Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0019	A. BUILDING _____ B. WING _____	12/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

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L 000	Initial Comments A licensure survey was conducted on December 15 through 18, 2008. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size was 24 residents based on a census of 158 the first day of survey and 27 supplemental residents.	L 000	Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider of the truth of the facts alleged or concluded in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because the provisions of Federal and State laws require it.	
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 staff interview and record review for three (3) of 24 sampled residents, it was determined that the charge nurse failed to review the total plan of care as evidenced by failing to:	L 051	The responses to the deficiencies in the Plan of Correction will be answered in the following numerical sequence: 1. How will the corrective actions be accomplished for those residents found to have been affected by the deficient practice? 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 3. What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not occur. 4. How do you plan to monitor your performance to make sure that solutions are sustained? 5 When will corrective action be completed?	

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L 051	Continued From page 1 clarify the code status for one (1) resident, inform the physician of a delay in obtaining an appointment for one (1) resident, initiate care plans for two (2) residents with allergies and one (1) resident with socially inappropriate behaviors and consistently document the administration of a controlled substance for one (1) resident. Residents #3, 21, 22 and JH6. The findings include: 1. The charge nurse failed to clarify Resident #3's code status and initiate a care plan for an allergy to Sulfa. A. The charge nurse failed to clarify the code status for Resident #3. Review of the November 2008 "Physician' s Order" form signed by the physician on November 16, 2008 directed, "...Advance Directives: Yes-CPR. Resident is DNR [Do Not Resuscitate], DNI [Do Not Intubate], RN [Registered Nurse Pronouncement, may hospitalize ..." A review of the plan of care "...Advance Directives DNR/DNI, RN Pronouncement, may hospitalize" last updated December 17, 2008 revealed, "...Goals- Resident's wishes for advance directives will be honored ..." There was no evidence that the charge nurse clarified the code status for Resident #3. A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that Resident #3's code status needed to be clarified on the physician order form. The record was reviewed	L 051	L051 1. Clarification of resident #3 code status was corrected on 12/18/08. 2. All residents with physician order for code status were checked and corrected if required. 3. The nursing leadership team was provided in-service on code status on 1/31, 2/1 and 2/3/09. 4. Resident code status will be monitored through CQI quarterly. 5. Completion date 2/5/09. Resident 3, 21 1. Residents #3 and 21 care plans were updated regarding allergies on 12/18/08 and resident #22 expired, therefore, the care plan was not updated. 2. All other residents with allergies and inappropriate behavior care plans were checked and updated if required. 3. The Director of Nursing provided in-service on Care Plan Updates to include allergies and inappropriate behavior for the Resident Care Coordinators on 2/2/09. 4. Care plans will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 051	Continued From page 2 on December 18, 2008. B. The charge nurse failed to develop a care plan for Resident #3 with allergies. A review of the "Physician Interim Order " sheet, signed by the physician on June 11, 2008, revealed " ...Allergies- Sulfa". A review of the care plans last updated on September 4, 2008 lacked evidence that a care plan for allergies was developed with goals and approaches to address the resident's allergy to "Sulfa " . A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee #4. He/she acknowledged that a care plan for Resident #3's allergy was not developed. The record was reviewed on December 18, 2008. 2. The charge nurse failed to initiate a careplan for Resident #21 for "Allergy to penicillin (PCN)". A review of Resident #21's clinical records on December 17, 2008 revealed an "Alert Sticker" for "Allergy to PCN" on the front of the chart. A review of the "Physician Order Sheet " signed September 9, 2008 revealed that the resident had an allergy to PCN. A review of care plans, last updated October 29, 2008, revealed that the charge nurse failed to implement a care plan his/her allergy to PCN. A face-to-face interview was conducted on December 17, 2008 at 10:55 AM with the Employee #4. He/she acknowledged that a care plan was not in place for an allergy to PCN. The	L 051		

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L 051	Continued From page 3 record was reviewed on December 17, 2008. 3. The charge nurse failed to inform the physician of a two (2) week delay in obtaining a GI (Gastroenterology) consult for Resident #22 and develop a care plan for socially inappropriate behaviors. A. Review of Resident #22's record revealed a physician's telephone order dated August 19, 2008 and signed by the physician on August 20, 2008, directing, "Consult with [Physician #1] G-tube (Gastrostomy tube) replacement." A review of the appointment book kept by the unit secretary, who was responsible for making resident appointments, revealed the following notation for August 18, 2008: "An appointment was requested for [Resident #22] for a GI consult at [Physician #1's] office ...the office will give us a call because the doctor is on leave until the end of the month." A review of the nurses' notes revealed the following: September 1, 2008 at 3:00 PM: "Resident alert ...G-tube intact and patent. G-tube site noted without drainage or redness ...Call placed to [Physician #1's] office to schedule appoint for G-tube replacement. [Physician #1's] receptionist stated that they will call the unit tomorrow (September 2, 2008) with appointment date ..." September 2, 2008 at 3:30 PM: "Attempts to schedule appoint with [Physician #1] was unsuccessful. [Primary medical doctor] notified ...gave order to schedule appointment with [Physician #2] ...appointment for G-tube replacement scheduled for September 18, 2008 ..."	L 051	1. Resident #22 expired, therefore, GI consult was not obtained. 2. All residents with physician orders for GI consults were checked and corrected if required. 3. The Nursing Leadership Team provided in-services on GI consults on 1/31, 2/1 and 2/3/09. 4. Orders for GI consults will be monitored and reported to CQI quarterly. 5. Completion date 2/5/09.	

