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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095035	A. BUILDING _____ B. WING _____	11/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW SKILLED NURSING	2041 GEORGIA AVE, NW WASHINGTON, DC 20060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 000	Initial Comments An annual licensure survey was conducted November 15 through 16, 2006. The following deficiencies were based on observations, staff interviews and record review. The survey included 8 sampled residents based on a census of 15 the first day of survey and one (1) supplemental resident.	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 and resident interviews for six (6) of eight (8) sampled residents, it was determined that facility staff	L 051	**1 A, B, C** The care plan for Resident #1 has been updated to monitor for possible side effects of Plavix. All future residents on Plavix will likewise be monitored. Resident #2 was discharged from the facility back into acute care. All patients identified as having physician orders for plavix, lovenox, coumidin, and aspirin will be monitored for possible actions/ Interactions. Care plans will be developed, reviewed and updated as necessary. Patient education will be a key aspect of care. We have put into place a system to monitor so as to ensure effectiveness. The intent is to monitor nurses' compliance to developing care plans relative to anticoagulant therapy, hemolytic agents, and plaque aggregation inhibitors.	11/27/06 11/27/06 11/27/06 11/27/06

Health Regulation Administration

Nora J. Wagner — TITLE Administrator — (X6) DATE 12/21/06

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

STATE FORM 6899 9XJS11 If continuation sheet 1 of 25

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L 051	Continued From page 1 failed to develop a comprehensive care plan with goals and approaches for: three (3) residents receiving anticoagulant therapy; activities for three (3) residents on isolation; nine (9) or more medications for six (6) residents; the medication needs for one (1) resident; and amend the care plans for two (2) residents for fluid restriction and falls. Residents #1, 2, 3, 4, 6 and 7. The findings include: 1. Facility staff failed to develop a comprehensive care plan with goals and approaches for three (3) residents receiving anticoagulant therapy. A. A review of Resident #1's record revealed a physician's order dated, October 31, 2006, " Plavix 75 mg po (orally) Q (every) day." There was no evidence that facility staff initiated a care plan with appropriate goals and approaches for monitoring the side effects of Plavix. A face-to-face interview with the Director of Nursing was conducted on November 15, 2006 at 2:30 PM. He/she acknowledged that there was no care plan developed for Plavix. The record was reviewed November 15, 2006. B. A review of Resident #2's record revealed a physician's order dated, October 18, 2006, " Lovenox 30 mg qd." There was no evidence that facility staff initiated a care plan with appropriate goals and approaches for monitoring the side effects of Lovenox. A face-to-face interview with the Director of Nursing was conducted on November 15, 2006 at	L 051	To ascertain that this solution is sustained and that compliance is achieved, results of the weekly monitoring of the new review tool will be presented to the Director of Nursing weekly. and will be incorporated into our performance improvement program with both monthly and quarterly reporting The Director of Nursing, the Medical Director, and Administrator will monitor for compliance	11/28/06

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L 051	Continued From page 2 2:30 PM. He/she acknowledged that there was no care plan developed for Lovenox. The record was reviewed November 15, 2006. C. A review of Resident #6's record revealed a physician's order dated, October 31, 2006, " Coumadin 5mg po Q (every) daily and Aspirin 81 mg po Qdaily." There was no evidence that facility staff initiated a care plan with appropriate goals and approaches for monitoring the side effects of Coumadin and Aspirin. A face-to-face interview with the Director of Nursing was conducted on November 15, 2006 at 2:30 PM. He/she acknowledged that there was no care plan developed for Coumadin and Aspirin. The record was reviewed November 15, 2006. 2. Facility staff failed to initiate a care plan with appropriate goals and approaches for recreational activities for three (3) residents on contact isolation. A. A review of Resident #2's record revealed an assessment for therapeutic recreational activities dated October 19, 2006. According to a telephone order dated October 18, 2006, the resident was placed on contact isolation. There was no evidence in the record that facility staff initiated a care plan with goals and approaches for recreational activities for the resident while on contact isolation. The record was reviewed November 15, 2006. B. A review of Resident #4's record revealed an assessment for therapeutic recreational activities dated September 26, 2006. According to a	L 051	2 A.B.C Care plans for Resident # 2 has been updated to include recreational interests and needs and the approaches and goals for contact isolation. Resident has since been transferred to the hospital as of November 27, 2006. The care plans for Resident # 4 and Resident # 6, have been updated to include recreational interests and needs and the approaches and goals for contact isolation. To identify other residents that may be affected by this deficiency, all care plans for residents on contact isolation have been reviewed. We have initiated care plans and we will continue to initiate and update care plans for the residents' recreational needs when residents conditions change to contact isolation. To prevent this from recurring, we will put a system in place which is a monitoring tool to match physician orders and corresponding care plans. This system will help the nurses, the recreation therapist and the social worker initiate and update care plans when residents conditions change and doctors orders change. Also the licensed nurse with primary responsibility for the residents will ensure that the care plans are in the residents' medical records.	11/13/06 11/19/06 11/20/06 12/8/06 & Ongoing

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L 051	Continued From page 3 telephone order dated November 1, 2006, the resident was placed in contact isolation. There was no evidence in the record that facility staff initiated a care plan with goals and approaches for recreational activities for the resident while on contact isolation. The record was reviewed November 15, 2006. C. A review of Resident #6's record revealed a "Recreation/Activities Interest List", undated. The resident was admitted to the facility on October 30, 2006. According to a telephone order dated November 13, 2006, the resident was placed on contact isolation. There was no evidence in the record that facility staff initiated a care plan with goals and approaches for recreational activities for the resident while on contact isolation. The record was reviewed on November 15, 2006. 3. Facility staff failed to initiate a care plan with appropriate goals and approaches for six (6) residents receiving nine (9) or more medications. A. A review of Resident #1's record revealed current physician's orders for 15 medications. The care plan, initiated on April 27, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the 15 prescribed medications. The record was reviewed on November 15, 2006. B. A review of Resident #2's record revealed current physician's orders for 10 medications. The care plan, initiated on October 18, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the 10 prescribed medications.	L 051	Continuation # 1, A,B,C To ensure that this does not recur, we will establish new system of monitoring physicians orders, with the corresponding interdisciplinary care plans, including updates of those care plans. Also the licensed nurse with permanent assignment for their respective residents will ensure that all disciplines update care plans as required. A second licensed nurse will also utilize tool and review chart for completeness of documentation. To make sure that this solution is sustained and that the correction is achieved tool will be presented to the Director of Nursing and Administrator weekly. This will be incorporated into our performance improvement program with both monthly and Quarterly reporting and analysis. The Director of Nursing, the Medical Director, and Administrator will monitor for compliance. **3. A, B, C, D, E, F** Plan of care has been initiated for resident #1 for potential/actual adverse drug interaction for the 15 prescribed medication. Resident #2 has been transferred to the hospital as of 11/27/06. Future residents with 9 or more medication will have care plans initiated.	11/22/06 & daily 11/27/06 11/27/06

