Revised 10/15/07
Revised 10/16/07

PRINTED: 09/14/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	08/30/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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L 000	Initial Comments An annual licensure survey was conducted on August 29 through 30, 2007. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 11 residents based on a census of 42 on the first day of survey and five (5) supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (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 record review and staff interview for one (1) of 11 sampled residents and one (1) supplemental resident, it was determined that the	L 051	**L051 3210.4** **NURSING FACILITIES** 1. Comprehensive care plans are developed for all residents on the SNF. During the recent survey, a problem area was identified that has been cited in this report. The following plan of correction addresses it: Findings for resident #11: 1. There is no further corrective action for resident #11, who has been discharged from this facility. — 7/18/07 2. The care plans for other residents having the potential to be affected by the same deficient practice were reviewed and revised accordingly. — 10/12/07 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: — 10/12/07 o The DON and/or his/her designee will continue to monitor all occurrence reports related to resident falls on an ongoing basis. o At the time of the occurrence, the charge nurse and the resident's nurse will immediately revise and/or amend the resident's care plan and update the appropriate documentation in the clinical record. o The MDS Coordinator will revise the current "high risk for falls" and the "potential for injury, related to history of falls" care plans. o The DON and MDS Coordinator will provide additional training for the nursing staff related to the process for activating, revising and/or amending care plans for residents at risk for falling. This will also include teaching the importance of appropriate notification and documentation in the clinical record. o The interdisciplinary care planning team	

Health Regulation Administration

TITLE (X6) DATE

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

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L 051	Continued From page 1 charge nurse failed to revise a care plan for multiple falls with subsequent injury for one (1) resident and correctly transcribe medication orders for one (1) resident. Residents #11 and JH3. The findings include: 1. The charge nurse failed to revise a care plan for multiple falls with subsequent injuries for Resident #11. Resident #11 was admitted to the facility on June 28, 2007 post fall at home and status post left hip hemiarthroplasty. The resident's initial care plan dated June 28, 2007 included: "Problem High risk for falls- Goal: Will not sustain any injury from___, will not experience fall due to___, and safety will be maintained through ___." Responses to these areas were blank. The interventions included: "Reorient resident to environment and use of call light; Reinforce use of call light and treaded shoes for ambulation; schedule toileting/bowel or bladder management; 30 minute hourly checks if indicated; B/P[blood pressure] for postural hypotension, while sitting, standing, lying; Monitor for syncope agitation, seizures bowel/bladder urgency; Keep bed in lowest position; Assist/supervise with mobility or transfers; Pt (patient) consult if needed; Evaluate for proper use of appliance -attention to safety; Move resident closer to nurses' station and apply bed check alarm Increase diversional activities; monitor labs as ordered; notify MD to modify treatment including appropriate medication intervention; educate and engage resident and family in all aspects of the fall protocol/safety	L 051	will discuss during their regular meetings any resident who has sustained a fall to ensure that proper revisions, amendments, and/or change in goals or approaches are reflected in the care plan. o The DON will develop a monitoring tool to track compliance with this plan of correction revising or amending the care plans for fall risk and potential for injury related to history of falls. o The fall risk assessment scoring has been updated to further identify higher risk residents. o Residents with a fall risk score of 15-30 will wear a blue fall risk bracelet designating them as high risk for falls. o The DON/charge nurse will monitor rooms to ensure that residents designated as high risk have their rooms flagged as high fall risk. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. 2. The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them: Findings for resident JH3: 1. There are no further corrective actions for resident JH3, who has been discharged from the facility. 2. Other residents' physician orders and medication administration record have been checked and transcribed correctly. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: o The staff will monitor the medication administration record and physician orders to ensure medications, strength and dosages are transcribed per physician orders. o The quality monitoring tool for eight-hour and 24-hour chart check compliance will	10/12/07 8/31/2004 10/12/07 10/12/07

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L 051	Continued From page 2 maintenance; reassess fall risk score if occurs." According to a nurse's note dated July 5, 2007, "...At 1345 (1:45 PM) Pt [patient] was found on the floor lying on [his/her] back by [name] who came to nursing station and called for help. No bruising noted no skin tear. Pt assisted back to bed x [times] 2 persons..." The resident sustained no injury from the fall. A nurse's note dated July 16, 2007 0550 (5:50 AM), documented "...At 0055 (12:55 AM) Pt was found on floor near [his/her] closet by staff ..." According to an x-ray taken on July 16, 2007, " IMPRESSION: Right hip hemiarthroplasty in place. There is an acute fracture of the greater trochanter and subtrochanteric region of the right femur. This is new in comparison to the previous study." A fall risk assessment was completed on June 28, July 5 and July 16, 2007. According to the evaluation tool, "Total score of 4 or above represents HIGH RISK". The resident's total score on June 28, 2007 was 9. The total score for July 5, 2007 was 16 and the total score for July 16, 2007 was 14. Facility staff identified that the resident's risk for falls had significantly increased on July 5, 2007. There was no evidence that facility staff initiated additional approaches or actions as a result of this assessment. The Interdisciplinary care team (IDT) met on July 5, 2007 to discuss the resident's status. According to the IDT notes, "IDT reviewed problem list. Min A (minimum assist) bed mobility, CTA (contact guard assist) transfers. Ambulating 20 feet with CGA. Will re-eval (evaluate)." There	L 051	o The quality monitoring tool for eight-hour and 24-hour chart check compliance will continue to be utilized. o Provide additional inservice training to nursing staff and secretarial associates on the importance of accuracy of transcription of medications. It will be reinforced with the nurse on the importance of verifying transcription of orders by the secretarial associates. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07