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L 051	Continued From page 4 There was no evidence in the record that the charge nurse notified the attending physician that Physician #1 was not available for approximately two (2) weeks after the primary medical doctor ordered the GI consult. A face-to-face interview was conducted with Employee #9 on December 16, 2008 at 1:00 PM. He/she acknowledged that the primary medical doctor was not notified of the delay in scheduling the GI consult. The record was reviewed December 16, 2008. B. The charge nurse failed to initiate care plans for Resident #22 for socially inappropriate behaviors. Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas " of male residents and staff and once grabbed the "private area " of a male staff member. A review of the care plans for Resident #22 failed to reveal a care plan with appropriate goals and approaches for the above cited behaviors. Included on the care plan for "[Resident #22] has a potential for injury related to physiologic deterioration of cognitive functions ... " was, "[Resident #22] also has inappropriate behaviors that include touching staff in the perineal areas."	L 051	Resident #22 1. Resident expired 11/11/08, therefore, care plan was not initiated. 2. All other residents with inappropriate behavior care plans were checked and updated if required. 3. The Director of Nursing provided an in-service on care plan update to Resident Care Coordinators on 2/2/09. 4. Care plans will be monitored quarterly through CQI 5. Completion date 2/5/09.	

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L 051	Continued From page 5 In reviewing the care plan, there were no interventions that were specifically developed to address inappropriate touching staff in the perineal areas. A face-to-face interview with Employee #5 was conducted on December 16, 2008 at 11:30 AM. He/she acknowledged that there were no care plans with the appropriate goals and approaches developed for the aforementioned identified behaviors. The record was reviewed December 15, 2008. 4. The charge nurse failed to consistently document the administration of controlled substances on the Medication Administration Records (MARs), the Controlled Substance Record, Behavior Monitoring Flow Record and the nursing notes reviewed for JH6. On December 17, 2008, at approximately 1:30 PM, a review of Resident JH6's record revealed a physician's order dated August 5, 2008 that directed, "Ativan 0.5mg, po [by mouth] bid [twice daily] prn [as needed] for agitation." The August and September 2008 MARs were reviewed and indicated that Ativan 0.5mg was administered August 14, 2008 as indicated by the nurse's initials entered in the allotted areas and there were no initials recorded for September 2008. The "Controlled Drug Record" indicated the Ativan 0.5mg was removed from the controlled substance drawer on August 5, 6 and 14 and on September 11, 2008. There was no evidence on the MARs, the Behavior Monitoring Flow Record or the nursing notes that Ativan 0.5mg was	L 051	JH6 1. There were no negative outcome to resident as a result of the staff not consistently documenting controlled substance medication given to the residents. 2. All other residents with orders for PRN controlled substance medications medical records were checked and corrected if required. 3. All appropriate licensed nurses were counseled regarding requirements of documentation for all controlled substance medications. Nursing Leadership provide in-service to the licensed nurses regarding Required Documentation of Control Substance Medications on 1/31, 2/1 and 2/2/09. 4. Documentation of Controlled Substance Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 051	Continued From page 6 administered on August 5 and 6, and September 11, 2008. The record was review on December 17, 2008.	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; (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	L 052		

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L 052	Continued From page 7 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, staff interview and record review for three (3) of 24 sampled residents and six (6) supplemental residents, it was determined that the sufficient nursing time was not given to each resident as evidenced by facility staff failing to: change a suprapubic catheter as per physician ' s orders for one (1) resident, administer medications per physician ' s orders for two (2) residents, obtain physician ' s orders to administer discontinued medications for three (3) residents, follow physician ' s orders for one (1) resident requiring a scoop plate, supervise one (1) resident for safety while toileting, and secure a bottle of hydrogen peroxide in one (1) resident ' s room. Residents #3, 9, 15, JH1, JH2, JH6, F1, F2, and F3. The findings include: 1. Facility staff failed to change Resident #9's suprapubic catheter as per physician's order. A review of Resident #9's clinical record revealed a physician's order, by the physician on October 5, 2008, which directed: "Suprapubic catheter: 22 Fr. [French] / 30ML Balloon. Change Suprapubic Tube once monthly on the 11th."	L 052	1. Resident #9's suprapubic catheter was changed on 12/18/08. 2. There were no other residents with suprapubic catheters. 3. The nursing leadership team provided in-services on Care of Suprapubic catheters on 1/31, 2/1 and 2/3/09. 4. Residents with Suprapubic Catheters will be monitored quarterly through CQI. 5. Completion date 2/5/09.	

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L 052	Continued From page 8 A review of a nurse's note dated December 11, 2008 at 6:00 AM revealed the following documentation, "Suprapubic cath [catheter] tube & [and] Foley bag not changed because no Foley Bag and cath in the house." A face-to-face interview was conducted with Employee #5 on December 17, 2008 at approximately 3:00 PM. He/she acknowledged that the suprapubic catheter was not changed on December 11, 2008 as ordered by the physician. The record was reviewed on December 17, 2008. 2. Facility staff failed to administer medication as per the physician ' s order for Residents #15 and JH1. A. Facility staff failed to administer medication to Resident #15 as per physician's orders. A Physician's order was signed and dated on December 7, 2008 that directed, "Acetaminophen 325 mg tablet, Give 2 tabs (650mg) by mouth 3 times a day for back pain *Not to exceed 4 grams in 24 hours* " for Resident #15. On December 15, 2008, at approximately 9:00 AM, during the medication pass for Resident #15, Employee #1 administered one (1) tablet of Acetaminophen 325 mg to the resident instead of two (2) tablets. A face-to-face interview was conduct on December 15, 2008, at approximately 2:00 PM with Employee #1. He/she acknowledged that one (1) tablet of Acetaminophen 325 mg was administered to the resident instead of two (2) tablets.	L 052	Resident #15 and JH1 1. Resident #15 was monitored and had no negative outcome after receiving dose of acetaminophen. Resident JH1 was monitored and no negative outcome from receiving Azopt ophthalmic solution one eye drop in the left eye. 2. Med pass observation was conducted for all residents with eye drops and acetaminophen orders to ensure accuracy of administration. There were no medication discrepancies observed. 3. Nursing Leadership team provided in-service on Accurate Administration of Medication on 1/31, 2/1 and 2/3/09. 4. Accuracy of Administering Medication will be monitored quarterly through CQI. 5. Completion 2/5/09.	