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L 051	Continued From page 4 The record was reviewed November 15, 2006. C. A review of Resident #3's record revealed current physician's orders for 11 medications. The care plan, initiated on October 13, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the 11 prescribed medications. The record was reviewed November 15, 2006. D. A review of Resident #4's record revealed current physician's orders for 12 medications. The care plan, initiated on September 23, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the 12 prescribed medications. The record was reviewed November 15 2006. E. A review of Resident #6's record revealed current physician's orders for nine (9) medications. The care plan, initiated on October 31, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the nine (9) prescribed medications. The record was reviewed November 15, 2006. F. A review of Resident #7's record revealed current physician's orders for 11 medications. The care plan, initiated on October 27, 2006, failed to include a plan of care for potential/actual adverse drug interactions for the 11 prescribed medications. The record was reviewed November 15, 2006. A face-to-face interview was conducted with the Director of Nursing on November 15, 2006 at 2:30 PM. He/she acknowledged that a care plan had not been developed for nine (9) or more medications for the aforementioned residents.	L 051	3 A B C D E F Resident #3 has been discharged home. Future residents with 9 or more medication will have care plans initiated. Plan of care has been initiated for resident #4 for potential actual adverse drug interaction for the 12 medications prescribed. Plan of care has been initiated for resident #6 for potential/actual adverse drug interaction for the 9 medications prescribed. Resident #7 has been discharged home as of 11/22/06. Future residents with 9 or more medications will have care plans initiated. To identify other residents with the potential for this deficiency we have reviewed all residents' charts, and identified all residents with physician orders for nine or more medications. We have updated care plans to include care plans for potential/actual adverse drug interactions. To ensure that this does not recur and that residents with nine or more medications have care plans for potential/actual adverse drug interactions, we will put a system in place which is a checklist to match doctors' orders with care plans. This will trigger nurses to do care plans for residents with nine or more	11/22/06 11/27/06 11/27/06 11/22/06 12/4/06 12/8/06

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L 051	Continued From page 5 4. Facility staff failed to initiate a care plan with appropriate goals and approaches for Resident # 7, who requested medication to be given after a rehabilitation session. A face-to-face interview with Resident #7 was conducted on November 15, 2006 at 3:25 PM. The resident stated, "I asked for my Lasix to be given after I get back from my therapy session, so I don't have any problem during the session. I go to therapy every day about 10 o'clock and I return about lunchtime." The physician's order dated October 23, 2006 directed, "Lasix 20 mg po daily." The medication was scheduled on the Medication Administration Record to be administered at 10:00 AM. The resident was scheduled for rehabilitation therapy at 9:45 AM, five (5) days per week. A review of the care plan, initiated October 27, 2006, revealed that the resident's request was not included in the plan of care. A face-to-face interview was conducted with the charge nurse on November 15, 2006 at 3:40 PM. He/she stated, "[Resident] asked me to hold the Lasix until [resident] returns from therapy." The record was reviewed on November 15, 2006. 5. Facility staff failed to amend the care plan for two (2) residents; one (1) on fluid restriction and one (1) resident with a history of falls. Residents #2 and 3. A. Facility staff failed to amend Resident #2's care plan for fluid restriction. A review of Resident #2's record revealed a physician's order dated November 8, 2006, "1000	L 051	3 A B C D E F medications. We have implemented a system of permanent assignment for nurses, and the nurses will initiate care plans and will ensure that care plans are completed for the residents, and that the care plans are in residents charts. #4 Resident #7 has been discharged home as of 11/22/06. Future residents admitted who requests change in their dosing times for medication will be care planned as to his/her right to make request, and reason for the request. To identify residents that may be affected nurses were asked as to whether they had received special requests from residents and they were instructed that such request should be discussed with the attending physician and care planned. We had put a system in place prior to the survey, of permanent assignment for licensed nurses. The nurse with primary responsibility for the residents will care plan care residents' requests for change in dosing times We also have developed a policy and procedure for Care Plan Development and updates	12/8/06 & Ongoing 11/22/06 11/22/06 & Ongoing 11/27/06 & Ongoing

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STATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 051	Continued From page 6 cc fluid restriction." A review of the care plan initiated October 18, 2006, revealed that the plan of care, " Potential for " Alteration in Nutritional/ hydration " was not amended to reflect the 1000 cc fluid restriction. A face-to-face interview with the charge nurse was conducted on November 15, 2006 at 11:30 AM. He/she stated, "The fluid restriction notice is posted on the wall (of the resident's room). We don't say how much fluid is supposed to be given each shift. We just record the total amount of fluid every day." The record was reviewed November 15, 2006. B. Facility staff failed to amend Resident #3's care plan after three (3) falls. A review of Resident #3 's record revealed that the resident sustained falls on October 30, November 3 and November 14, 2006. The care plan, "Alteration in Safety" was dated October 14, 2006. The care plan was not amended with new approaches or interventions after each fall. A face-to-face interview was conducted on November 16, 2006 at 3:45 PM with the unit manager. He/she acknowledged that the care plan was not amended after the three (3) falls. The record was reviewed November 16, 2006.	L 051	5A&B Resident #2 has been transferred to a hospital as of November 27, 2006. For future residents that may have a doctors order for fluid restriction, staff have been reminded to implement the fluid restriction protocol already in place, including updating care plan. Resident #3 has been discharged home as of November 22, 2006. However patient education was provided to resident about fall precaution. For future residents who are admitted to the unit and have more falls after the initial care plan, care plan for falls will be updated with new goals and objectives. To identify other residents with potential to be affected by this, we have reviewed care plans for all residents. We continue to review residents' care plans to ensure that care plans for falls and fluid restrictions are initiated and also updated as necessary. Below is the Performance Improvement monitoring for all To ensure that the solutions are effective and sustained the Director of Nursing will assess the permanent nursing assignments weekly and make adjustments as needed. Also results of the checklists developed for care plans will be presented weekly to the Director of Nursing. The Nurse Coordinator, the Director of Nursing and Administrator will monitor for compliance. These will be incorporated in our performance improvement program.	11/22/06 11/22/06 12/1/06 & Ongoing 12/15/06 & Weekly & Qtrly
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			

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L 052	Continued From page 7 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 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.	L 052		

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L 052	Continued From page 8 This Statute is not met as evidenced by: Based on observations, staff interview and record review for five (5) of eight (8) sampled residents, it was determined that sufficient nursing time was not provided to the residents as evidenced by failure to: administer insulin and obtain a CMP (Comprehensive Metabolic Panel) according to physician's orders for one (1) resident; initiate and record intake and output for one (1) resident; administer medications timely for two (2) residents; and maintain contact precautions for three (3) residents on contact isolation. Residents #1, 2, 4, 6 and 7. The findings include: 1. Facility staff failed to administer insulin according to physician's orders, notify the physician for a fingerstick of 65 mg/dl and obtain an ordered CMP for Resident #1. A. Resident #1's physician orders dated October 31, 2006 revealed, "Novolog 18 units sq (subcutaneously) before breakfast, Novolog 18 units sq before lunch, Novolog 17 units sq before dinner, Lantus 60 units QHS (every hour of sleep) and Med (Medium) dose algorithm (Premeal " correction dose" algorithm for hyperglycemia) - 150-199 = 1 unit, 200-249 = 3 units, 250-299 = 5 units, 300-349 = 7 units and .349 = 8 units". The November 2006 Medication Administration Record (MAR) indicated the following: Date/Time Fingerstick level November 5 at 11:30 AM 172 mg/dl November 8 at 5:30 PM 65 mg/dl On November 5, 2006 at 11:30 AM, the nurse indicated on the MAR with initials that Novolog 18 units sq was administered before lunch.	L 052	1 A The licensed staff has started routinely inform attending physician when Resident # 1's blood sugar level is below 70 or above 115 mg/dl. We will revise the current "Blood Glucose Monitoring Form" which includes the following components: Finger stick Results Action taken Outcome and Time of Documentation Normal Glucose Values for Adults at 70-115mg/dl Call Physician This improved tool will serve as a reminder to follow the established protocols and to administer insulin as/when ordered, and communicate to physician. To identify other residents that may be affected, we have reviewed all charts and identified those residents with physician orders for fingerstick.. We continue to review fingerstick documentation to ensure that physicians are been notified when residents' glucose monitoring show reading below 70 mg/dl. The licensed nurses will be responsible to daily monitor all diabetic residents on their permanent assignment to see that this form is utilized correctly.	11/22/06 & Ongoing 12/1/06 11/22/06 & Ongoing 11/22/06 & Ongoing