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L 051	Continued From page 3 was no time noted on the IDT notes, indicating if the team met prior to the fall. The IDT notes for July 9, 2007 indicated, "IDT reviewed. Progressing towards goals. IDT to re-eval." There was no evidence that the resident's fall of July 5, 2007 was discussed at the IDT team meeting, or that additional approaches were initiated because of the resident's fall. The resident fell in his/her room on July 16, 2007 and sustained a fracture of the greater trochanter and subtrochanteric region of the right femur. After surgical intervention, the resident returned to the skilled nursing unit on July 25, 2007. The same plan of care that was initiated on June 28, 2007 was initiated on July 25, 2007 without additional/new interventions. On August 30, 2007 at approximately 9:00 AM a face-to-face interview was conducted with the Employees #3, 4 and 5. Employee #3 stated, "[Resident #11] was confused and non-compliant with calling for help. That's why the resident's room was close to the nurse's station." Additionally, he/she acknowledged that no additional interventions were implemented between the falls. The record was reviewed August 29, 2007. 2. The charge nurse failed to correctly transcribe a medication order Resident JH3. On August 30, 2007 at 11:00 AM, during the reconciliation of the morning medication pass with the physician's orders and the MAR, it was determined that facility staff incorrectly transcribed a medication order for Resident JH3.	L 051		

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L 051	Continued From page 4 A review of the hospital discharge summary, faxed to the facility on August 28, 2007 at 11:26 AM, included, "K-Dur 40 meq (milliequivalents) po daily for 10 days." The medication was transcribed onto the facility's admission orders on August 28, 2007 at 3:00 PM as, "K-Dur 40 mg po daily x 10 days for supplement." The physician signed the admission orders on August 29, 2007, no time indicated. It was observed that the medication received from the facility's pharmacy was, "KCL 40 mEq/30 ml." A face-to-face interview was conducted with Nurse #3 on August 30, 2007 at 11:30 AM. He/she stated that the physician would be contacted to clarify the order.	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;	L 052	**L052 3211.1** **NURSING FACILITIES** **1.** The Renaissance SNF provides services that meet the professional standards of quality and safety. During the recent survey, a problem was identified that has been cited in this report: Findings for resident #11: 1. There are no further corrective actions for resident #11, who has been discharged from this facility. — 7/18/07 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission to the facility. — 10/12/07 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: — 10/12/07 o The fall risk assessment form has been revised and a new high risk category has been established. o The DON, charge nurse and other nursing staff will complete the newly revised fall risk assessment tool to differentiate "at risk" from "high risk" residents. o The appropriate goals and approaches	

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L 052	Continued From page 5 (d) Protection from accident, injury and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review and staff interviews for four (4) of 11 sampled residents and three (3) supplemental residents, it was determined that sufficient nursing time was provided to ensure each resident received the following: adequate supervision for one (1) resident with multiple falls and subsequent injury; clarification of medication strength and/or transcribe medication orders for three (3) residents; follow up with the physician for	L 052	will be put in place based on the risk level including hourly supervision and supervised toileting at least every two hours. o All residents admitted to the SNF as a result of a previous fall in another setting will receive a score designation of "high risk for falls." o The interdisciplinary care planning team will review, revise and update care plans, goals and approaches at their regular meeting for high risk residents. Documentation related to the discussion will be in the meeting notes. o The nursing staff will receive inservice training to ensure correct information is documented in the clinical record. o The charge nurse will monitor inter-shift reports to ensure the nursing staff passes on fall risk information to the CNAs. o The DON and/or his/her designee will continue to monitor occurrence reports related to resident falls to ensure that the revision of the care plan, goals and approaches have been updated appropriately. o Resident safety will be reinforced with the resident and/or family member/Power of Attorney (POA) o Fall prevention guidelines will be given to the residents and/or the family upon admission. o The DON and/or the charge nurse will monitor the resident's environment daily ensuring that all assistive devices are safely placed and are within safe reach of the resident. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. Findings for practice steps: 1. No residents were affected by the unsecured skid strip in the practice steps in the physical therapy treatment room. All skid strips have been replaced and are secure. 2. Any resident who uses the practice steps has the potential to be affected by the deficient	10/12/07 8/29/07 10/12/07