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L 052	Continued From page 9 B. Facility staff failed to administer medication to Resident JH1 as per physician's orders. A physician's order was signed and not dated by the physician in December 2008 that directed, "Azopt ophthalmic solution, Instill 1 drop in left eye 2 times a day for glaucoma." On December 15, 2008, at approximately 10:00 AM, during the medication pass for Resident JH1. Employee #2 instilled Azopt ophthalmic drops into the right eye instead of the left eye. A face-to-face interview was conduct on December 15, 2008, at approximately 3:00 PM with Employee #1. He/she acknowledged that the Azopt ophthalmic drops were instilled into the right eye instead of the left eye. 3. Facility staff failed to obtain physician ' s orders to administer a discontinued medication without for Residents #3, JH2 and JH6. A. Facility staff administered four (4) doses of Lorazepam 0.25 mg to Resident #3 after the medication was discontinued. A physician's order was signed and dated on November 12, 2008 that directed, "Decrease Ativan to 0.25 mg po [by mouth] qhs [at bedtime] x [times] 7 (seven) days, then Ativan 0.25mg po [by mouth] qhs [at bedtime] every other day x [times] 7 days and stop. " On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all " as needed " medications.	L 052	1. Residents' #3, JH2 and JH6 anti-psychotic medications were dis-continued on 12/17/08. All three residents were monitored and had no negative outcome. 2. All residents with physician orders for antipsychotic medications were checked and corrected if indicated. 3. The Nursing Leadership team provided in-services to the licensed staff on Administration of Accurate Antipsychotic and Reduction of Anti-psychotic Medications on 1/31 and 2/1/09. 4. Reduction of Anti-Psychotic Medications and Accuracy in Administering Anti-Psychotic Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 052	Continued From page 10 Resident #3's "Controlled Substance Record" was reviewed for Lorazepam 0.25mg. The medication had a physician's stop order as above. The staff administered four (4) doses of the medication after the stop date. The "Controlled Substance Record" dated November 11, 2008, indicated that the Lorazepam 0.25mg was removed from the controlled substance drawer to administer on November 29, and 30, 2008 and December 11 and December 12, 2008. There was no documentation that the physician had written orders to restart the Lorazepam 0.25mg dose. B. Facility staff administered Ativan 0.5 mg to Resident JH2 after the order was discontinued. A physician's order was signed and dated on July 16, 2008 that directed, " D/C [Discontinue] Ativan 0.5mg po [by mouth] q6h every 6 hours prn [as needed] agitation/combativeness ... " On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all " as needed " medication. Resident JH2 ' s " Controlled Substance Record" was reviewed for Lorazepam 0.5 mg. The medications had a physician's order that discontinued the medication on July 16, 2008, however, the staff continued to administer the medications to the resident. The "Controlled Substance Record" dated December 27, 2008, indicated that the Lorazepam 0.25 mg was removed from the controlled substance drawer to administer on December 2, 2008. There was no documentation	L 052	JH2, JH6, 1. There were no negative outcome to residents as a result of the staff not consistently documenting controlled substance medication given to the residents. 2. All other residents with orders for PRN controlled substance medications medical records were checked and corrected if required. 3. All appropriate licensed nurses were counseled regarding requirements of documentation for all controlled substance medications. Nursing Leadership provide in-service to the licensed nurses regarding Required Documentation of Control Substance Medications on 1/31, 2/1 and 2/2/09. 4. Documentation of Controlled Substance Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 052	Continued From page 11 that the physician had written orders to restart the Lorazepam 0.5 mg dose. C. Facility staff administered Ativan 0.5 mg to Resident JH6 after the order was discontinued. A physician's order was signed and dated on June 19, 2008 that directed, " Disc. [Discontinue Ativan 0.25 mg po [by mouth] bid [twice daily] x [times] 14 days for organic syndrome." There were no additional orders to administer Ativan 0.25 mg after the above cited order. On December 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the facility staff was requested to identify all " as needed " medication. Resident JH6's "Controlled Substance Record" was reviewed for Lorazepam 0.25 mg. The medications had a physician's order that discontinued the medication on June 19, 2008, however, the staff continued to administer the medications to the resident. The "Controlled Substance Record" indicated that Ativan 0.5 mg was removed from the controlled substance drawer on July 7, 8, 19, 21 and 27, 2008 and August 14 and 22, 2008 and November 7, 2008 and December 13, 2008. There was no documentation that the resident was administered the above cited medications. A face-to face interview was conduct on December 17, 2008 with Employees #2, 4 and 16 after each medical record review. They acknowledged that the medications were removed from the controlled substance drawer and administered without a physician's order. 4. Facility staff failed follow the physician's order	L 052	JH6 1. The resident was monitored for adverse effects of Ativan. The resident did not have any negative outcome as a result of receiving medication that had been discontinued. 2. All other residents with discontinued orders for Ativan were checked and corrections were made if required. 3. Nursing Leadership team provided in-service on Discontinuing Medications as order on 1/31 and 2/1/09. 4. Discontinued Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09.	