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L 052	Continued From page 9 However, there were no initials beside the medium dose algorithm indicating that sliding scale insulin of 1 unit was administered. On November 8, 2006 at 5:30 PM, the nurse circled his/her initials on the MAR indicating that Novolog 17 units sq before dinner was not administered. There were no physician's orders to hold insulin. The facility's procedure "PCx Blood Glucose Monitoring" dated May 20, 2005 included: "... e. Circumstances that require follow-up and/or validation from the lab: 1. Notify the physician if the blood glucose is 70 mg/dl or less for adults..." There was no evidence in the record that the physician was notified of the November 8, 2006 level of 65 mg/dl. A face-to-face interview was conducted with the Director of Nursing on November 15, 2006 at 2: 30 PM. He/She acknowledged that the correction dose of 1 unit was omitted on November 5, 2006 and that the nurse held the Novolog 17 units at 5: 30 PM on November 8, 2006 without a physician's order to hold. B. A review of Resident #1's record revealed a physician's order dated November 10, 2006, " ... CMP - today " . A review of the record failed to show evidence of a CMP level drawn on November 10, 2006. A face-to-face interview was conducted with the Director of Nursing (DON) on November 15, 2006 at 2:30 PM. The DON showed the surveyor the results of a Chemistry 7 obtained on November 10, 2006. The surveyor explained to the DON that the Chemistry 7 was not a CMP. A CMP result for November 10, 2006 was not presented	L 052	Continuation of # 1 Prior to the survey we troduced a new system of perman ntly assigning licensed staf . Their responsibilities include eviewing orders to see that they ave been carried out, obtain lab/ ray results for work that has been dered, review/update the plan f care, ascertain that all docun entation is up to date, and providir ; patient education to specifically assigned patients. Having just be n initiated, monitoring will begin 12 11/06 to determine compliance a d will continue to monitor wee ly or as necessary until compli ce has been achieved. Directo of Nursing Will also b e meeting re ularly with licensed staff to clarify i ues or answer questions re: pr cesses. To ensure that the solut n is effective and sustained e Director of Nursing will assess t permanent assignment nd make adjustments as needed. The Nurse Coordinator and Directo of Nursing will monitor for proper u: age of the revised Blood Glucose r onitoring tool. L 052 1B on separate sheet	11/ /06 12/ 5/06 Ong oing

		L052	We have also reviewed certified nurse aide current job responsibilities and duties do not include work outside their scope of service to ensure that this solution is sustained and that it is effective the Administrator, the Director of Nursing, will monitor for compliance. Lab for CMP (Comprehensive Metabolic Panel) orders by physician has been carried out as ordered for resident #1. The results have been obtained, and have been communicated to the physician and the results placed in the residents medical record. We will continue to review resident's charts to make sure that we have carried out correct laboratory orders. We have put a system in place to reduce and/or eliminate errors in ordering CMP (Comprehensive Metabolic Panel) as opposed to CBC. All nursing staff has been instructed as to the component of CMP and CBC soon to ensure the original lab is ordered. Also, the permanent nurse assignment that we have instituted will have instituted will help bring more consistency in patient care. It will enable nurses to review resident charts and residents care in a nurse consistent and comprehensive manner. A second licensed nurse will monitor the nurse coordinator, the Director of Nursing, and Medical Director will monitor for compliance.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL VIEW SKILLED NURSING	2041 GEORGIA AVE, NW WASHINGTON, DC 20060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 10 to the surveyor before the end of the survey. The record was reviewed on November 15, 2006. 2. Facility staff failed to initiate and record the intake and output for Resident #2 when ordered by the physician. A review of Resident #2's record revealed a physician's order dated November 8, 2006 directed, "1000cc fluid restriction". There was no evidence in the record that the intake and output was recorded from November 8 through 13, 2006. An intake and output (I&O) sheet was in the resident's room and entries were present for November 14 and 15, 2006. A face-to-face interview was conducted with the charge nurse on November 15, 2006 at 11:30 AM. He/she stated, "The fluid restriction notice is posted on the wall (of the resident's room). We don't say how much fluid is supposed to be given each shift. We just record the total amount of fluid every day. We just started recording the I&O yesterday. I didn't know it was ordered before yesterday." The record was reviewed November 15, 2006. 3. Facility staff failed to administer the G tube bolus feeding and two (2) oral medications timely to Resident #4. A. The physician's order dated November 9, 2006 and the November 2006 MAR directed, "... Isosource one (1) can tid [three times a day] 10:00AM, 2:00PM and 8:00PM..." On November 15, 2006 at 11:30 AM, the charge nurse was observed administering one (1) can of Isosource to Resident #4 via peg-tube, one-and-a	L 052	2. Intake and Output was being recorded prior resident # 2 's transfer to the acute hospital We have identified other residents that need to be on intake and output and monitor them accordingly. We have initiated a new kardex/Care Plan/ assignment sheet, which has section to alert nurses to which residents are on Intake and Output. Also we have put a system in place for permanent assignment for nurses. Nurses will have primary responsibility for their residents, which will lead to more consistency in patient care, and more familiarity with the needs of the residents. Nurses will be counseled and instructed on the importance of maintaining proper documentation. To ensure that the solution is effective and sustained, the Director of Nursing will assess the permanent assignment weekly, and make adjustments as necessary. The Nurse Coordinator and the Director of Nursing, will review charts and analyze results of the review weekly. The Director of Nursing, Nurse Coordinator will monitor.	

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L 052	Continued From page 11 -half hours (1 ½) late. B. The November 2006 Medication Administration Record directed, Zestril, Lovenox, Prevacid, Plavix and Norvasc to be given daily at 10:00 AM via peg tube. On November 15, 2006 at 12:00 PM, the charge nurse was observed administering the above cited medications to Resident #4 via peg-tube, two (2) hours late. A face-to-face interview was conducted on November 15, 2006 at 11:40 AM with the charge nurse. He/she stated, "The resident gets the feeding at 10:00 AM and 2:00 PM every day." He/she also acknowledged that the bolus feeding was being administered one-and one-half hour late and that the oral medications were administered two (2) hours late. The record was reviewed on November 15, 2006. 4. Facility staff failed to administer six (6) oral medications timely to Resident #7. The November 2006, Medication Administration Record, directed "Prevacid, Lasix, Quinapril, Trusopt, Timolol and Atenelol" to be given daily at 10:00 AM. A face-to-face interview was conducted on November 15, 2006 at 3:25 PM with Resident #7. He/she stated, "I did not get my medication before I went to therapy. When I returned from therapy, a little after 12:00 Noon, I received my medications." A face-to-face interview was conducted on November 15, 2006 at 3:40 PM with the charge nurse. He/she stated, "The resident went to	L 052	3 A & B Resident # 4 has started to consistently receive her Isosource via G-Tube bolus feeding timely at 10:00 A.M. The licensed nurses have been instructed to administer peg-tub feeding timely as ordered by the physician. Resident # 4 has started to consistently receive her zestril, Lovenox, Prevacid, Plavix, and Norvasc timely at 10:00 A.M. The licensed nurses has been instructed to administer medications via peg-tube consistently timely as ordered by the physician. It has been reinforced to licensed that all orders should be given timely as ordered by the physician. To identify other residents that may be affected by this we continue to review doctors orders and Medication Administration Record, and observe nurses giving daily medication to ensure that the medication is being given timely and consistently timely To prevent this from recurring, we have put a system in place just prior to the survey of permanent assignment for nurses. This will lead to consistency of patient care and more familiarity of residents and their needs to ensure timeliness of medication administration. In addition another	11/22/06 11/27/06 11/22/06 11/27/06 12/8/06 11/16/06