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L 052	Continued From page 6 observation of a vaginal discharge for one (1) resident; obtain a physician's order to apply a treatment for one (1) resident; obtain a physician's order for a wound cleanser for one (1) resident and failed to identify a wound irrigation solution for one (1) resident. Residents # 11, 3, 7, 9, JH3, P1 and T1. The findings include: 1. Facility staff failed to ensure adequate supervision for Resident #11 with multiple falls and subsequent injury. According to a nurse's note dated July 5, 2007, " ...At 1345 (1:45 PM) Pt was found on the floor lying on [his/her] back by [name] who came to nursing station and called for help. No bruising noted no skin tear. Pt assisted back to bed x 2 persons ...House Officer Dr [name was called and ordered x-ray - spine, thoracic lumbar sacral done ... " According to a nurse's note dated July 16, 2007 0550 (5:50 AM), " ...At 0055 (12:55 AM) Pt was found on floor near [his/her] closet by staff. Pt stated ' I wanted to get OOB to my bedside commode and to my closet to get something out. I lost my balance and fell to the floor. 2 staff members assist pt to walker to bed. Writer assess surgical site for apparent injuries. Surgical site Rt. hip was red and warm to touch steri strips remain intact. Pt did voice c/o pain to the site. Pt stated ' I fell on my right hip. ' Writer offered Pt 2 tabs of Tylenol 500mg po at 0100 for c/o of pain to S//P fall V/S (vital signs) B/P (blood pressure)121/70, T (temperature in degrees Fahrenheit) 97.9, R (respirations)19, P (pulse) 90. Writer called House Surgeon Dr. [name] to make aware. Dr. [name] ordered x-ray pelvis and	L 052	practice. The practice steps will not be used if any skid strips are loose. 3. The following systemic changes will be put in place: o All equipment in physical therapy and occupational therapy treatment rooms will be inspected monthly and repaired, if necessary. o A monthly equipment log will be developed to track this action. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. 2. The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them: Findings for resident #3: 1. There are no further corrective actions for resident #3, who has been discharged from the facility. 2. Other residents' medication orders and orders for Tylenol with Codeine were checked to ensure that the correct strength was specified by the physician and transcribed correctly. 3. The following systemic changes have been put in place to ensure the deficient practice does not recur: o The nursing staff and secretarial associates will monitor the physician orders and medication administration records to ensure the medication strength has been identified and transcribed correctly. o The eight-hour chart review followed by the 24-hour chart review of the medication administration record will be utilized to monitor orders for accuracy and completeness. o The nursing staff will receive inservice training on the importance of the clarification of medication orders to prevent a delay in treatment for the resident and to ensure appropriate dosing.	10/12/07 10/12/07 9/5/07 10/12/07 10/12/07

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L 052	Continued From page 7 right hip and CBC for the am lab. Dr. [name] want to be called back once x-rays are completed to further assess and complete occurrence report. Pt. was instructed to use call light at all times for all assist. Call light left at pt's reach side rails up x 2. Bed lock in lowest position. Writer will continue to monitor." The spinal x-rays taken on July 5, 2007 were negative for any fractures. The review of an x-ray report dated July 16, 2007 indicated, " IMPRESSION: Right hip hemiarthroplasty in place. There is an acute fracture of the greater trochanter and subtrochanteric region of the right femur. This is new in comparison to the previous study. " A fall risk assessment was completed on June 28, July 5 and July 16, 2007. According to the evaluation tool, " Total score of 4 or above represents HIGH RISK. " The resident's total score on June 28, 2007 was 9. The total score for July 5, 2007 was 16 and the total score for July 16, 2007 was 14. Facility staff identified that the resident's risk for falls had significantly increased on July 5, 2007. There was no evidence that facility staff initiated additional approaches or actions as a result of this evaluation. According to an evaluation by the physical therapist conducted on July 6, 2007 at 9:00 AM, after the resident's initial fall on July 5, 2007, " Res fell yesterday. X-ray cleared any dislocation. Res can continue therapy. Res. getting better as evidenced by decreased assistance required for her functional activities. " There was no evidence that the physical therapist initiated any additional modalities because of the resident's fall	L 052	clarification of medication orders to prevent a delay in treatment for the resident and to ensure appropriate dosing. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. **3.** The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: <u>Findings for resident #7 and P1</u>: 1. There are no further corrective actions for resident #7, who has been discharged from the facility. The order for the correct irrigation for the wound VAC has been clarified by the physician for resident P1. 2. Other residents having the potential to be affected by the same deficient practice will be identified through review of physician orders for wound care upon admission. The appropriate wound cleansing and/or irrigation solution for the identified therapies will be identified. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o Provide additional inservice training for nursing staff to review policy and procedures for wound care. o The charge nurse and DON will utilize direct observation of wound care dressing changes to monitor and ensure compliance. o The Infection Control nurse will provide inservice training for the nursing staff on the importance of cleansing wounds to prevent infection. o The nursing staff will notify the physician if wound care orders are not complete according to policy and procedure. o Annual unit competencies will be instituted to reinforce wound care. Staff will be required to demonstrate knowledge of policy and procedures.	10/12/07 9/19/07 10/12/07 10/12/07

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L 052	Continued From page 8 on July 5, 2007. The Interdisciplinary care team (IDT) met on July 5, 2007 to discuss the resident's status. According to the IDT notes, " IDT reviewed problem list. Min A (minimum assist) bed mobility, CTA (contact guard assist) transfers. Ambulating 20 feet with CGA. Will re-eval (evaluate). " There was no time noted on the IDT notes, indicating if the team met prior to the fall. The IDT notes for July 9, 2007 indicated, " IDT reviewed. Progressing towards goals. IDT to re-eval . " There was no evidence that the resident's fall of July 5, 2007 was discussed at the IDT team meeting, or that additional approaches were initiated because of the resident ' s fall. The care plan for falls, initiated June 28, 2007, lacked evidence that new goals or approaches were initiated after the resident fell on July 5, 2007. On August 30, 2007 at approximately 9:00 AM a face-to-face interview was conducted with Employees #3, 4 and 5. Employee #3 stated, " [Resident #11] was confused and noncompliant with calling for help. That ' s why the resident ' s room was close to the nurse's station. " The record was reviewed August 29, 2007. 2. Facility staff failed to clarify a medication strength and transcribe two (2) PRN (as needed) medications for Resident #3. A. A review of Resident #3' s record revealed admission orders signed by the physician but undated, directing, " Acetaminophen	L 052	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. **4.** The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them: Findings for resident #9: 1. There are no further corrective actions for the resident #9, who as has been discharged from the facility. 2. Other residents having the potential to be affected by the same deficient practice will be identified during routine care and nursing assessment of the resident. The nurse will ensure all abnormal findings are documented and reported to the physician for treatment. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o Provide additional inservice training to the staff on the importance of physician notification for any noted abnormal finding. o The nursing staff will ensure all calls made to physicians related to abnormal findings or changes in condition have been returned. o The charge nurse will continue to monitor inter-shift reports for concerns that may need physician intervention. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. **5.** The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them: Findings for resident T1: 1. There are no further corrective actions for this	10/12/07 9/6/07 10/12/07 10/12/07 10/12/07 8/31/07