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L 052	Continued From page 12 for use a scoop plate at meal time for Resident F1. On December 15, 2008 between 1:30 PM and 1:40 PM, Resident F1 was observed being fed by Employee #17. The resident was being fed with plastic cutlery and the food was served on a black styrofoam plate. A review of the tray ticket for Resident F1 revealed,"...Styrofoam Only and Hard Plastic Only". A review of the December 2008 " Physician ' s Order " form signed by the physician on December 9, 2008 directed, " Diet: ...Scoop Plate at all meals- No glass or ceramic dishes..." A review of the plan of care " ...Nutrition/hydration due to need for a mechanically altered diet... Resident throws dishes off meal tray... " last updated December 4, 2008 revealed, " ...Interventions- ...nothing glass or ceramic, scoop plate 2nd [to] throws plate..." A face-to-face interview was conducted on December 18, 2008 at 11:00 AM with Employee # 4. He/she acknowledged that Resident F1 was not being served on a scoop plate as ordered by the physician. The record was reviewed on December 18, 2008. 5. Facility staff failed to provide adequate supervision for Resident F2 who was observed using the bathroom with temporarily stored equipment. On December 17, 2008 at 10:17 AM, the tub room/bathroom was observed during the environmental rounds. The tub/bathroom was	L 052	1. The attending physician discontinued scoop plate for resident #F1 on 12/17/08. The above resident did not have any negative outcomes. 2. Other residents with orders for scoop plates were observed. There were no other residents missing scoop plates. 3. Nursing Leadership provided in-service to the staff on use of special equipment on 2/1 and 2/3. 4. Residents with special feeding adaptive equipment will be monitored through quarterly CQI. 5. Completion date 2/5/09.	

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L 052	Continued From page 13 observed to have approximately two (2) battery chargers for equipment, one (1) standing/ upright fan, one (1) geri chair recliner stationed in front on the hand wash sink, one (1) [name brand] lift in front of the paper towel dispenser, one (1) electric wheel chair, two (2) wheel chairs, and one (1) tub which was currently out of order. On December 17, 2008 at 10:23 AM, Resident F2 was observed entering the above observed tub/bathroom without assistance and he/she closed the door to the room. The surveyor summoned Employee #23 and queried as to Resident F2 using this particular tub/bathroom alone. He/she replied, " He/she is alert and comes in here [the tub/bathroom] or his/her room to use the bathroom." The quarterly Minimum Data Set completed December 10, 2008, revealed, "Section B2 [Memory] coded resident F2 and having short and long term memory loss; Section G1. [Physical Functioning and Structural Problems] coded resident as requiring supervision and setup help only when toileting. A face-to-face interview was conducted on December 17, 2008 at 10:33 AM with Employee #4. He/she stated, "The room [tub/bathroom] is occasionally used. We put the Geri chairs here. The tub is not working. We temporarily store things here. Occasionally, alert residents use the bathroom in here. If residents are not alert they are taken to the bathrooms in their rooms." The record was reviewed on December 18, 2008. 6. Facility staff failed to secure a bottle of hydrogen peroxide in Resident F3 ' s room. On December 17, 2008 at 10:03 AM, a bottle of hydrogen peroxide was observed on the night stand in Resident F3's room.	L 052	Resident # F2 and F3 1. Resident #F2 had no negative outcome from using the bathroom in a room with stored equipment. The equipment was removed from the tub room on 12/17/08 and the resident continues to be monitored Resident #F3 had no negative outcome from the hydrogen peroxide being left at the bedside. The hydrogen peroxide was removed from the resident's room on 12/17/08. 2. All other nursing units were checked to ensure that residents were not using the bathrooms in the tub room without supervision. There was no stored equipment in the tub rooms on the other nursing units. All residents rooms were checked and no hydrogen peroxide was found at the residents bedside. 3. Nursing Leadership provided an in-service on Supervision of Residents' Safety and Prevention of Chemical Liquids at Bedside to Avoid Accidents to the nursing staff on 1/31 and 2/1/09. 4. Supervision of Resident Safety and Prevention of Residents Accidents will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 052	Continued From page 14 A review of Resident F3's clinical record lacked orders and/or directives for use of hydrogen peroxide. The finding was observed in the presence of Employees #11 and 13; and on December 18, 2008 at 11:07 AM, Employee #4 observed and acknowledged the bottle of hydrogen peroxide on the night stand in the resident's room. The record was reviewed on December 18, 2008.	L 052		
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 that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on a closed record review and staff	L 128		

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L 128	Continued From page 15 interview for one (1) of 24 sampled residents, it was determined that the pharmacist failed to report that there was no attempted dose reduction for Resident #22 who was prescribed Klonopin for nine (9) months. The findings include: A review of Resident #22's record revealed a physician's order initiated November 11, 2007, directing, "Klonopin 0.5 mg at bedtime for psychotic features." The above cited order was renewed December 31, 2007, January 28, February 11, March 23, April 28, May 27, June 6, July 29, August 28, September 18, and October 27, 2008. According to the "Chronological Record of Drug Regimen Review," the pharmacist conducted a review of the resident's medication on December 3, 2007, January 20, February 5, March 5, April 1, May 6, June 30, July 31, August 30, September 25, and October 21, 2008. There was no evidence that the pharmacist reported to the physician and Director of Nursing that a gradual dose reduction for Klonopin was not attempted since the medication was ordered on November 11, 2007. A face-to-face interview was conducted with Employee #9 on December 16, 2008 at 11:30 AM. He/she acknowledged that there were no irregularities reported by the pharmacist regarding the use of Resident #22's Klonopin. The record was reviewed December 15, 2008.	L 128	1. There was no noted negative outcomes of resident #22 as a result of no attempted dosage reductions of Klonopin for nine months. Resident expired on November 11, 2008. 2. A thorough audit of all residents on Klonopin was conducted and no reductions were required at this time. 3. An in-service to consultant pharmacist was conducted by Pharmacy Director on importance of psychotropic dosage reductions. 4. Dosage reduction will be monitored quarterly through CQI. 5. Completion date 2/5/09	
L 142	3226.2 Nursing Facilities	L 142		

