STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	05/30/2008

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L 000	Initial Comments An annual licensure survey was conducted on May 27 through May 30, 2008. The following deficiencies were based on record review, observations and staff and resident interviews. The sample included 24 residents based on a census of 116 residents on the first day of survey and 11 supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for nine (9) of 24 sampled residents, it was determined that the charge nurse failed to:	L 051		

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L 051	Continued From page 1 develop a care plan for potential adverse drug interactions for nine (9) or more medications for one (1) resident; ensure that tube feeding orders for one (1) resident were transcribed accurately; ensure that two (2) residents receiving hospice care had integrated care plans; clarify a tube feeding order for one (1) resident; differentiate between the usage of pain medications for two (2) residents; ensure that a PSA (Prostatic Specific Antigen) level was drawn as per physician's orders for one (1) resident; adequately monitor and implement preventive measures for one (1) resident who had suicidal ideation and obtain a psychiatric consult timely; obtain a psychiatric consult for one (1) resident on admission; and failed to document that the physician was notified regarding a stool specimen that was not collected for one (1) resident in isolation. Residents #2, 3, 7, 9, 10, 11, 17, 18 and 21. The findings include: 1. The charge nurse failed to develop a care plan for potential adverse drug interactions for nine (9) or more medications for Resident #2. A review of the clinical record for Resident #2 revealed a physician's order dated and signed April 10, 2008 that included the following medications; Acetaminophen, Amiodarone, Ascorbic Acid, Fentanyl, Hydralazine HCL, Keppra, Multivitamin, Oyster-Cal, Prevacid, Senokot, Tegretol Transderm and Zinc Sulfate. A review of the care plan that was last updated on May 1, 2008, revealed there was no problem identified, with appropriate goals and approaches, for potential adverse drug interactions involving nine (9) or more medications.	L 051	**#1** 1. A care plan for nine (9) or more medications were added on May 27, 2008 to the clinical record of Resident #2. **#2** Resident charts has been reviewed and we continue to review all charts to identify residents on nine (9) or more medication. This review revealed no other resident were affected by this deficient practice. **#3** A system will be put in place for randomly sampled, biweekly audits by the Unit Managers to identify any potential omissions within the care plans. Also, all licensed nurses and interdisciplinary team members will be reeducated on ensuring a care plan is in place for residents taking nine or more medications. An audit will be performed, ensuring the appropriate care plans are in place in the clinical record. **#4** We will ensure that compliance is maintained and monitored monthly by the Director of Nursing and Q.I. Director.	June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 051	Continued From page 2 A face-to-face interview was conducted with Employee #5 at approximately 2:30 PM on May 27, 2008. He/she acknowledged that the record lacked a care plan for nine (9) or more medications and should have been updated. The record was reviewed on May 27, 2008. 2. The charge nurse failed to ensure that tube feeding orders for Resident #3 were transcribed accurately. A review of Resident #3's record revealed a telephone order dated March 24, 2008 at 1:00 PM that directed, "1) D/C (discontinue) old tube feeding order. 2) Diabetic Resource 85cc 18 hrs = 1530cc ..." The April 2008 Physician's Order Form signed by the physician on April 8, 2008 included, "...Tube feed Diabetic Source via G-tube via pump 80 ml time 18 hours ..." The origination date for this order was January 15, 2008. The May 2008 Physician's Order Form signed by the physician on May 26, 2008 included, " ...Tube feed Diabetic Source via G-tube via pump 80 ml [the zero was written in ink on top of a pre-printed number 5] time 18 hours ..." The origination date for this order was March 24, 2008. The TARs (Treatment Administration Records) for March and April 2008, beginning on March 24, 2008, included a rate of 85 cc/hr for the Diabetic Resource. However, the May 2008 TAR included a rate of 80ml/hr [the zero was written in ink on top of a pre-printed number 5] for the Diabetic Resource. On May 28, 2008 at 8:05 AM, it was observed	L 051	**#1** 2. The physician orders and the TAR now have been corrected and reflect the accurate infusion rate and time for the tube feeding for resident #3 & #7 **#2** We have reviewed the charts for all residents on tube feedings who may have the potential to be affected. **#3** We will be put in place a system of biweekly audits, conducted by Unit Manager and Dietician to ensure that all tube feeding orders infusion rates and times are accurately transcribed and that there are no inconsistencies with physician orders. The audit tool will enable the dietician to monitor physician orders against tube feeding infusing rate. Licensed staff will be reeducated on how to transcribe physician orders for tube feedings. **#4** To sustain compliance, the results of the audit will be presented at our monthly Quality Improvement meeting. The Director of Nursing, the Q.I. Director and Medical Director will monitor for compliance monthly.	