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L 052	Continued From page 9 (Tylenol)/Codeine 1 tab po (by mouth) PRN - every 4 hours for pain." The strength for the medication was not indicated. According to the manufacturer's description, Acetaminophen (Tylenol) with Codeine comes in the following strengths: Tylenol #1: 8 mg (milligrams) of codeine and 300 mg of Tylenol Tylenol #2: 15 mg of codeine and 300 mg of Tylenol Tylenol #3: 30 mg of codeine and 300 mg of Tylenol Tylenol #4: 60 mg codeine and 300 mg Tylenol A face-to-face interview was conducted with Employee #10 on august 30, 2007 at 11:30 AM. He/she stated, " The only one we use is Tylenol #3. That' s all the pharmacy every sends us." The record was reviewed on August 30, 2007. B. Facility staff failed to transcribe PRN (as needed) medication orders for Resident #3. A review of the admission orders for Resident #3, signed by the physician but undated, revealed, "Tylenol 650 mg po q 4 hours PRN for temp greater than 101 (degrees Fahrenheit) or mild pain" and " MOM (Milk of Magnesia) 30cc po daily - PRN constipation." The facility prints a Medication Administration Record (MAR) for each day. A review of the MARs from August 23 through August 28, 2007 revealed that the above cited orders for PRN Tylenol and Milk of Magnesia were not transcribed onto the daily MARs. A face-to-face interview with Employee #11 was	L 052	identified immediately during the nursing admission assessment or upon discovery of a wound. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o The nurse will cover the area with a dry, sterile gauze to prevent infection. o The nurse will call the attending physician to obtain wound care orders and subsequently carry those orders out for the resident. o The DON and/or the charge nurse will review skin care sheets and treatment records to ensure orders are accurate and complete. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. 6. The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: <u>Findings for residents JH1, JH2, T1 and #2:</u> 1. There are no further corrective actions for residents JH1, JH2 and T1 because these residents have been discharged from the facility. Resident #2 is receiving Metamucil according to manufacturer's directions and physician's orders. 2. Other residents' medication orders were checked to ensure that the physician orders were transcribed correctly. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o The staff will monitor the medication administration records and physician orders every shift to ensure all orders have been carried out and transcribed accordingly. o The nursing staff will follow facility medication administration policy and procedures with each medication pass, ensuring that all medications are given as	10/12/07 10/12/07 8/31/07 10/12/07 10/12/07

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L 052	Continued From page 10 conducted on August 30, 2007 at 2:15 PM. He/she acknowledged that the PRN orders for Tylenol and Milk of Magnesia were not transcribed onto the MARs. The record was reviewed August 30, 2007. 3. Facility staff failed to obtain an order for a wound cleanser for Resident #7. A record review revealed a physician's order dated August 16, 2007, "1. Wet-to-Dry 4x4 and Saline to Right Leg Wound BID." The next order, dated August 23, 2007 directed, "Please [change] Wound Care to Adeptic + (and) Bacitracin Ointment, then Kling to open wounds of (R) + (L) Legs." There was no order for a wound cleanser in the August 23, 2007 order. A face-to-face interview with Employee #3 was conducted on August 30, 2007 at 10:15 AM. He/She stated, "Normal saline is used routinely to cleanse wounds before putting on clean dressings." He/she acknowledged that there was no cleansing agent in the most recent wound treatment order dated August 23, 2007. The record was reviewed August 30, 2007. 4. Facility staff failed to follow up with the physician for observation of a vaginal discharge for Resident #9. A record review revealed a nurse's note dated August 24, 2007 at 2:15 AM "...vaginal discharge observed during bath [with] strong odor. A call placed to Dr. [name] who wants me to give him/her a call back." The record lacked evidence of further evaluations regarding the vaginal discharge in the nursing	L 052	prescribed. o The eight-hour chart reviews followed by 24-hour chart and medication administration reviews will be utilized to monitor orders for accuracy and completeness. o Additional inservice training will be provided to the nursing staff and secretarial associates on the importance of the accurate transcription of medications. The importance of verifying transcription of orders by the secretarial associates will be reinforced to the nurses. o The quality monitoring tool for 8 and 24-hour chart check compliance will continue to be utilized. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting. 7. The Renaissance SNF provides services that meet professional standards of quality. During the recent survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: <u>Findings for resident #7 and P1</u>: 1. There are no further corrective actions for resident #7, who has been discharged from the facility. The order for the correct irrigation for the wound VAC has been clarified by the physician for resident P1. 2. Other residents with wound care orders were checked to ensure that the proper wound cleansing and/or irrigation solutions were correct per physician order. All records were checked to ensure appropriate orders for wound care were obtained from the physician and utilized. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o Provide additional inservice training for nursing staff to review policy and procedures for wound care. o The charge nurse and DON will utilize direct observation of wound care	10/12/07 9/19/07 10/12/07 10/12/07