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L 052	Continued From page 12 therapy at 9:45 AM and the pharmacy had not delivered the medications for today, so the resident didn't get his/her medications. The resident received his/her medications around 12:15 PM when he/she returned from therapy." He/she acknowledged that the medications were administered over two (2) hours late. The record was reviewed on November 15, 2006. 5. Facility staff failed to maintain contact precautions for three (3) residents on contact isolation. A green sticker entitled, "Contact Precautions" was posted outside the rooms of Residents #2, 4 and 7 and included the following information: " Visitors report to nurses' station before entering room. 1. Private room .... 2. Wear gloves when entering room. Change gloves after contact with infective material. Remove gloves before leaving patient's room. 3. WASH YOUR HANDS immediately with antimicrobial agent before leaving the patient's room. After glove removal and hand washing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganism to other patients or environments. 3. Wear a gown if you anticipate that your clothes will have contact with the patient, environmental surfaces, or items in the patient's room ..." A. A review of Resident #2's record revealed a physician's telephone order dated October 18, 2006 at 9:00 PM indicated, "Contact isolation for MRSA (Methicillin Resistant Staphylococcus Aureus) in the sputum." The following observations were made concerning the care Resident #2 received:	L 052	Continuation #3 A & B registered nurse will do weekly review of residents' charts and compare physicians orders and medication administration record to report any discrepancies. All insistencies will be reported to the Director of Nursing weekly to take corrective action. We will also put a system in place of quarterly medication pass observation by the Director of Nursing, the Pharmacist, and/or the Nurse Coordinator for timeliness of medication pass. Top ensure that this solution is effective and sustained we will analyze the permanent assignment to ascertain how well it is working and make adjustment as necessary. The weekly reporting to the Director of Nursing, and the quarterly medication observation will be incorporated into our performance improvement program. The Nurse Coordinator, Director of Nursing, and the Medical Director will monitor for compliance	12/15/06 & Weekly 12/31/06 & Qrtly 11/22/06 & Ongoing 12/31/06 & Monthly & Quarterly

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L 052	Continued From page 13 A Certified Nurse Aide (CNA) was observed on November 15, 2006 at 11:05 AM repositioning the resident wearing gloves and no gown. A second CNA joined he/her at 11:10 AM to assist in turning and repositioning the resident. The second CNA wore gloves with no gown. A face-to-face interview was conducted immediately after the two (2) CNAs exited the room. The CNAs were queried as to what isolation precautions were in place for the resident. Both CNAs replied that the resident was on contact isolation and that they didn't need to wear a gown because they were only turning the resident. On November 15, 2006 at 3:30 PM the charge nurse was asked the location of Resident #2's intake and output sheet. The intake and output (I&O) sheet was located by the charge nurse in the resident's room. The charge nurse was queried as to why the I&O sheet was located in the resident's room, since the resident was in isolation. He/she replied, "We always put the I&O sheet in the room. Then we don't forget to fill it out." The charge nurse was reminded that the resident was in isolation and asked if placing the I&O sheet in the room was appropriate. He/she did not respond to the question. On November 15, 2006 at 3:45 PM, a CNA was observed coming out of Resident #2's room with the blood pressure machine. When asked if the machine had been cleaned prior to exiting the resident's room, the CNA stated, "The resident has [his/her] own blood pressure cuff. I take the one off the machine and put it in the basket (attached to the back of the machine). I attach the resident's cuff to the machine, take the blood pressure, take off the resident's cuff and put the other cuff back on. I didn't clean the machine	L 052	5A All staff, including certified nursing assistants, have been instructed to always wear gowns plus gloves before they enter a Contact Isolation rooms, if they (staff) enter the room to provide any care services for the residents, including turning resident # 1. They have been instructed to follow contact isolation protocol always. Staff have removed the Intake and Output sheets from Resident # 2's room. We have put I & O sheets directly in the resident's medical record and staff will record information in the medical records every shift. The staff have cleaned and continues to clean blood pressure machine with LPH solution before machine is taken out of Resident # 2's room. To identify other staff and residents rooms that may be affected we continue to reinforce to all staff the need and requirement for following contact isolation protocol. L 052 5A continued on separate sheet	11/22/06 & Ongoing 11/22/06 & Ongoing 11/22/06 & Ongoing 11/22/06 & Ongoing

			Continuation #5A We have put an immediate syst m in place of daily observation of staff when they enter and exit contact isolation rooms to ensur that they follow the protocol of wearing gloves and gowns befor they enter residents' rooms, and that they remove those gloves a gowns before they exit the residents' rooms. We will also pu a visual sign by the entrance to t isolation room: Sign will read "T Staff: Please Observe Protocol before You Enter Room". For residents who require recording of intake and output, w have put a system in place to put such I & O sheets directly in residents' chart/medical records a the nurses station. Nursing staff will record the daily resident's intake and output in resident's medical records every shift. For blood pressure machines and other noncritical machines, we have put a system in place of having the staff to immediately clean the machine with LPH solution after each use prior to the staff leaving the contact isolation room. Because LPH is a strong and potentially harmful substance, it will be kept in the soiled utility room. When a staff member needs to use LPH, the bottle of LPH will be put in the bottom drawer of the isolation cart prior to entering the room. After finish using the blood pressure machine, and before using the LPH, the staff member will have to remove their gloves, reglove to get the LPH bottle and clean the machine, careful not to set down in the room. We have also added Infection Control as a more frequent Core Competency for all staff. The core competency will be required twice a year.	12/4/06 & Daily & Ongoing 11/22/06 & Ongoing 11/22/06 & Daily & Ongoing 12/31/06 & Biannually