May 30, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 051	Continued From page 3 that Resident #3's tube feeding bottle was labeled to infuse at a rate of 85cc per hour and the pump was set at a rate of 85cc per hour. A face-to-face interview was conducted with Employee #5 on May 28, 2008 at 9:25 AM. He/she acknowledged the inconsistency with the physician's orders and the observed infusion rate of the tube feeding. The record was reviewed on May 28, 2008. 3. The charge nurse failed to ensure that Resident #7, who was receiving hospice care, had an integrated care for coordination of care and clarify a tube feeding order. A. A review of Resident #7's record revealed a physician's telephone order dated May 9, 2008 at 10:00 AM which directed, "Resident is on Hospice care." The record revealed two (2) separate care plans. The facility's care plans were last reviewed and/or updated on March 21, 22, April 23 and May 13, 2008. The hospice care plan was dated May 20, 2008 and was signed by the hospice nurse. The record lacked evidence of an integrated plan of care for Resident #7 between the facility and the hospice service. A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 10:35 AM. He/she acknowledged that the resident had two (2) separate care plans and no coordination of care. The record was reviewed on May 28, 2008. B. A review of Resident #7's record revealed a physician's telephone order dated May 27, 2008 which directed, "TF order D/C (discontinue) Iso	L 051	**#1** 3(A) & 7. Care plans for residents #7 & #17 receiving hospice have been corrected. These residents now have integrated care plans. **#2** We have reviewed all charts to identify residents receiving hospice care and the need for integrated care plans. All other residents receiving hospice care has a corrected and integrated care plan. **#3** A system of biweekly audits, performed by the Unit Managers, MDS Coordinator, and Q.I. Director, has been put in place. The audits will check the clinical records of hospice residents, ensuring an integrated care plan is present. The interdisciplinary team members will be inservice on maintaining an integrated care plan for residents receiving hospice care. **#4** To ensure that compliance is sustained, the Director of Nursing, and the Q.I. Director will analyze the results of the audits. These results will be presented at the monthly Quality Improvement meetings to assess effectiveness of the plan.	June 26, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 051	Continued From page 4 1.5 @ 70 x 18 and use Novasource, pulmonary until Iso 1.5 is available". The order for Novasource lacked the infusion rate and time. A face-to-face interview was conducted with Employee #1. He/she stated," We need to clarify that (the order for the rate and time for Novasosurce)." The record was reviewed on May 28, 2008. 4. The charge nurse failed to differentiate between the usages of pain medications for Resident #9. A review of Resident #9's record revealed pain medication orders on the May 2008 Physician's Order Form as follows: "Tylenol 325 mg 2 tabs by mouth every four hours as needed for pain and Motrin 400 mg 1 tab by mouth every six hours as needed for pain." A face-to-face interview was conducted with Employee #4 on May 27, 2008 at 2:45 PM. He/she acknowledged that there was no differentiation between the use of the two (2) pain medications. A review of the Medication Administration Records from November 2007 through May 2008 revealed that the resident had not received either medication. The record was reviewed on May 27, 2008. 5. The charge nurse failed to ensure that a PSA (Prostatic Specific Antigen) level was drawn as per physician's orders for Resident #10. A review of Resident #10's record revealed a urology consult dated December 6, 2007 which included the following: "PSA - 4.52 mg/ml	L 051	Continued From page 4 **#2** 3(B). We have reviewed the charts for all residents on tube feeding to identify residents who may have the potential to be affected. **#3** We have put in place a system of biweekly audits, conducted by Unit Manager and Dietician to ensure that all tube feeding orders infusion rates and times are accurately transcribed and that there are no inconsistencies with physician orders. The audit tool will enable the dietician to monitor physician orders against tube feeding infusing rate. Licensed staff will be reeducated on how to transcription of physician orders for tube feedings. **#4** To sustain compliance, the results of the audit will be presented at our monthly Q.I. meeting. The Director of Nursing, the Q.I. Director and Medical Director will monitor monthly for compliance. **#1** 4. The order pertaining to the usage of pain medication, Tylenol & Motrin, for Resident #9 was clarified on May 27, 2008. **#2** An audit was conducted on all residents with multiple analgesic orders to ensure that there are instructions on usage. All orders are now clarified.	May 30, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing June 26, 2008