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L 052	Continued From page 11 notes from August 25 to 30, 2007. A face-to-face interview with Employee #3 and #10 was conducted on August 30, 2007 at 2:20 PM. Both stated, "Aloe Vesta cream was being used as ordered. It may have been the cream." Additionally, Employee #3 acknowledged that there was no further investigation of the vaginal discharge. The record was reviewed on August 30, 2007. 5. Facility staff failed to obtain a physician's order to apply a treatment to Resident T1's right lower leg blisters. During an observation of Resident T1's right lower leg blisters on August 29, 2007 at 1:05 PM, it was observed that Employee #6 removed the dressing that covered the blisters. The dressing was inclusive of an ABD (abdominal) pad and several yellow pieces of cloth which covered the blistered areas. The dressing was soiled with blood and brown tinged drainage; the area under the dressing was then assessed. There were several open blisters and several fluid filled blisters that were draining on the right shin and the right calf. Additionally, there were red and brown tinged dried areas on the resident's skin in between and surrounding the blisters. Employee #6 proceeded to apply Adeptic dressing, an ABD pad and then wrapped the dressing with an ace bandage to the aforementioned areas. Employee #6 stated, "I am covering the blisters dressing this way [with the Adeptic, ABD pad and the Ace wrap] until I speak with the doctor." A face-to-face interview was conducted on August 29, 2007 at 1:20 PM with Employee #6.	L 052	appropriate wound cleansing and/or irrigation solution for the identified therapies will be identified. 3. The following systemic changes will be put in place to ensure the deficient practice will not recur: o Provide additional inservice training for nursing staff to review policy and procedures for wound care. o The charge nurse and DON will utilize direct observation of wound care dressing changes to monitor and ensure compliance. o The Infection Control nurse will provide inservice training for the nursing staff on the importance of cleansing wounds to prevent infection. o The nursing staff will notify the physician if wound care orders are not complete according to policy and procedure. o Annual unit competencies will be instituted to reinforce wound care. Staff will be required to demonstrate knowledge of policy and procedures. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	10/12/07 10/12/07

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L 052	Continued From page 12 He/she acknowledged that the yellow cloth that covered the blistered areas to the resident's right lower leg was Xeroform and required a physician's order in order to use and Adeptic for a treatment. A review of the physician's orders from August 27 through 29, 2007, lacked evidence that an order was obtained to apply any treatments to the resident's right lower leg blisters. The record was reviewed on August 29, 2007. 6. Facility staff failed to transcribe medication onto Resident JH1 Medication Administration Record. On August 30, 2007 at 11:45 AM during the reconciliation of the morning medication between the August 2007 MAR and the physician ' s orders, it was determined that Nurse #1 failed to administer Cestagen to Resident JH1 A physician ' s order dated August 24, 2007 directed " Cestagen 1 tab po (orally) daily. " A review of the MARs for August 26, 27 and 29, 2007 revealed that Cestagen was not transcribed onto the afore mentioned MARs. A face-to-face interview with the Employee # 3 was conducted on August 29, 2007 at 1:00 PM. After reviewing the resident ' s record, he/she acknowledged that the medication was no transcribed onto the August 26, 27 and 29 2007 MARs. 7. Facility staff failed to identify an irrigation flushing solution for a V.A.C. (Vacuum Assisted Closure) surgical wound treatment for Resident P1.	L 052		

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L 052	Continued From page 13 A record review revealed a TO (telephone order) for a V.A.C. surgical wound order dated August 27, 2007: "V.A.C.: Settings 25 mmHg/Cont. (continue)/10 intensity Change Dsg (dressing) on M (Monday) - W (Wednesday - F (Friday) Silver foam." There was no order for wound irrigation; however it was observed that the nurse irrigated the wound during the treatment. A face-to-face interview with Employee #9 was conducted on August 30, 2007 at 9:15 AM. He/She stated "... use of normal saline is part of the protocol ... it is a given ...just like you cut the foam for fit ...it is in the V.A.C. wound care manual." A review of the facility"V.A.C. Therapy" protocol, page 16, indicated "Topical Solutions or Agents: When using Granufoam silver dressings do not use topical solutions or agents that may cause adverse interaction with silver such a [as] saline solution. Use sterile water for irrigations." The record was reviewed on August 29, 2007.	L 052		
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry;	L 088	**L088 3217.3** **NURSING FACILITIES** 1. The Renaissance SNF provides infection control measures to maintain a sanitary environment to prevent the development and transmission of disease and infection. During a recent survey, a number of problems were identified that have been cited in this report. The following plan of correction addresses them:	

