, at approximately 9:56 AM during the medication pass, Employee #23 left medication unattended on the medication cart in front of Resident # JH7's room while he/she attended to the resident. The following medications remained on top of the medication cart: Multivitamin/Iron, Lisinopril 20mg, Isosorbid Dinitrate 20mg, Hydrochlothiazide 25mg, Digoxin 0.25mg, Caredilol 25mg and Docusate 100mg when Employee #23 entered the resident's room. The medication cart was out of the sight of Employee #23. A face-to-face interview was conducted at the time of this observation with Employee #23. He/she acknowledged that the medications were left on the medication cart.	L 214	**3234.1 Nursing Facilities** (continued) **5. Resident #19** (continued) 3. Inservice training will be given to the facility staff regarding making frequent rounds and checking all residents during their tour of duty paying close attention to resident's body parts during the rounds Monitoring of the side rail incidents will be done through the Nursing Quality Improvement Team. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **6. Unlocked Med Cart** 1. Med carts found unlocked at the time of the survey were locked promptly upon discovery. 2. All med carts were assessed for ability to be locked and being locked when in use of being stored. No other issues were found 3. Inservice training was given to facility staff about the importance of making sure that med carts are locked when not in use for safety reasons. Monitoring of the locking of med carts will be done through the Nursing Quality Improvement Team and their "Med Pass" tool. Results of their data collection will be brought to the Director of Nurses for her review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator .	3/31/09 4/3/09 1/16/09 1/31/09 3/31/09 4/3/09

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L 410	Continued From page 41	L 410		
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, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled ceiling tiles, floors, walls, wheel chairs/chairs/gerichairs, faucets, roller carts, and hair dryer; damaged ceiling tiles, doors, wheelchair arms, baseboards and walls; excessive items in resident rooms; and items stored on the floor in storage areas. The environmental tour was conducted on January 12, 2009 from 3:06 PM to 4:10 PM, January 13, 2009 from 9:25 AM to 4:20 PM and January 14, 2009 8:15 AM to 4:25 PM in the presence of Employees #11, 29, and 30. The findings were acknowledged at the time of the observations. 1. The following areas were observed soiled: Ceiling Tiles Two (2) of six (6) soiled utility rooms, 1S and 2N; two (2) of six (6) clean linen rooms, 1N and 1S; 11 of 31 resident rooms, 137, 159, 110, 116, 122, 136, 231, 232,244, 206 and 333; one (1) of six (6) storage rooms, 1S; one (1) of six (6) nourishment rooms, 1S; one (1) of 12 resident hallway bathrooms, 1S; and one (1) of 12 resident lounge areas, 1N	L 410	**3256.1 Nursing Facilities** **Soiled Ceiling Tiles** 1. Ceiling tiles were changed upon discovery. 1/14/09 2. Ceiling tiles throughout building were assessed and changed if needed. 1/16/09 3. All areas of the building are assessed my maintenance on a frequent basis for soiled or damaged ceiling tiles. Ceiling Tile is a criteria for review under "Resident Floor Maintenance" in the Maintenance Quality Improvement Program. The Maintenance QI team will collect data on this criteria and forward it to the Director of Maintenance for review and evaluation. 3/31/09 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. 4/3/09 **Soiled Floors and practice Stairs** 1. The floor and stairs in the Rehab Gym were scrubbed and waxed upon discovery. 1/15/09 2. The floor in the Rehab Gym is scheduled for cleaning every afternoon. 1/15/09 3. The Director of Housekeeping and her Team of supervisors visually verifies the cleanliness of the Rehab Gym floor/stairs each morning and makes immediate corrections when needed. Cleanliness of the floor is found in the "Common Area" section of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 3/31/09	