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L 051	Continued From page 5 (previous PSA 2.6, 2.92 ... Plan... (2) F/U (follow up) PSA in 2-3 mos (months)". A physician's order dated December 6, 2007 directed, "F/U PSA in 2-3 months". The record lacked evidence of a PSA level for February or March 2008. A urology consult dated March 13, 2008 included, "...No recent PSA available ... Plan Repeat PSA, done at Dr's (doctor's) office". A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 9:35 AM. He/she acknowledged that the PSA level was not drawn as ordered. The record was reviewed on May 28, 2008. 6. The charge nurse failed to adequately monitor and implement preventive measures for Resident #11 who had suicidal ideation and obtain a psychiatric consult timely. A nurse practitioner's progress note dated February 16, 2008 at 1:30 PM included: "...while on rehab therapy expressed? suicidal idea "I want to die" ..." The nurses' notes revealed the following: February 16, 2008 at 11:00PM, "...Resident was seen today by NP (nurse practitioner) due to c/o (complaint of) pain and suicidal ideation ... also order for psychiatric consultation was given ... call made to psych MD [name], message left on [his/her] voice mail, return call pending ..." February 17, 2008 at 2:45 PM, "...Call placed to psych MD [name] for psychiatric consultation,	L 051	Continued From page 5 **#3** Physician and all licensed nurses will be reeducated on residents receiving multiple pain medication, and the differential use of these drugs. A system of biweekly chart audits will be put in place. **#4** The results of the chart audit will be presented for review to the Q.I. Committee. Unit Manager, Q.I. Director, and Director of Nursing will monitor and report to the Q.I. Committee on a monthly basis. **#1** 5. The PSA was drawn on March 13, 2008 at the Physician office. The results are now placed in Resident #10 clinical record. **#2** To identify other residents that may have the potential to be affected an audit was performed of all other residents to see if labs ordered were drawn as ordered. **#3** A system has been put in place whereby labs due dates and results are maintained in a log-book. A follow-up of the lab log-book is done by the Unit Managers. All licensed nurses will be reeducated on the facility's lab process, including the lab follow-up form, to track and monitor completion of all labs	July 14, 2008 July 14, 2008 & ongoing May 30, 2008 June 26, 2008 June 23, 2008 & ongoing

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L 051	Continued From page 6 message left on voice mail, return call pending, resident being monitored for suicidal ideation ..." A nurse practitioner's order dated February 16, 2008 at 1:30 PM included, "...Psychiatry consultation for eval of R/O Depression ..." There was no reference to the resident's suicidal ideation in this order. A nurse practitioner's order dated February 19, 2008 at 3:00 PM directed, "...Psychiatry F/U for eval of dose reduction of Lexapro received by pharmacist consultant ". The first psychiatric consultation was completed on March 19, 2008, 32 days after the original order. The consult included, "...Reason for consult/Follow-Up regarding Med Review - Patient has been on Lexapro & Aricept for Depression & Dementia to which [he/she] continues to respond fine - No recurrent depressive or agitated behaviors reported. [He/she] eats & sleeps fine. No MSE (mental status examination) changes ... Next visit in 3 months ..." The aforementioned psychiatric consultation did not include reference to suicidal ideation. The record lacked evidence of a care plan for the initiation of increased monitoring and preventive measures for the above complaint of suicidal ideation. On April 8, 2008 at 3:00 PM, the nurse's note revealed, "...Physical Therapist informed writer, resident stated, "I want to die" while at therapy. Upon assessment, resident denied. Told writer "I don't want to go to therapy". N/P notified. Psych consult ordered. Call placed to [psych doctor]. Awaiting response. Resident placed at	L 051	**#4** The Unit Manager, licensed nurses, Q.I. Director and Director of Nursing will conduct audits for the next three months, to ensure labs are drawn and placed in the clinical record. All results will be reported to the Q.I. Committee. The Director of Nursing and Q.I. Director will continue to monitor. **#1** 6. Resident #11's need for Social Service intervention has been addressed by the Social Worker regarding resident's suicidal ideation. **#2** To identify other residents who may have the potential to be affected, the interdisciplinary team has addressed the need and importance for Social Service intervention. We continue to review the charts to identify residents who may have suicidal ideation. Currently, no other resident has suicidal ideation. **#3** Social Services, Nursing and Unit Managers in tandem, will audit the consultant book (i.e. psychiatry problem list) maintained on each unit. A policy has been developed to address Social Service interventions once a resident has been identified as needing psychiatric interventions. The Social Worker will maintain a close follow-up with nursing. All staff will be inservice by the Staff Development Coordinator on the steps to follow when a resident expresses suicidal ideation. Annual inservice education training will also be maintained.	