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L 088	Continued From page 14 (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on observation and staff interviews for two (2) supplemental residents, it was determined that facility staff failed to wash their hands during a wound treatment for one (1) resident and cleanse a wound before applying a clean dressing for one (1) resident. Residents P1 and T1. The findings include: 1. Employee #9 failed to wash his/her hands three (3) times during a V.A.C. (Vacuum Assisted Closure) surgical wound dressing change for Resident P1. On August 29, 2007 at 9:45 AM during a dressing change it was observed that nurse #9 removed the soiled V.A.C. dressing from the resident's lumbar surgical site, he/she put the soiled dressing in a red bio-hazard bag, inside a red bio-hazard receptacle and removed his/her gloves. Without washing his/her hands, he/she obtained additional supplies and answered a cell phone from his/her pocket.	L 088	Findings for residents T1 and P1: 1. There are no further actions for resident T1, who has been discharged from the facility. Resident P1 remains on the Unit and appropriate hand washing and infection control measures are being maintained. 2. Other residents with wound care orders were checked to ensure that the proper wound cleansing solutions were correct according to physician orders and utilized. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: o Nursing staff will receive inservice training on wound care policy and procedures. o The DON and/or his/her designee will review with the nursing staff the importance of hand washing and good infection control practices. o The charge nurse and DON will utilize direct observation of wound care procedures to monitor hand washing compliance. o The charge nurse and nursing staff will monitor wound care orders for accuracy and completeness on a shift-by-shift basis. o The wound VAC therapy protocol manual will be placed inside the nurses' stations for review by the nursing staff for residents being admitted for this therapy. o The DON or his/her designee will use direct observation and monitor the wound treatment orders for presence of cleansing solutions. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly Quality Assurance meeting.	9/14/07 10/12/07 10/12/07 10/12/07

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L 088	Continued From page 15 Employee #9 washed his/her hands and donned clean gloves. He/She left the room, wearing the gloves, to obtain supplies. He/she removed his/her gloves and without washing his/her hands, donned clean gloves. The nurse proceeded to flush the surgical wound site and removed his/her gloves. He/She washed his/her hands and donned a sterile glove on his/her left hand and moved the trash can close to the bedside with his/her ungloved right hand. He/She donned a sterile glove on his/her right hand without washing his/her hands. The treatment continued without further incident. A face-to-face interview with Employee #9 was conducted on August 30, 2007 at 9:15 AM. He/ She acknowledged that he/she failed to wash his/her hands three (3) times during the V.A.C. dressing change. The record was reviewed on August 30, 2007. 2. Facility staff failed to clean the open blisters and the area surrounding the closed blisters prior to applying a clean dressing to Resident T1's right lower leg blisters. During an observation of Resident T1's right lower leg blisters on August 29, 2007 at 1:05 PM, it was observed that Employee #6 removed the dressing that covered the blisters. The dressing was inclusive of an ABD (abdominal) pad and several yellow pieces of cloth which covered the blistered areas. The dressing was soiled with blood and brown tinged drainage; the area under the dressing was then assessed. There were several open blisters and several	L 088		

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L 088	Continued From page 16 fluid filled blisters that were draining on the right shin and the right calf. Additionally, there were red and brown tinged dried areas on the resident's skin in between and surrounding the blisters. Employee #6 then proceeded to apply Adeptic dressing and an ABD pad and the wrapped the dressing with an ace bandage to the aforementioned areas. Employee #6 stated, " I am covering the blisters dressing this way [with the Adeptic, ABD pad and the Ace wrap] until I speak with the doctor. " A face-to-face interview was conducted on August 30, 2007 at 12:20 PM with Employee #3. He/she acknowledged that the blister and the area surrounding the blisters should have been cleaned before applying a new dressing.	L 088		
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: soiled sheet pans, serving trays, shelf surfaces, a ventilation hood, cooking hoods, reach-in cart, supply lines near convection ovens, surfaces of the convection ovens and salamander grill, cold boxes, dessert box gasket, hotel pans and unlabeled or undated foods stored in refrigerators. These observations were made in the presence of Employees #3, 12, 13 and 14. The findings include:	L 099	**L099 3219.1** **NURSING FACILITIES** 1. Sibley Memorial Hospital stores, prepares, distributes and serves food under sanitary conditions. During the survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: 1. No specific residents were identified in the survey report as being affected by the deficient practices. The following corrective actions have been taken to address the survey findings: o Finding 1: All pots and sheet pans will be cleaned in our three bay sinks and dried completely before storing. Additional drying racks will be purchased. — 8/29/07 o Finding 2: The plate warmer lid/cover and hinges were cleaned and will be continually to be cleaned weekly or as often as necessary. — 8/29/07 o Finding 3: The interior and bottom surfaces of serving trays will be kept clean. If stains are visible they will be discarded. — 8/29/07 o Finding 4: The shelf surface of the pots and pans rack will be cleaned as often as needed to ensure that all pots and pans are stored on a clean surface. — 8/29/07 o Finding 5: The exterior & interior — 8/29/07	