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L 142	Continued From page 16 Each dose of medication shall be properly and promptly recorded and initiated in the resident's medical record by the person who administers it. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that for six (6) of 13 resident observed in the medication pass, that facility staff failed to consistently document the administration of controlled substances on the Medication Administration Records (MARs), remove discontinued medication from the medication carts and reconcile the dispensation for four (4) of four (4) residents reviewed receiving antibiotics. The findings include: 1. The facility staff failed to consistently document the administration of controlled substance on the May, June, September, October and November 2008 MAR for Residents JH2, JH3, JH4, JH6, JH8 and #3. A. On December 16, 2008, at approximately 2:00 PM, a review of Resident JH2's record revealed a physician's order dated April 10, 2008 that directed, "Lorazepam 0.5 mg, Give one (1) tablet by mouth every 6 hours as needed for agitation/combativeness." The May and June 2008 MARs were reviewed and indicated that Lorazepam 0.5 mg was administered on May 4, 2008, as evidenced by nurse's initials entered in the allotted areas for May 4, 2008. There was no evidence the resident received the medication in June 2008 as evidenced by a lack of nurse's initials entered in the allotted area.	L 142	JH2, JH3, JH4, JH6, JH8, and 3 1. There were no negative outcome to residents as a result of the staff not consistently documenting controlled substance medication given to the residents. 2. All other residents with orders for PRN controlled substance medications medical records were checked and corrected if required. 3. All appropriate licensed nurses were counseled regarding requirements of documentation for all controlled substance medications. Nursing Leadership provided in-service to the licensed nurses regarding Required Documentation of Control Substance Medications on 1/31, 2/1 and 2/2/09. 4. Documentation of Controlled Substance Medications will be monitored quarterly through CQI. 5. Completion date 2/5/09	

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L 142	Continued From page 17 The "Controlled Drug Record " indicated the Lorazepam 0.5 mg was removed from the controlled substance drawer on May 19 and 29 and June 8, 2008. There was no evidence on the May or June 2008 MAR that the Lorazepam 0.5 mg was administered on May 19 and 29, and June 8, 2008. The record was review on December 16, 2008. B. On December 16, 2008, at approximately 12:20 PM, a review of Resident JH3's record revealed a physician's order dated November 24, 2008 that directed, "Ativan 0.25 mg [po] by mouth [q12h] every 12 hours [prn] as needed for agitation." The November and December 2008 MARs were reviewed and indicated that Ativan 0.25 mg was administered on November 24 and 25, 2008 and December 12 and 15, 2008, as evidence by nurse's initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Ativan 0.25 mg was removed from the controlled substance drawer on November 26, 27, 29 and 30, 2008 and in December 1, 2, 11 and 15, 2008. There was no evidence on the November or December 2008 MARs that the Ativan 0.25 mg was administered on November 26, 27, 29 and 30, 2008 and in December 1 and 2, 2008 to the resident. The record was review on December 16, 2008. C. On December 16, 2008, at approximately 11:30 AM, a review of Resident JH4's record revealed a physician's order signed, but not dated for November 2008, that directed, "Oxycodone/APAP (Roxicet) 5 mg-325 mg	L 142		

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L 142	Continued From page 18 tablet, Give 2 tabs (via peg-tube) every 4-6 hours as needed for pain *Not to exceed 4 grams in 24 hours*. " The November and December 2008 MARs were reviewed and indicated that Oxycodone/APAP (Roxicet) 5 mg-325 mg was administered November 12, 20 and 25 and December 16, 2008, as evidence by nurse's initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record " indicated the Oxycodone/APAP (Roxicet) 5 mg-325 mg was removed from the controlled substance drawer on November 12, 14, 17, 20 and 25 and December 1, 5 and 16, 2008. There was no evidence on the November or on the December 2008 MAR that the Oxycodone/APAP (Roxicet) 5 mg-325 mg was administered on November 14 and 17, 2008 and December 1 and 5, 2008. The record was review on December 16, 2008. D. On December 17, 2008, at approximately 1:30 PM, a review of Resident JH6's record revealed a physician's order dated August 5, 2008 that directed, "Ativan 0.5 mg, po [by mouth] bid [twice daily] prn [as needed] for agitation." The August and September 2008 MARs were reviewed and indicated that Ativan 0.5mg was administered August 14, 2008, as indicated by the nurse's initials entered in the allotted areas. There were no nurse's initials recorded for September 2008. The "Controlled Drug Record " indicated the Ativan 0.5mg was removed from the controlled substance drawer on August 5, 6 and 14, 2008.	L 142		