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L 052	Continued From page 14 before I took it out of the room. It didn't touch the resident." B. A review of Resident #4's record revealed a physician's telephone order dated November 1, 2006 which directed, "...Contact isolation for C-Diff". A dressing change was observed to the right heel on November 16, 2006 at 11:30 AM. The nurse donned an isolation gown but not gloves. The nurse folded the covers back to reveal the resident's foot and placed a barrier under the resident's leg. On November 15, 2006, after Resident #4 had completed lunch, lunch tray was placed on top of a cart that was being used as an isolation cart, at approximately 1:10 PM. The lunch tray was not removed until 2:00 PM. The top and side of the cart was locked. There were no items available to clean the top of the cart after the tray had been removed. C. A review of resident #6's record revealed a physician's telephone order dated November 13, 2006 at 6:40 PM which directed, "Place pt. (patient) on contact Isolation for C-Diff in stool". On November 15, 2006 at 4:00 PM, a CNA was observed gloving outside the resident's room. He /She took the glucometer (measures blood sugar) into the room, performed a fingerstick and exited the room without cleaning the glucometer. The CNA stated, "I clean it with alcohol, but there were no alcohol pads in the isolation cart." A face-to-face interview was conducted with the Infection Control Nurse on November 16 2006 at 9:40 AM. He/She stated, "I just completed an in-	L 052	5B The licensed nurse has been reminded to always wear gloves prior to entering room not when in room, in addition to gowns in order to maintain contact isolation protocol and requirements for Resident # 4. A policy was written and presented to the staff regarding removal of dirty trays from contact isolation rooms. Trays are to be brought out of the contact isolation room and taken immediately to the dietary cart to be taken down to the kitchen. This will prevent resident completed lunch tray and other meal trays from been placed on top of isolation cart by resident # 4's room.. To identify other residents that have the potential to have lunch completed meal trays outside on top of isolation cart. We continue to reinforce to staff and observe all staff interactions with residents when staff enter and exit contact isolation rooms to ensure that contact isolation requirements are met. We have put an immediate system in place of daily observation of staff when they enter and exit contact isolation rooms to ensure that they follow the protocol of wearing gloves and	11/22/06 & Ongoing 11/27/06 11/22/06 & Ongoing 11/22/06 & daily & Ongoing

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L 052	Continued From page 15 service on October 6, 2006 for this unit about infection control procedures, and following the guideline for all types of isolation. In that in-service, I reviewed that all items taker into the residents's room should be cleaned with LPH (antimicrobial disinfectant) before they are brought out to use on other residents." Immediately after the above interview, the Administrator was queried as to the location of the LPH on the unit. The Administrator stated, " The LPH is in the soiled utility room." Upon examination of the soiled utility room, the Administrator and surveyor found no LPH present . The Administrator immediately queried the housekeeper as to the location of the LPH. The housekeeper stated that a bottle of LPH was kept on the housekeeping cart and not in the isolation rooms. The Administrator directed the housekeeper to place a bottle of LPH on each of the isolation carts.	L 052	Continuation for #1B Gowns before they enter residents' rooms and before they exit the rooms. We will also put a visual sign by the entrance of the isolation room: Sign to read "To Staff: Please Observe Protocol before You Enter Room". We have also added Infection Control as a more frequent Core Competency for all staff. This core competency will be done biannually. To ensure that this solution is effective and sustained results of the daily observations will be provided to the Director of Nursing. These results will be analyzed for rate of compliance by staff. Core competencies will also be reviewed to ensure that we have full participation by staff. These will be included in the performance improvement program. L 052 5C on separate sheet	12/8/06 12/31/06 & Biannually
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 service were not adequate to ensure that meals were prepared and served in a sanitary manner as evidenced by: soiled grease barrels in the dairy refrigerator, interior areas of deep fryer cabinets, soup bowls, salad dishes, colander and hotel pans and storage racks; and the temperature of cold food was above 41 degrees Fahrenheit (F) on the tray line ready for serving. These findings were			

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		L052	SC The CNA has been instructed to clean glucometer with LPH solution before she leaves the isolation resident's room. The staff continues to clean the blood pressure machine with LPH solution before they exit Resident #6's room.	11/16/06
			To identify other residents and ensure that blood pressure machine is cleaned prior to exiting contact isolation rooms, all staff have been instructed to always follow infection control protocol and clean machines before they leave residents' rooms.	11/16/06 & Ongoing
			We have put an immediate system in place of daily observation of staff when they enter and exit contact isolation rooms to ensure that they follow the protocol of cleaning equipments with LPH solution. We wil also put a visual sign by the entrance of the contact isolation room. Sign to read "To Staff: Please Observe Protocol before you Enter Room and When You Exit Room". We will monitor daily to ensure that LPH solution is maintained on the unit in the soiled utility room.	11/22/06 & Ongoing 12/8/06
			To ensure that the solution is effective and sustained, results of the daily observation tool will be presented to the Director of Nursing weekly. Corrective measures will be taken as needed. The availability of LPH solution on the unit will be added to the Environment of Care Rounds checklist. This will be incorporated in our performance improvement program. The Director of Nursing, the Environmental Services manager, and the Administrator will monitor for compliance.	12/15/06 & Weekly 12/31/06 & Qtrly

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L 099	Continued From page 16 observed in the presence of food service managers. The findings include: 1. The top and side surfaces of grease barrels stored in the dairy refrigerator were soiled with accumulated grease in three (3) of three (3) observations at 9:20 AM on November 15, 2006. 2. The interior electrical and stationary parts of deep fryer cabinets were soiled with accumulated grease in three (3) of three (3) observations at approximately 9:10 AM on November 15, 2006. 3. The interior and exterior areas of soup bowls, salad dishes and colander and hotel pans were not thoroughly cleaned and were soiled with food particles and pans were stored on racks before drying: soup bowls in seven (7) of seven (7) observations; plastic salad dishes 18 of 21 observations; colander pans six (6) of six (6) observations; and hotel pans 30 x 14 x 6 inches in 18 of 23 observations. All findings were observed between 9:25 AM and 10:15 AM on November 16, 2006. 3. The shelf surfaces of storage racks in the pot and pan wash area were soiled with debris in three (3) of three (3) observations at 10:20 AM on November 16, 2006. 4. The temperature of cold foods on the tray line during the lunch meal ready for serving was above 41 degrees F, such as whole milk 58 degrees F, diet tea 48 degrees F, peaches 50 degrees F, ice tea 50 degrees F, fruit punch 56 degrees F and skim milk 48 degrees F in six (6) of six (6) observations between 12:20 PM and 12:45 PM on November 16, 2006.	L 099	# 1, 2, 3, 3 The top and side surfaces of grease barrels stored in the refrigerator soiled with accumulated grease have been cleaned. New grease barrels have been ordered from a local vendor. The interior electrical and stationary parts of deep fryer cabinets soiled with accumulated grease have been cleaned. The interior and exterior areas of soup bowls, salad dishes and colander and hotel pans 30x14x6 inches, soiled with food particles have been thoroughly cleaned, and placed separately in racks to air dry. The shelf surfaces of storage racks in the pot and pan wash area soiled with debris have been cleaned. To identify other areas in the kitchen that have the potential to be affected, the Food Service Supervisor and Food Service Director continue to do daily observation of all areas in the kitchen to ensure that proper cleaning is maintained. L 099 # 4 on separate sheet	12/4/06 11/17/06 11/16/06 & 11/17/06 11/17/06

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		L099	#4 The cold food items, including whole milk, diet tea, peaches, ice tea, fruit punch, and skim milk have been relocated in the box, and served with temperatures below 41 degrees F. To identify other cold food items that may have the potential to be affected by this deficient practice, the Food Service Supervisor, and Food Service Director continue to test food temperature before they are served on the tray line, to make sure the temperature is below 41 degrees F. To prevent this from recurring, we have put a system in place to put cold food items thirty minutes in the freezer before the start of each meal tray line. We have also relocated the dairy product in the refrigerator box to ensure that the product is kept below 41 degrees F. We will also keep a record of test done on cold items temperatures during tray line. To ensure that the solution is effective and that it is sustained We will review weekly the results of this new system as we analyze the results of the tests. The Food Service Supervisor, the Food Service Manager and the Administrator will monitor for compliance. This will be incorporated in our performance improvement program.	11/16/06 11/17/06 & Ongoing 11/30/06 & Ongoing 11/15/06 & Weekly & Qtrly