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L 099	Continued From page 17 1. The interior surfaces of regular and perforated sheet pans were soiled with leftover food after washing and pans were not allowed to dry before storing on racks for reuse in 11 of 11 sheet pan observed on August 30, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 2. The outer surfaces and hinged lids of the plate warmer in the dish room were soiled with accumulated debris in one (1) of one (1) plate warmer observed at approximately 1:30 PM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 3. The interior and bottom surfaces of serving trays were soiled with debris after washing in 18 of 49 trays observed at 1:00 PM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 4. The shelf surfaces of pot and pan racks were soiled with debris in one (1) of one (1) storage shelf observed at 1:10 PM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 5. The interior surfaces of a ventilation hood in the pot and pan wash area were soiled with splattered food and debris on one (1) of two (2) ventilation hoods observed at approximately 1:40 PM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 6. The interior surfaces of cooking hoods, filters	L 099	surfaces of the ventilation hood in the pots and pans area have been cleaned. Ducts/hoods are scheduled every quarter which was the same day of the inspection. (Ducts & hoods already scheduled for that evening prior to survey.) o Finding 6: Same action as finding 5. These hoods are all contract cleaned and were scheduled for quarterly cleaning on 08/29/07, prior to survey. — 8/29/07 o Finding 7: The reach-in cart located in the walk-in refrigerator was cleaned. All carts will be put on a cleaning rotation. — 10/12/07 o Finding 8: The gaskets surface in the cold salad prep area box was cleaned and will be put on the cleaning rotation. — 8/29/07 o Finding 9: The exterior surfaces of the gas supply lines near the ovens were cleaned and also will be added to our cleaning rotation. — 8/29/07 o Finding 10: The top and exterior surfaces of the ovens and the salamander grill were cleaned. This will also be added to our cleaning rotation. — 8/29/07 o Finding 11: The exterior and interior surfaces of the cold box were cleaned and will be placed on the cleaning rotation checklist. — 8/29/07 o Finding 12: The dessert box door gaskets were cleaned and will be added to our cleaning rotation list to maintain compliance. — 8/29/07 o Finding 13: Same action plan as finding 1. All hotel pans will be cleaned in our three bay sinks and dried completed before storing. Additional drying racks will be purchased. — 10/12/07 o Finding 14: All food trays will be labeled and dated. Daily monitoring will be completed to make sure we are in compliance. All items without a date and label will be discarded. — 8/29/07 o Finding 15 & 16: The refrigerator/freezer in 3 North and 3 South day rooms will not store any food products unless they are labeled and dated. All unlabeled and dated items will be discarded. Inservice training of the staff will take place to be in compliance for discarding non-dated — 10/12/07	

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L 099	Continued From page 18 and sprinkler supply lines were soiled with grease and food debris in three (3) of three (3) observations of cooking hoods in food preparation areas at 10:00 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 7. A reach in cart stored in the walk in refrigerator was soiled with food spillages and debris on the exterior and interior surfaces in one (1) of two (2) observations of reach in carts at 10:15 PM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 8. The gasket surfaces of the cold and reach boxes in salad preparation areas were soiled with mildew accumulation in one (1) of two (2) cold and reach boxes observed at 9:55 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 9. The exterior surfaces of gas supply lines near convection ovens, deep fryers and gas ovens were soiled with accumulated dust and debris in three (3) of three (3) supply line observations at 10:30 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 10. The top and exterior surfaces of three (3) convection ovens and the salamander grill were soiled with accumulated deposits and grease in four (4) of four (4) equipment observations at 10:40 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation.	L 099	and labeled food items. 2. The monthly Food Safety Audit will be used to identify other potential residents who could be affected by the deficient practices. The same corrective actions listed in 1 above will be used to address any deficiencies found in these areas. 3. The following measurements will be put in place to make sure that the deficient practices do not continue: o Monthly Sanitation audits (Physical Safety Audit) o Monthly Food Safety Audits o Weekly walk-through inspections of the floors, hoods, vents, carts, top of equipment, pot & pans area, plate warmer and doors. All of which will be on the cleaning rotation checklist. o The cleaning rotation list will be given and/or posted to the sanitation team and all employees involved every week. This will be monitored by Supervisors, Managers and the Director. 4. Performance will be monitored through regular inspections and review of checklists. Progress reports will be provided at the quarterly Quality Assurance committee meetings.	10/12/07 10/12/07 10/12/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	08/30/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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L 099	Continued From page 19 11. The exterior and interior surfaces of cold boxes in the salad preparation area were soiled with debris in two (2) of two (2) cold boxes observed at 10:45 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 12. The dessert box door gasket surfaces were soiled with mildew accumulation in two (2) of two (2) dessert boxes observed at 10:50 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 13. Hotel pans (8x 10x 6) inch stored on racks in the pot and pan wash area were not thoroughly cleaned after washing and were stored on racks before pans were allowed to dry in 11 of 11 hotel pans observed at 12:10 PM on August 30, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 14. Food trays stored on the shelves in the reach in refrigerator on were not labeled or dated to identify the entrée such as tomatoes, chocolate pudding, vanilla pudding, cheese and salads in five (5) of five (5) food items observed at 9:50 AM on August 29, 2007. Employees #12, 13 and 14 acknowledged the above cited findings at the time of the observation. 15. The refrigerator in the 3 North sitting room was observed to contain the following unlabeled and or undated food items: 1 carton of skim milk with an expiration date of August 28, 2007 A container of pineapple labeled but undated 2 cartons of yogurt labeled but undated	L 099		