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L 410	Continued From page 42 Floors- in the Rehabilitation Gym and practice stairs in the rehabilitation gym Walls- in two (2) of 31 resident rooms 135 and 136; and two (2) of three (3) in the resident dining rooms, 2nd and 3rd floors Chairs Wheel chair/gerichair- room 110 in one (1) of 39 observed Resident arm chairs three (3) of 12 soiled in the 3N resident lounge area Beauty Shop Two (2) of two (2) sink faucets; two (2) of two (2) hair roller carts; and one (1) of three (3) hair dryers were observed soiled 2. The following items/areas were observed damaged: A. Walls- in two (2) of 31 rooms, 110 and 136; and one (1) of six (6) janitor ' s closet, 3S B. Ceiling tiles-1N resident hallway bathroom, room 109, C. The entry door to resident ' s room was observed to be split at the top in one (1) of 31 resident entry doors, room 257. D. Wheel chair - armrest was damaged in two (2) of 39 observed, wheel chairs observed in room areas 126A and 102B. E. Baseboards- in one (1) of six (6) janitor ' s closet; in one (1) of six (6) nourishment rooms; in one (1) of 12 resident lounge areas; and in two (2) of 31 rooms 110 and 122	L 410	**3256.1 Nursing Facilities** (continued) 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator. **Walls** 1. Both resident rooms and dining room walls were scrubbed upon discovery. 2. Other resident rooms and the 1st floor dining room were evaluated for cleanliness and corrections made when indicated. 3. Housekeeping Supervisors are monitoring the walls for on-going cleanliness each day with a daily report of their findings done each day. Wall cleanliness is part of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **Chairs** 1. The one geri-chair and 3 arm chairs, identified at the time of the survey as being soiled was cleaned immediately. 2. All facility geri-chairs and wheelchairs were checked for cleanliness and corrections were made if any were necessary. 3. All geri-chairs and wheelchairs are on a routine monthly and PRN cleaning schedule. Chair cleanliness is part of the Housekeeping Quality	4/3/09 1/16/09 3/31/09 3/31/09 4/3/09 1/16/09 1/16/09

Chairs (continued)

Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 3/31/09

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator . 4/3/09

Beauty Shop

1. Items found soiled were cleaned upon discovery. 1/16/09

2. All areas of the Beauty Shop were evaluated for cleanliness and corrections were made if necessary. 1/16/09

3. Cleanliness of the Beauty Shop Is included in the "Common Areas" Section of the Housekeeping QI Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping. 3/31/09

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

C. Entry Door

1. The door was replaced immediately upon discovery. 1/16/09

2. Other doors were evaluated for damage and corrections were made if necessary. 1/16/09

3. Door are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 3/31/09

4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which 4/3/09

C. Room Door (continued)
is chaired by the Administrator

D. Wheelchair

1. The two armrests were replaced upon discovery. 1/16/09
2. Other wheelchair armrests were evaluated and replaced if necessary. 1/16/09
3. Wheelchair repairs are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

E. Baseboards

1. Damaged baseboards were replaced or repaired upon discovery. 1/16/09
2. Other baseboards were evaluated for the need for repair or replacement and action was taken when necessary. 3/31/09
3. Baseboards are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator 4/3/09

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L 410	Continued From page 43 F. Walls - in one (1) of six (6) clean linen rooms, 1N; in one (1) of six (6) soiled utility room, 1S; and in one (1) of six (6) janitor ' s closet, 3N 3. The following items/areas were observed marred/scarred: The wall in the 1S- resident lounge area in one (1) of 12 resident lounge areas observed and one (1) of 31 resident rooms observed, room 232 4. Excessive items were observed in resident rooms in five (5) of 31 resident rooms observed: rooms 110, 233, 317, 305 and 357 5. The following items were observed stored on floor(s): 1N - supply room five (5) of five (5) boxes 3N-five (5) of five (5) boxes stored on the floor in the storage closet Multiple prosthetic items and boxes were store on the floor in the storage closet of the Rehabilitation gym.	L 410	**3256.1 Nursing Facilities** (continued) **F. Walls** 1. Noted wall damage was corrected Immediately upon discovery. 2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary. 3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator **3. Marred and Scarred** 1. The two wall areas noted as being marred or scarred at the time of the survey were repaired upon discovery. 2. Other wall areas were reviewed in Ancillary spaces and corrections were made if necessary. 3. Walls are included Maintenance QI Program. The Maintenance QI Team will collect data on this criteria and forward their information and recommendations to the Director of Maintenance for his review and evaluation. 4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator .	1/16/09 1/16/09 3/31/09 4/3/09 1/16/09 1/16/09 3/31/09 4/3/09

4. Excessive Items

1. Excessive items were removed upon discovery.	1/16/09
2. Resident rooms were evaluated for the storage of excess items. Family members were called and asked to remove the items whenever it was necessary to do so.	3/31/09
3 Resident Room Cleanliness/Clutter is part of the Housekeeping Quality Improvement Program. The Housekeeping QI Team will collect data on this criteria and forward their information and recommendations to the Director of Housekeeping.	3/31/09
4. The Department Head will present a report of the data collected and any action plans implemented to ensure sustained compliance at the monthly Quality Improvement Committee which is chaired by the Administrator	4/3/09

.5. Items stored on the Floor

1. All items were removed and properly Stored upon discovery.	1/16/09
2. Other areas of Rehab were evaluated for proper storage and corrections made if necessary.	1/16/09
3. The Director of Rehabilitation inserviced his staff regarding the proper storage of rehab equipment kept in their department.	3/31/09
4. The Rehab Director will ensure, through monthly inspection and evaluation, that sustained correction has been made in this area.	4/3/09