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L 142	Continued From page 19 There was no evidence on the MARs that Ativan 0.5 mg was administered on August 5 and 6, 2008. The record was review on December 17, 2008. E. On December 17, 2008, at approximately 2:30 PM, during a review of Resident JH8's record revealed a physician's order dated November 8, 2008 that directed, "Oxycodone w/APAP 5mg/325mg tablet, one[1] tablet by mouth every four hours as needed for pain.* Not to exceed 4 grams in 24 hours." The November 2008 MAR was reviewed and indicated that Oxycodone w/APAP 5 mg/325 mg tablets were administered on November 9 (twice), 12, 13 (twice), 18 and 20, 2008, as evidence by the nurse's initials entered in the allotted areas. The "Controlled Drug Record" indicated the Oxycodone w/APAP 5 mg/325 mg tablet was removed from the controlled substance drawer on November 8, 9(once), 10, 12, 13 (twice), 15, 19, 20, 22 and 26. There was no evidence on the November 2008 MAR that the Oxycodone w/APAP 5 mg/325 mg tablet was administered on November 8, 10, 15, 19, 22 and 26, 2008. The November 2008 MAR indicated that the Oxycodone w/APAP 5 mg/325 mg tablet was administered on November 9(once) and 18, 2008. There was no indication on the "Controlled Drug Record" that the medications were removed from the controlled substance drawer. The record was review on December 17, 2008	L 142		

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L 142	Continued From page 20 F. On December 18, 2008, at approximately 2:10 PM, a review of Resident #3's record revealed a physician's order dated March 19, 2008 that directed, "Lorazepam 0.5 mg po [by mouth] q8h [every 8 hours] prn [as needed] for agitation times 2 weeks." The March 2008 MAR was reviewed and indicated that Lorazepam 0.5 mg was administered on March 19, 20, 21 and 25, 2008 as evidence by nurse's initials entered in the allotted areas. The "Controlled Drug Record" indicated that Lorazepam 0.5 mg was removed from the controlled substance drawer on March 19, 21 and 25. There was no evidence that the Lorazepam 0.5 mg was removed from controlled substance drawer on March 20, 2008. A face- to- face interview was conducted immediately after each resident's record was reviewed with Employees #2, 3, 4, 10, 15 and 16. They acknowledged that the documentation between the above cited MARs and the "Controlled Substance Records" was inconsistent for all the above cited residents. The records were review on December 18, 2008. 2. Facility failed to reconcile the dispensation of antibiotics for four (4) of four (4) residents reviewed. Residents: JH5, #5, 9 and 16. On December 17, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, a list of residents on antibiotics was requested; randomly chosen resident records of antibiotic medications were requested to be reviewed. Residents: JH5, #5, 9 and 16.	L 142	1. The residents were monitored for signs and symptoms of infection. The residents vital signs including temperature remained within normal limits. There we no negative outcomes to residents that did not receive the complete doses of the antibiotics as ordered No new orders were received for above residents. 2. All other residents with orders for antibiotics were checked and corrections were made if required. 3. All appropriate licensed nurses were counseled regarding administration of all medications as ordered by the attending physician. Nursing Leadership provided in-services on Medication Administration on 1/31, 2/1 and 2/2/09. 4. Accurate Medication Administration will be monitored through quarterly CQI. 5. Completion date 2/5/09	

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L 142	Continued From page 21 A. A physician's order signed and dated December 11, 2008 directed, "Nitrofurantoin 100 mg capsule po [by mouth] one caps qid [four times a day] for UTI [Urinary Tract Infection] x [times] 2 [two] days " for Resident JH 5. On December 17, 2008, the Nitrofurantoin blister package sent from the Pharmacy on December 12, 2008 was observed to contain eight (8) doses of the antibiotic. During the review of the December 2008 MAR for Resident JH5, nurse's initials in the allotted area indicated that eight (8) doses were administered. At the time on the observation, five (5) of the eight (8) doses remained in the blister package. A face-to-face interview was conducted with Employee #5 on December 17, 2008 at 9:50 AM. He/she stated that the additional required doses of Nitrofurantoin were administered from medication that the resident brought to the facility with him/her. There was no evidence on the December 2008 MAR that the additional five (5) doses were given from the medication that the resident brought into the facility. B. A physician's order signed and dated December 10, 2008 that directed, "Bactrim DS 1 [one] po [by mouth] bid [twice a day] x [times] 10 days for UTI." for Resident #9. The Bactrim DS blister package sent from the Pharmacy contained 20 doses of antibiotic. During the review of the December 2008 MAR for Resident #9, nurse's initials in the allotted area indicated that 16 doses were administered. At the time on the observation, eight (8) of the 16 doses remained in the blister package.	L 142		

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L 142	Continued From page 22 C. A physician's order signed and dated December 10, 2008 that directed, "Bactrim DS 1 [one] po [by mouth] bid [twice a day] x [times] 7 [seven] days for UTI. " for Resident #16. The Bactrim DS blister package sent from the Pharmacy contained 14 doses of antibiotic. During the review of the December 2008 MAR for Resident #16, nurse's initials in the allotted area indicated that nine (9) doses were administered. At the time on the observation, five (5) of the 16 doses remained in the blister package. D. A physician's order signed and dated December 12, 2008 that directed, "Nitrofurantoin 25mg / 5ml; 20 mls (100 mg) via g-tube every 12 hours for 4 [four] days" for Resident JH4. The Pharmacy dispensed a bottle of 160 ml of Nitrofurantoin suspension to the facility. During the review of the December 2008 MAR for Resident JH4, nurse's initials in the allotted area indicated that 160 mls were administered. At the time on the observation, 60 mls of the 160 mls remained in the container. A face-to-face interview was conducted immediately after the review of the residents' records with Employees #5 and 10. They acknowledged that the number of doses of antibiotics remaining did not match the number of doses that were initialed as administered to the resident, without additional explanation.	L 142		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from	L 161		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 23 usage. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 24 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to remove discontinued medications from the medication carts for Residents JH7, JH6, JH5, JH2 and #3. Facility staff failed to remove discontinued medications that were discontinued as per physician order from the medication carts for Residents JH7, JH6, JH5, JH2 and #3. On December 16 and 17, 2008, between 9:00 AM and 3:00 PM, during the inspection of the medication carts, the following medications were observed stored in the medication carts after the physician discontinued the medication. 1st Floor Diphenoxylate/ Atropine [Lomotil] 2.5-0.25 mg, 15 tablets, physician's order dated September 16, 2008 at 1:00 PM, "D/C Lomotil" for Resident JH7. Lorazepam 0.25mg, 17 tablets, physician's telephone order dated June 19, 2008, no time, continue Ativan 0.25 mg po bid x 14 days for organic syndrome" for Resident JH6. Nitrofurantoin 100mg, 8 capsules, physician's order dated December 11, 2008 at 6:00 PM, "Nitrofurantoin...100 mg caps, qid (four times daily) for UTI (Urinary Tract Infection) x 2 days" for Resident JH5. 2nd Floor Lorazepam 0.5mg, 24 tablets, physician's order	L 161	JH7, JH6, JH5, JH2 1. All discontinued medications were removed from the medication carts for above residents. The residents were monitored and had no negative outcome. 2. All medication carts were checked for evidence of discontinued medications and were removed if required. 3. Nursing Leadership Team provided in-service on Removing Expired Medication from Medication Cart on 2/1 and 2/3/09. 4. Discontinued Medications in Medication Cart will be monitored quarterly through CQI. 5. Completion date 2/5/09.	