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L 099	Continued From page 20 1 plastic container with white liquid, labeled but undated, that smelled sour when opened in the presence of Employee #3. The freezer in the 3 North sitting room contained the following unlabeled and undated items: 20 ounces of red colored water with additional vitamins 16 ounce of frozen water 11 ounce can of cappuccino diet drink 4 ounces of strawberry ice cream 4 ounce container of apple sauce 1 pint, half full of strawberry ice cream 3.5 ounce vanilla fudge bar on a stick, with the wrapper torn open ½ gallon, with about ½ the amount of ice cream consumed 16 ounce bottle of water, not frozer 1 blue bag containing 6-4 ounce cups of ice cream Employee #3 acknowledged the above cited findings at the time of the observation. 16. The freezer in the 3 South sitting room contained the following unlabeled items: 1 box of frozen omelets 1 box of frozen biscuits Employee #4 acknowledged the above cited findings at the time of the observation.	L 099		
L 104	3219.6 Nursing Facilities Each food service employee shall wear either a hair net or other head covering. This Statute is not met as evidenced by: Based on observations during the survey period, it was it was determined that dietary staff were performing duties in the main kitchen without	L 104	**L104 3219.6** **NURSING FACILITIES** Sibley Memorial Hospital operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and within accepted professional standards and principles. The following plan of correction addresses a problem identified during the survey:	

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L 104	Continued From page 21 appropriate hair covering. The findings include: On August 29, 2007 at 9:30 AM, the dietary manager and one (1) dietary employee were observed in the main kitchen without a hair net or other hair covering.	L 104	1. No specific residents were identified in the survey report as being affected by the deficient practices. The following corrective actions have been taken to address the survey findings: o All employees and Managers will have a hair net or other hair cover while in the kitchen. 2. The following measurements will be put in place to make sure that the deficient practices do not continue: o Daily walk through to insure compliance o Food Safety Audits 3. Performance will be monitored through regular inspections and review of the daily and monthly walk-through/Food Safety Audits. 4. Performance will be monitored through regular inspections and review of checklists. Progress reports will be provided at the quarterly Quality Assurance committee meetings.	8/29/07 10/12/07 10/12/07 10/12/07
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 initial kitchen and environmental tour, it was determined that facility staff failed to maintain the facility in a clean and sanitary manner as evidenced by: soiled floor surfaces behind equipment, supply vents in dry storage room, window sills and bathroom vents, and a missing threshold. The findings include: 1. Floor surfaces were soiled and stained behind equipment under cooking hoods and the ice machines in the main kitchen near the serving area in two (2) of two (2) observations of a soiled floors between 8:36 AM and 9:19 AM on August 29, 2007. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations. 2. The exterior surfaces of supply vents and duct work in the dry storage room of the main kitchen were soiled with dust accumulation in six (6) of	L 410	**L 410 3256.1** **NURSING FACILITIES** Sibley Memorial Hospital's Renaissance Skilled Nursing Facility (SNF) provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During the survey, a number of problem areas were identified that have been cited in this report. The following plan of correction addresses them: <u>Findings 1, 2 and 5:</u> 1. No specific residents were identified in the survey report as being affected by the deficient practices. The following corrective actions have been taken to address the survey findings: o Finding 1: The floor surfaces behind the equipment, under cooking hoods and the ice machine have been cleaned daily or as needed. This will be monitored by our closing check list. o Finding 2: The exterior surfaces of the supply vents and duct in the dry storage room and kitchen have been cleaned. Ducts cleanings are scheduled every quarter which was the same day of the inspection.	8/29/07 8/29/07

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L 410	Continued From page 22 eight (8) supply vents observed on August 29, 2007 at 9:00 AM. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations. 3. Window sills were observed to be soiled with accumulated dust in the following rooms: 306, 310, 312, 315, and the South sitting room in six (6) of 12 window sills observed on August 29, 2007 between 8:50 AM and 10:30 AM. These observations were made in the presence of Employees # 1 and 2 who acknowledged the above findings at the time of the observations. 4. Vents in resident's bathrooms were observed to be soiled with accumulated dust in the following rooms: 308, 310 and 315 in three (3) of six (6) vents observed on August 29 2007 between 8:50 AM and 10:30 AM. These observations were made in the presence of Employees #1 and 2 who acknowledged the above findings at the time of the observations. 5. The threshold located at the rear entrance door to the main kitchen was missing and floor surfaces were soiled with accumulated debris in one (1) of one (1) threshold observed at 8:50 AM on August 29, 2007. These observations were made in the presence of Employees #12, 13 and 14 who acknowledged the above findings at the time of the observations.	L 410	o Finding 5: The threshold located at the rear entrance door to the main kitchen has been requested to be fixed. Cleaning will be monitored for compliance. 2. The following measures will be put in place to make sure that the deficient practices do not continue: o Monthly Sanitation audits (Physical Safety Audit) o Daily walk-through inspection of the floors, hoods, vents, and doors. 3. Performance will be monitored through regular inspections and review of the daily and monthly walk-through/Physical Safety Audits. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance committee meeting. Findings 3 & 4 1. The following corrective action has been taken in the identified rooms. The window sills and the bathroom vents have been cleaned. 2. Other residents having the potential to be affected by the same deficient practice will be identified through regular environmental rounds and inspection of window sills and bathroom vents. Rooms that are found to be dusty will be cleaned. 3. The following systemic changes will be put in place to ensure the same deficient practice will not recur: o The DON will conduct regular environmental rounds with the Day Operations Manager of the Environmental Services Department to insure compliance. o Staff from Environmental Services will continue to retrain on the 7-step cleaning method to ensure high dusting is completed on a regular basis. o The day operations manger will conduct room inspections at the time of discharge. 4. The quality assurance process will be utilized to monitor and sustain compliance. The findings will be presented at the quarterly Quality Assurance committee meeting.	10/12/07 10/12/07 10/12/07 10/12/07 08/29/07 10/12/07 10/12/07 10/12/07