July 14, 2008 & ongoing May 30, 2008 June 23, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 051	Continued From page 7 nurses' station." A physician's telephone order dated April 8, 2008 directed, "Psych consult secondary suicidal thought ..." Review of the nurses' notes revealed the following: April 8, 2008 at 10:00 PM, "...No suicidal ideation noted on this shift ..." April 9, 2008 at 6:40 AM, "...No suicidal ideation verbalized, denied having plan of taking own life ..." April 9, 2008 at 2:40 PM, "...No suicidal ideation verbalized ..." A psychiatric consultation dated April 9, 2008 revealed, "...Follow-up- Patient seems to be exhibiting depressive symptoms, recurrent, at the time Lexapro is being weaned off - he/she is not actively suicidal ... No suicidal or homicidal tendency as we speak ... Should suicidal ideations recur, send patient to [hospital] ER for further investigation. Next visit PRN." The facility's policy entitled "Suicide Ideation" with an effective date of January 31, 2008, included the following: " Purpose: To provide immediate intervention to address residents with suicidal ideation. Policy: A. In the event that a resident displays any signs of mental disorder or the likelihood of causing harm to self or other, the nurse assigned to the resident shall take the following steps. B. Physician and Psychiatrist will be notified of resident's suicidal ideation. C. Family will be notified of resident's suicidal ideation. D. Nursing Documentation will reflect monitoring of residents suicidal ideation and preventive measures that have been implemented. E. Based on outcome of	L 051	**#4** The Social Work Director will report monthly to the Q.I. Committee. The Director of Nursing and QI Director will also monitor for compliance.	

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L 051	Continued From page 8 psychiatric consult facility will follow through accordingly ..." On May 28, 2008 at 11:45 AM, Resident #11 was observed in the dayroom/dining room seated at a table in his/her wheelchair. There was a CNA (Certified Nurse Aide) in the room and two (2) other residents. Resident #11 stated that he/she was waiting for lunch. A face-to-face interview was conducted with Employee #1 on May 28, 2008 at 12:00 PM. He/She stated, " We were monitoring [him/her] hourly after the fall. At that time we had two (2) psych doctors, we now have one (1). [Resident] is up everyday and [he/she] comes out and sits at the nurse's station until time for [him/her] to eat. We usually bring [him/her] close by where we can see [resident]. He/She goes to activities". The record was reviewed on May 28, 2008. 7. The charge nurse failed to ensure that Resident #17, who was receiving hospice care, had an integrated care for coordination of care. A review of Resident #17's record revealed a physician's order dated February 22, 2008 which directed, "Admit into (Hospice company)." The record revealed two (2) separate care plans. The facility's care plans were last reviewed and/or updated on February 23, 29 and April 23, 2008. The hospice care plans were dated February 28 and April 10, 2008. The hospice care plans were signed by the hospice nurse. The record lacked evidence of an integrated care plan for the care of Resident #17. A face-to-face interview was conducted with	L 051		

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L 051	Continued From page 9 Employee #19 on May 29, 2008 at approximately 10:30 AM. He/she acknowledged that the resident had two (2) separate care plans and no coordination of care. The record was reviewed on May 29, 2008. 