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L 099	Continued From page 17 The dietary staff removed the aforementioned items from the tray line and replaced them with items that were below 41 degrees F.		Recipes for entrees for the menu for December 4, 2006 and future menus will be posted in advance. Menus will be posted for daily prep planning and production meetings to insure that product / recipes are utilized.	12/4/06 & Ongoing
L 119	3222.4 Nursing Facilties A file of each tested recipe, adjusted to appropriate yield, shall be maintained and used by each employee who prepares food. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that recipes were not available and/or prepared in advance for review by dietary staff to prepare entrees on therapeutic and regular diets. These findings were observed in the presence of the food service manager. The findings include: Recipes for entrees on the menu for November 15 and 16, 2006 were not prepared in advance and/or were not available for staff review in order to prepare regular and therapeutic diets in one (1) of one (1) observation at approximately 11:00 AM on November 15, 2006.	L 119	To identify other residents that have the potential to be affected, the Food Service Supervisor, and Manager continue to observe production meetings to ensure that recipes are available in advance for entrees regular and therapeutic diets, and that the staff reviews the recipes. We have put a immediate system in place for Food Service Supervisor to observe production meetings, and verify that recipes are available in advance for staff review for entrees for regular and therapeutic diets. The Food Service Director will develop a daily checklist of required items that staff needs for effective food production meetings. Also prep: pull sheets will be utilized in production area to ensure that product is delivered timely for production meetings and advance recipe review. To ensure that the solution is effective and is sustained, the Food Service Director will present the results of the daily checklist to the Administrator on a weekly basis for analysis. Compliance rate will be determined. This will be incorporated into our performance Improvement program, The Food Service Supervisor, the Food Service Director, and the Administrator will monitor for compliance.	12/4/06 & Ongoing 12/4/06 & Daily 12/15/06 & Daily 12/15/06 & Weekly & Qrly
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			

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L 128	Continued From page 18 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 observation, record review and staff interview for one (1) supplemental resident, it was determined that the pharmacist failed to report the incompatibility of two Intravenous (IV) antibiotic medications to the attending physician and the Director of Nursing. Resident JH1. The findings include: On November 16, 2006, at approximately 10:00 AM, during the medication pass observation, the nurse hung Vancomycin 1 gram IV for Resident JH1, to be infused over one (1) hour. The nurse stated that the resident also receives Ceftriaxone 2 gram IV at 10:00 AM. A review of the Medication Administration Record (MAR), revealed that the resident was scheduled for both the Vancomycin 1 gram IV and the Ceftriaxone 2 gram IV at the same time, 10:00 AM. This order was written on November 8, 2006 and renewed on November 16, 2006.	L 128	Resident JH1 has been discharged to home as of November 16, 2006 For future residents with orders for Vancomycin IV and Ceftriaxone IV, we will get order clarification from the attending physician, so medication order will not be administered at the same time. We continue to review all residents' charts and Medication Administration Record to ensure that there are no doctor's orders for Vancomycin IV and Ceftricaxone IV to be given at the same time. Pharmacy has a system that raises a "red flag" for incompatible IV antibiotics and other drugs, and we have asked pharmacy to provide this report to the Director of Nursing, or to the Charge Nurse, and to the attending physician. We will also write a policy and procedure to state that multiple IV Antibiotics will be given at minimum two hours apart. Also as part of the Drug Regimen Review the pharmacist will include a statement in the residents' medical records and in her/his report to the Administrator. The Medical Director and Direcor of Nursing will also be informed. The statement by the pharmacist will include information that there are no incompatible drugs, or if there are incompatible drugs what measures have been taken.	11/15/06 11/15/06 11/22/06 & Ongoing 11/17/06 & Ongoing 12/8/06 & Weekly

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	095035	A. BUILDING _____ B. WING _____	11/16/2006

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L 128	Continued From page 19 During a telephone interview with the IV pharmacist on November 16, 2006 at 11:00 AM, he/she stated that the two IV antibiotics were incompatible and should not be administered at the same time. The Drug Regimen Review on November 15, 2006 at 10:00 AM documented, "Medication orders reviewed, they are written with diagnoses. Pt. (patient) on 10 meds due to multiple diagnoses." There was no documentation regarding the incompatibility of the IV medications.	L 128	To ensure that the solution is effective and that it is sustained, the Director of Nursing will review and analyze the pharmacy report monthly. This will be incorporated in our performance improvement program. The Director of Nursing, the Pharmacist, and the Medical Director, and Administrator will monitor for compliance.	12/15/06 & Weekly & Monthly
L 187	3230.3 Nursing Facilities A resident activities program shall include, but not be limited to, the following: (a)Active, passive, individual and group activities; and (b)Activities for residents who are unable to leave their rooms, which shall be directed toward maintaining and promoting the well-being of each resident. This Statute is not met as evidenced by Based on staff interview and record review for two (2) of three (3) residents on contact isolation, it was determined that facility staff failed to reassess the therapeutic recreational activity needs of the residents once they were placed on contact isolation. Residents #4 and 6. The findings include: 1. A review of Resident #4's record revealed an	L 187	1 & 2 Resident # 4's recreational needs reassessment has been completed and documented in the Social Worker's section of the resident's medical records, and we will continue to provide related activties for resident. Resident # 6's recreational needs reassessment has been completed and documented in the Social Worker's section of the resident's medical records, and we will continue to provide related activities for resident. To identify other residents that may be affected, all charts have been reviewed, to ascertain if the resident has a need for recreation reassessment. Residents have been reassessed and the reassessments have been documented in the residents medicalrecords	11/22/06 11/22/06 11/22/06 & Ongoing

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L 187	Continued From page 20 assessment for therapeutic recreational activities dated September 26, 2006. According to a telephone order dated November 1, 2006, the resident was placed on contact isolation. There was no evidence in the record that facility staff reassessed the therapeutic recreational needs of the resident or identified recreational activities for the resident in isolation. The record was reviewed November 15, 2006. 2. A review of Resident #6's record revealed a " Recreation/Activities Interest List", uncated. The resident was admitted to the facility on October 30, 2006. According to a telephone order dated November 13, 2006, the resident was placed on contact isolation. There was no evidence in the record that facility staff reassessed the therapeutic recreational needs of the resident or identified recreational activities for the resident in isolation. The record was reviewed November 15, 2006. A face-to-face interview was conducted with the Administrator on November 15, 2006 at 9:30 AM. He/she stated, About 2 weeks ago the activity therapist left. We are looking for a replacement, but right now one of the CNA's (Certified Nurse Aide) and the Social Worker provide activities for our residents."	L 187	To prevent this from recurring, we have put a system in place for residents to be reassessed, when conditions change. In the absence of the recreation therapist, the Social Worker will identify residents whose conditions have changed to contact isolation, etc. These residents will be reassessed for 1:1 activities, or other activities based on their interest or individuality. The reassessment will be documented and dated, and placed in the residents' medical records. To ensure that this solution is sustained and effective, a monitoring tool to review all charts for reassessments of recreation needs of residents will be established. This tool will be utilized monthly, to ascertain compliance, and will be incorporated in our Performance Improvement program. The Administrator, the Director of Nursing, and Nurse Coordinator will monitor for compliance.	12/15/06 & On going 12/15/06 & Weekly & Ongoing
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:	L 410		