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	HFD02-0019	A. BUILDING _____ B. WING _____	12/18/2008

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L 161	Continued From page 24 dated July 15, 2008 at 4:00 PM, "D/C Ativan 0.5 mg po [by mouth] q [every] 6 hrs prn [as needed] for agitation/combativeness secondary to non-use..." for Resident JH2. Lorazepam 0.25mg, 20 tablets, physician's order dated November 12, 2008, no time, "Decrease Ativan to 0.25 mg po [by mouth] qhs [at bedtime] x 7 days then Ativan 0.25 mg po [by mouth] qhs [at bedtime] every other day x 7 days and stop" for Resident #3. Lorazepam 0.5 mg, 11 tablets, physician's order dated March 19, 2008 no time, "Ativan 0.5 mg po [by mouth] q [every] 8 hrs [hours] prn [as needed] agitation x 2 weeks" for Resident #3. A face- to- face interview was conducted immediately after each resident's record review with Employees #4 and 5. They acknowledged that the medication should have been removed when the physician discontinued the medication.	L 161		
L 182	3229.4 Nursing Facilities In conjunction with the resident's admission, stay, and discharge, the functions of the social services program shall include the following: (a)Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b)Advocacy on behalf of residents; (c)Discharge planning; (d)Community liaison and services;	L 182		

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L 182	Continued From page 25 (e)Consultation with other members of the facility's Interdisciplinary Care Team; (f)Safeguarding the confidentiality of social service records; and (g)Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality. This Statute is not met as evidenced by: Based on record review of a closed record and staff interview for one (1) of 24 sampled resident records, it was determined that the social worker failed to follow-up with the home health agency for Resident #24 who was discharged home. The findings include: A review of Resident #24's record revealed that the resident was admitted to the facility on October 24, 2008 and discharged home on December 1, 2008. A review of the social worker' s note dated November 12, 2008, no time indicated, "This social worker completed a face to face discussion with resident regarding discharge and projected date ...Resident reported that [he/she] had home health aide prior to [facility] admission and expressed a desire to continue the services from that agency. However, [he/she] could not recall name of agency or phone. Resident agreed to try to locate name and telephone number of agency and forward this information to this social worker. Resident expressed a willingness to switch to another agency if contact information could not be located."	L 182	1. There was no documentation on the discharge summary re: home health agency name and telephone number but, resident received home health services on the day after discharge. 2. All resident discharges to home were reviewed for completeness of documentation in the discharge summary form. All discharges needing home health services had the name of the home health agency identified. 3. The Social Services Director provided an in-service on the importance of complete documentation on the discharge summary and progress notes on to the Social Worker on 2/4/09. 4. Documentation on discharge summary will be monitored through quarterly CQI. 5. Completion date: 2/5/09	

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L 182	Continued From page 26 There was no further entry of the social worker's progress notes in the record. A review of the facility's discharge summary revealed that the home health agency name and telephone number were not documented on the form. A face-to-face interview with Employee #5 was conducted on December 16, 2008 at 11:10 AM. Employee #5 acknowledged that the name of the home health agency was not included on the discharge summary form. The record was reviewed December 16, 2008.	L 182	1. Resident #18 had no negative outcome as a result of wandering behavior. Medical records updated to include wandering behavior. Resident #22 expired on November 11, 2008, therefore, Medical record cannot be updated. 2. All other residents with wandering and inappropriate behavior medical records' were check and updated as needed. 3. Nursing Leadership provided an in-service on Documentation regarding Socially Inappropriate Behavior and Wandering on 1/31, and 2/3/09. 4. Residents with inappropriate behavior and history of wandering will be monitored for documentation through quarterly CQI. 5. Completion date 2/5/09.	
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 24 sampled residents and one (1) supplemental resident, it was determined that facility staff failed to consistently document the resident's condition: one (1) resident for socially inappropriate behaviors and wandering behaviors for one (1) resident for Residents #18 and 22. The findings include: 1. Facility staff failed to document wandering behaviors for Resident #18. A review of the Interim Order Form for Resident #18 revealed: "Resident transferred from Rm	L 199		