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L 410	Continued From page 21 Based on observations during the survey period, it was determined that housekeeping services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled over bed lamps, floor surfaces and exhaust vents in the laundry room; the front lower panel covers of dryers were marred and damaged; an unsecured oxygen tank; unstable chairs, end caps missing on hallway rails, a housekeeping cart containing hazardous cleaning products left unattended; mineral deposits on the water spout of the ice machine; and a soiled shower stretcher. These findings were observed in the presence of maintenance, housekeeping and nursing staff. The findings include: 1. The inner panels of over bed lamps in residents' rooms were soiled with dust and debris in rooms 48, 49, 51 and 55 in four (4) of nine (9) observations between 8:10 AM and 1:30 PM on November 15, 2006. 2. Floor surfaces in the rear of furnishings were soiled and stained in rooms 55, 57 and the dayroom in three (3) of 10 observations between 8:10 AM and 1:40 PM on November 15, 2006. 3. The exhaust vents on the clean and soiled side of washers in the laundry room were soiled with accumulated dust and debris in eight (8) of eight (8) observations between 10:30 AM and 11:30 AM on November 15, 2006. 4. The lower panel covers on the front of dryers in the main laundry room were damaged and marred in four (4) of four (4) observations at 11:30 AM on November 15, 2006.	L 410	1 & 2 The inner panels of over bed lamps in the resident rooms in room # 48, 49, 51, 55 have been cleaned. Floor surfaces in the rear of furnishings in rooms # 55, 57, and the dayroom have been cleaned. To identify other rooms and residents that may have the potential to be affected by this, we continue to do a walkthrough to observe for dust in residents rooms. To prevent this from recurring, we will put a system in place of weekly inspection by the Environmental Supervisor together with the nursing staff. In addition the environmental staff will do more frequent extensive dusting of over bed lamps and floor surfaces. These items will be added on to the Environment of Care Rounds checklist. To ensure that the solution is effective and that it is sustained, we will present the results of the environment of care rounds will be analyzed by the Administrator and the Environmental Services Manager weekly. Adjustments will be made to the cleaning schedule as warranted. The Director of Nursing, the Environmental Service Manager, and the Administrator will monitor for compliance.	11/17/06 11/17/06 12/4/06 & Ongoing 12/8/06 & Ongoing 12/31/06 12/31/06 & Weekly & Qtly

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L 410	Continued From page 22 5. One (1) oxygen tank, E size, was observed unsecured sitting on the floor of room 6C62 on November 15, 2006 at 8:10 AM in one (1) of one (1) observation. 6. Chairs were observed to be unstable in the following areas: rooms 49, 51, 55, 57 and two (2) chairs in the dayroom in six (6) of nine (9) observations on November 15, 2006 between 8:10 AM and 12:30 PM. 7. End caps were observed missing from hallway handrails in the following areas: near room 6B30 and near the pantry in two (2) of nine (9) observations on November 16, 2006 at 2:30 PM. 8. One (1) housekeeping cart was observed unattended from 1:10 PM until 2:45 PM on November 16, 2006 in the hallway near the day room. Chemicals such as Tylex and LPH (disinfectant), were unsecured on top of the cart. 9. The inner surfaces of the ice machine water spout and cover were soiled with debris and mineral deposits in one (1) of one (1) observation at approximately 11:45 AM on November 15, 2006. 10. The mesh surfaces of a shower stretcher in the shower room were soiled with debris between the pads, and the lower mesh cover was soiled with dark residue in two (2) of two (2) observations at approximately 11:30 AM on November 15, 2006.	L 410	# 3 & 4 The exhaust vents in the laundry room will be cleaned by the Engineering staff December 8, 2006 The panels will be painted and a protector rail will be installed by December 15, 2006. Continuation of F253 # 3 & 4 To identify other areas in the laundry room that may have accumulated dust and debris and other areas that may need painting on panel covers, we continue to make a walkthrough in the laundry, to take corrective action as needed. To ensure that these do not recur, we have put a system in place to have a cleaning schedule for the laundry exhaust vents. This schedule will be made available to the Administrator. Cleaning schedule of the exhaust vents and panel covers on the front of dryers will be included in the Environment of Care Rounds checklist. The Administrator will report to the Facilities Management Director and Chief Operating Officer if cleaning is not maintained. In order to make sure that the solution is effective and is sustained, the results of the Environment of Care Rounds will be analyzed weekly for rate of compliance.	11/16/06 11/16/06 12/08/06 & Ongoing 12/8/06 & Weekly 12/15/06 & Weekly
L 999	DC CODE This Statute is not met as evidenced by:	L 999		

		L 410	5 The oxygen tank in Room SC 62 h s been removed and placed in a sec e rack in the clean utility room. Staff have been instructed to always pla e oxygen tanks in a secure rack in th clean utility room.	11/15/06
			To identify other residents that may have the potential to have oxygen t nk in their rooms we have done a walkthrough of all residents' rooms. We continue to do walkthrough.	11/22/06 & Ongoing
			To prevent this from recurring all sta have been instructed to ensure that oxygen tanks are secured in the rac and are not placed lying on the floor. We will write a protocol for storage o oxygen tanks, and continue to reinforce to all staff the requirement securing all oxygen tanks. We will al include observation of oxygen tanks our weekly Environment of Care Rounds, and record the results of our observations, in the Environment of Care Rounds Tool. The Nurse Coordinator will also participate in the weekly Environment of Care Rounds, in order to monitor for compliance of the protocol.	11/17/06 & Ongoing 12/8/06 & Weekly
			To ensure that the solution is effective and that it is sustained, we will include the results of our weekly Environment of Care Rounds in our performance improvement program. The compliance rate will be analyzed weekly and monthly. The Safety Officer, the Nurse Coordinator, the Director of Nursing, and the Administrator will monitor for compliance.	12/15/06 & Weekly & Monthly

		L410	6 & 7 # Chairs that were found to be unstable in rooms 49, 51, 55, 57, and two chairs in dayroom will be repaired, and/or discarded if cannot be safely repaired.	12/8/06
			End caps of hallway handrails near 6B30 and near the pantry will be replaced. Outside contractor has been secured for the replacement. Purchase order has been issued as of December 4, 2006, for the installation.	12/4/06
			In order to identify other areas that have the potential to be affected and other residents that may be affected, we continue to do weekly observation and walkthrough.	12/4/06 & Ongoing
			To prevent a recurrence of this, we have included these two items in our Environment of Care Rounds checklist. Weekly rounds will help to identify and corrective action will be taken, concerning the unstable chairs, and the end caps of hallway hand rails. The Engineering Director, the Safety Officer, and the Administrator will do weekly walkthrough on the unit and identify areas that need corrective action.	12/15/06 & Weekly
			To ensure that the solution is effective and that it is sustained, the Engineering Director, the Safety Officer, and Administrator will analyze the results of weekly rounds and determine the compliance rate. This will be incorporated in our performance improvement program. The Engineering Director, Safety Officer, and the Administrator will monitor for compliance.	12/15/06 & Weekly & Qtrly

Health Regulation Administration

Capitol View Skilled Nursing
Survey completed 11/16/2006

		L 410	As of November 17, 2006 housekeeper has been instructed not to leave housekeeping cart unattended for long periods in the hallway. The staff has been instructed to remove cart and have the cart within their immediate area of work. To identify other housekeeping carts that may be left unattended, we continue to observe the environment to make sure housekeeping carts are not left in the hallways unattended. To make sure that this does not recur, an in-service training was conducted by the Environmental Service Manager for all housekeeping staff. Observation of housekeeping carts will also be included in the checklist to be for Environment of Care Rounds. To make sure that the solution is effective, we will continue with weekly environment of care rounds including observation of housekeeping carts in hallways. The Environment of Care Supervisor, will do weekly environment of Care rounds with the Nurse Coordinator. The Housekeeping Manager and the Administrator will monitor for compliance.

		L 410	9 The inner surface of the ice machin the ice machine water spout and cover, have been cleaned of debris and mineral deposit.	11/15/06
			To identify other equipment that ma be soiled of mineral deposits, we wil continue to inspect the ice machine and other machines to ensure that they are cleaned regularly.	11/22/06 & ongoing
			To prevent this recurring build up of mineral deposits, we have put a system in place of regular cleaning schedule of the ice machine. The Director of Engineering will have the schedule posted on the unit for timely follow up by staff. If scheduled cleaning is missed, the Director of Engineering will be contacted for corrective measures.	12/15/06 & Monthly 12/15/06 12/31/06 &
			To ensure that the solution is effective and sustained, we will include cleanin of the ice machine spout and cover in our Environment of Care Rounds checklist. The engineering Director, the Safety Officer, and the Administrator will monitor for compliance. This will also be included in our performance improvement program.	Monthly & Ongoing
			# 10 The mesh surface of the shower stretcher has been cleaned thoroughly.	11/17/06
			We have made a walkthrough and will continue to do walkthrough to identify shower stretcher and other shower items, to ensure that they are thoroughly cleaned.	11/17/06 & Ongoing
			We have revised our policy and procedure on cleaning of the shower stretcher, to ensure that it is cleaned after each use, and also to be cleaned weekly even if not in use by residents. We will also post a cleaning schedule for staff to follow for regular routine cleaning. We will monitor for cleanliness. To ensure that this solution is effective and sustained, we will review the results of the Environment of Care Rounds, for compliance. The Nurse Coordinator, the Director of Nursing, and Administrator will monitor for compliance.	12/4/06 12/8/06 & Weekly

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L 999	Continued From page 23 Based on record review, observations and staff interview, it was determined that the facility did not comply with State and local laws as evidenced by failure to: supervise the LGSW (Licensed Graduate Social Worker) as required and ensure that CNAs were working within their scope of practice. The findings include: 1. Facility staff failed to ensure that the LGSW received at least one (1) hour of supervised practice for every 32 hours of work. Title 17 DCMR, Chapter 70, Social Work, item 7011.6 read as follows: "At least one (1) hour of every thirty-two 32 hours of supervised practice shall be under immediate supervision". According to documented supervision of the nursing facility's licensed Graduate Social Worker by a licensed Independent Clinical Social Worker, the requirements of at least one (1) hour of every 32 hours of supervised practice was not under immediate supervision for the months of September and October 2006. Information provided to the surveyor documented one (1) meeting in September and two (2) meetings in October dated: September 20, 2006 and October 11 and 25, 2006. These documents were reviewed on November 15, 2006. 2. Facility staff failed to ensure that CNAs were working within their scope of practice as evidenced by CNAs performing blood glucose monitoring [an invasive procedure]. According to Title 29 Chapter 32, 3204.5, Nurse Aide Certification, the nurse aide training program is not inclusive of fingersticks/blood glucose	L 999	1 The licensed graduate social worker has been instructed to ensure that she follows the required guidelines for one hour of weekly, consistent supervision from the designated licensed independent social worker To identify the potential for missed supervision sessions, the Administrator has met and had discussion with the Licensed Independent Social Worker supervisor and reinforced the requirement and the need for consistent supervision sessions. To prevent this from recurring the licensed graduate social worker will report the dates and times of the weekly supervisor sessions to the Administrator on a monthly basis. The Administrator will review dates times of weekly sessions to ensure the requirement is met consistently. To ensure that this solution is effective and is sustained, the Director of Nursing and the Medical Director will receive report monthly and quarterly about compliance. This monthly reporting will be incorporated into our performance improvement program.	11/17/06 11/17/06 11/22/06 12/08/06 & Ongoing

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L 999	Continued From page 24 monitoring. A review of Resident # 1, 2 and 6's November 2006 "Blood Glucose Legend" revealed Certified Nursing Assistants signatures [under signature and title], indicating that they performed the blood glucose monitoring. On November 15, 2006 at 4:00 PM, a CNA was observed performing blood glucose monitoring (fingerstick [FS] with a glucometer) for Resident # 7. A face-to-face interview was conducted with CNA #1 on November 15, 2006 at 4:03 PM. The CNA was queried regarding the process of blood glucose monitoring. He/she stated, "We started about two weeks ago to do the FS. We got special training. If the reading is below 50 or above 300 I have to tell the charge nurse." A face-to-face interview was conducted with CNA #2 at 4:10 PM. The CNA was queried regarding the process of blood glucose monitoring. He/she stated, "The education person taught us that if we have any trouble we call the nurse. If the reading is 50 something that is too low. If the reading is 200 or more, that is too high. Then we call the nurse." According to the facility's policy, "PCX Blood Glucose Monitoring" , #POCT/300/2005/1, page 2 , "e. Circumstances that require follow-up and /or validation from the lab: 1. Notify the physician if the blood glucose is 70mg/dl or less for adults ... 2. Notify the physician if the blood glucose is above 250 mg/dl ..." A face-to-face interview was conducted with the staff development educator on November 15,	L 999	2 Effective November 17, 2006 the Administrator has instructed Certified Nursing Assistants not to perform blood glucose monitoring on patients as it is beyond their certified nursing assistant scope of service. Resident # 1, 2, and 6 no longer have their blood glucose monitoring done by Certified Nursing Assistants. To identify other certified nursing aides or other residents that may be affected by this we have instructed all licensed nurses that certified nursing aides must no longer perform blood glucose monitoring on residents. We also continue to review residents' charts to ensure that only licensed nurses continue to do blood glucose monitoring. To prevent this from recurring, we have put a system in place to refer to the scope of professional practice from the Board of Nursing and, accepted professional standards and practice, before we make decision to train, certify, and offer competency to certified nurse aides for blood glucose monitoring.	11/17/06 11/17/06 Ongoing 11/17/06 Ongoing

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L 999	Continued From page 25 2006 at 4:20 PM. He/she stated, "We just started in October (2006) about 2 weeks ago having the CNAs do the FS. The training is done by the educator from the lab (laboratory)." A face-to-face interview was conducted with the laboratory educator on November 15, 2006 at 4:45 PM. He/she stated, "The in-service for teaching the CNAs about FS is one hour long. We review the policy and have a skills lab. Then the CNAs are given a competency check list. The CNAs are taught the normal range, and that if the low range is less than 70 and the high range is above 250, the MD (physician) must be notified. "	L 999	#2 We have also reviewed certified nurse aide current job responsibilities and duties to ensure they do not include work outside their scope of service. This will enable us to make sure that this solution is sustained and that it is effective. The Administrator and the Director of Nursing, will monitor for compliance.	11/17/06