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L 199	Continued From page 27 (Room) 120 to 131B." According to a nurse's note dated December 8, 2008 at 6:00 PM, "Resident transferred to room 131B all personal belongings moved ...to new room ... " The resident's clinical record and facility's 24 hour report record lacked evidence of the resident's alleged wandering behavior. On December 18, 2008 the resident was observed several times throughout the day, sitting quietly with other residents in the dayroom . A face-to-face interview was conducted with Employee #5 on December 18, 2008 at approximately 12:45 PM. He/she stated, "The resident attempted to leave the unit three (3) times via the stairs close to room 120. The door alarm did not deter the resident on each occasion. I know the staff failed to document the resident's wandering behavior. They failed to document in the resident's chart. I cannot find any documentation in the 24 hour report log either. The resident has since calmed down with less wandering." A face-to-face interview was conducted with Employee #14 on December 18, 2008 at approximately 1:00 PM. He/she acknowledged that the resident was transferred to room 130 for increased supervision because of three (3) attempts to leave the unit via the stairs and was undeterred by the door alarm. The record was reviewed December 18, 2008. 2. Facility staff failed to document socially inappropriate behaviors for Resident #22.	L 199		

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L 199	Continued From page 28 Face-to-face interviews were conducted with Employees #5 and 6 on December 15, 2008 at 3:15 PM. Both employees stated that Resident #22 frequently spit on the walls and curtains, masturbated daily, removed the feeding tube dressing and would place [his/her] feeding tube into her vagina several times per week, and two (2) to three (3) times per week would disrobed, suggestively dance in front of male residents and staff, rub the "private areas" of male residents and staff and once grabbed the "private area" of a male staff member. The "Behavior Monitoring Flow Records" for Resident #22 were reviewed from March through November 2008. The behaviors cited above were not included on the monitoring sheets for the months reviewed. "Inappropriate touching" was monitored for August, September and October, 2008. According to the "Behavior Monitoring Flow Record" episodes for inappropriate touching occurred on August 11 and 21, 2008 and October 25, 29 and 30, 2008. There were no nurses' notes explaining the episodes of inappropriate touching for the above cited dates. A face-to-face interview with Employee #9 was conducted on December 16, 2008 at 9:30 AM. He/she acknowledged that the aforementioned behaviors were not monitored and that the incidents that occurred on the above cited dates should have been explained in the nurses' notes. The record was reviewed December 15, 2008.	L 199		
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title	L 359		

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L 359	Continued From page 29 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations in the main kitchen on December 15, 2008 between 9:00 AM and 12:40 PM, it was determined that the facility failed to maintain the stove and steam table in good operating condition. The findings include: 1. The stove was observed to have three (3) of six (6) knobs missing 2. The steam tables were observed to have four (4) of six (6) knobs missing Employee #12 acknowledged these findings at the time of these observations.	L 359	1. The missing knobs on the stove and steam tables were all replaced. 2. All equipment were checked for missing knobs. There were no other equipment in need of knob replacement. 3. Knob check was included as part of the preventive maintenance procedure and replacement knobs maintained in the department. 4. Environmental rounds will include observation of missing knobs. Findings will be reported to CQI quarterly. 5. Completion date: 2/5/09 L410 #1 1. The damaged tile in the second and third floor shower rooms were replaced. 2. All shower rooms were checked for evidence of cracked or damaged tiles. There were no other damaged tiles found. 3. Protective wall covers were installed as a means of protecting damage to walls. 4. Environmental rounds will include observation for evidence of cracked tiles. Findings will be reported to CQI quarterly. 5. Completion date: 2/05/09 L410 #2 1. Bed frames observed to be dusty were immediately cleaned. No residents were affected by this observation.	12/19/08 12/19/08
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 environmental tour, it was determined that facility staff failed to maintain a clean and sanitary environment as evidenced by: damaged tile in the shower rooms, soiled/dusty bed frames, and privacy curtains and over the bed trapeze bars. The environmental tour was conducted on December 17, 2008 from 9:10 AM through 11:35 AM in the presence of Employees #11 and 13. The findings include:	L 410		

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L 410	Continued From page 30 1. Tile was observed damaged in two (2) of six (6) resident shower rooms observed; 2nd and 3rd floor shower rooms. 2. Bed frames were observed with accumulated dust in four (4) of 25 resident rooms observed; rooms: 311, 315, 318, and 322. 3. Privacy curtains were observed soiled in four (4) of 25 resident rooms observed; rooms: 311, 315, 318, and 322. 4. Trapeze bars were observed with accumulated dust in two (2) of 25 resident rooms observed; rooms: 315 and 322. Employees #11 and 13 acknowledged these findings at the time of these observations.	L 410	L 410 #2 - Continued 2. Housekeeping staff will perform routine cleaning. Daily inspection will be done by EMS supervisor to ensure compliance. 3. In-service on Environmental Infection Control: high and low dusting bed cleaning steps. 4. CQI process will be put in place to monitor compliance quarterly. 5. Continuous monitoring procedure. L 410 #3. 1. Privacy curtain observed to be soiled were changed immediately. No residents were affected by this observation. 2. All other rooms were inspected for soiled curtains and changed as needed. 3. In-service on Cubicle Curtain Changing Procedure given to staff by supervisor. 4. CQI process will be put in place to monitor compliance 5. Continuous inspection in effect procedure is going on a daily basis. L 410#4 1. No residents were affected by this observation. Housekeeping services corrected it immediately. 2. All other trapeze bars were checked for dust accumulation and cleaned as needed. 3. Daily inspection will be done by EMS supervisor will ensure compliance. In-service on environmental services, high and low dusting procedure. 4. CQI process will be put in place to monitor compliance quarterly. 5. Continuous monitoring procedure is going on a daily basis.	on going. 12/17/08 on-going 12/17/08