8. The charge nurse failed to obtain a psychiatric consult as ordered for Resident #18 on admission and differentiate between the usage of pain medications. A. Facility staff failed to obtain a psychiatric consult as ordered for Resident #18 on admission. Resident #18 was admitted on May 16, 2008 to the facility and admission orders included, "Psych consult, reason Depression/Anxiety". The record lacked evidence that a psychiatric consult was done. The record was reviewed on May 28, 2008 A face-to-face interview was conducted with Employee #5 on May 29, 2008 at 11:20 AM. He/She stated, "I didn't see it (the psyc consult)". Employee #5 acknowledged that the record lacked evidence that a psychiatric consultation was done. B. Facility staff failed to differentiate between the usage of pain medications. Resident #18's admission orders dated May 16, 2008 included the following medications to be administered for pain: Motrin 400 mg 1 tab po Q6 hly PRN (by mouth every 6 hours when needed) pain; Percocet 5/325 mg 2 tabs po Q4 hly PRN pain; and Tylenol 325 2 tabs po Q4 hly PRN pain/headache. There was no evidence in	L 051	**#1** 8(A). The psychiatric consult has been completed by the Psychiatrist for Resident #18. The report has been placed in the resident's medical record. **#2** We have reviewed charts for residents admitted to ascertain if psychiatric consults are outstanding. We will continue to review the charts. **#3** To ensure that psychiatric consults are carried out timely, we will secured additional psychiatric coverage for the residents of the facility. In addition, the Unit Managers and Unit Secretaries will maintain the consult log-book on each unit, and review the log weekly. **#4** In order to ensure that our action plan is sustained, the Unit Managers will present the results of the audit at the monthly Q.I. meetings. The Medical Director, Q.I. Director and Director of Nursing will continue to monitor for monthly compliance. **#1** 8(B). The order pertaining to the usage of pain medication, Percocet & Motrin, for Resident #18 was clarified. The Motrin was discontinued on May 27, 2008 and the Percocet discontinued on May 29, 2008.	June 11, 2008 June 23, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 051	Continued From page 10 the record that the orders for Motrin and Percocet were clarified with the physician to determine when to use either medication. From May 17 through 29, 2008, Resident #18 was administered Percocet 22 times. Documentation on the Medication Administration Record (MAR) for the reason for the use of the Percocet was for "complaint of pain, complaint of general pain or complaint of pain at back." Motrin was not administered during May 2008. A face-to-face interview was conducted with Employee #5 on May 28, 2008 at 11:20 AM. He/she acknowledged that there was no differentiation between the use of Motrin and Percocet. The record was reviewed on May 28, 2008. 9. The charge nurse failed to document that the physician was notified regarding a stool sample that was not obtained from Resident #21 for five (5) days. Resident #21 was admitted on May 15, 2008 with a diagnosis of Clostridium Difficile (C-diff). The resident was in contact isolation. A review of Resident #21's record revealed a physician's order dated May 20, 2008 at 9:00 AM and signed by the physician on May 21, 2008 that directed, "Stool for c-diff (x1). Diagnosis: history of positive stool for c-diff." According to the nurses' notes: May 21, 2008 at 11:30 PM: "...Stool for c-diff continues not obtained due to resident's lack of bowel movement ..." May 23, 2008 at 11:15 PM: "...No bowel movement noted today ..."	L 051	Continued From page 10 **#2** An audit was conducted on all residents with multiple analgesic orders to ensure that there are instructions on usage for these medication. All orders are now clarified. **#3** Physician and all licensed nurses were reeducated on residents receiving multiple pain medication, and the fact that there is differential use of these drugs. A system of biweekly chart audits has been put in place. **#4** The results of the chart audit will be presented for review to the Q.I. Committee. Unit Manager, Q.I. Director, and Director of Nursing will monitor and report to the Q.I. Committee on a monthly basis. **#1** 9. The Physician has been notified of inability to collect stool culture and notification has been documented. **#2** Residents charts have been reviewed, to identify residents whose charts may lack documentation for notification of physician, if stool sample cannot be obtained. **#3** We will put a system in place for chart audits to be done by Unit Managers, Director of Nursing, and Q.I. Director, to ensure that physician notifications are documented.	July 14, 2008 & ongoing July 14, 2008 & ongoing May 30, 2008 July 14, 2008 July 14, 2008

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L 051	Continued From page 11 May 24, 2008 at 3:00 PM: "Unable to collect stool at this time as resident did not pass any stool..." May 24, 2008 at 10:00 PM: "No stool collected as resident did not pass any stool ..." May 25, 2008 at (no time noted): "Specimen of stool obtained and submitted to lab for testing ..." According to the physician's orders: May 22, 2008 at 1:00 PM: "Senokot - S two (2) tabs via G-tube (gastrostomy tube) daily for constipation." May 24, 2008 at 8:30 AM, "Lactulose 60 ml via G-tube daily x 2 days then 45 ml via GT daily for constipation ..." There was no documented evidence that facility staff notified the physician of the stool sample not being collected. A face-to-face interview was conducted on May 29, 2008 at 1:00 PM with Employee #1. He/she acknowledged that there was no documented evidence that facility staff notified the physician that a stool sample had not been collected. The record was reviewed on May 29, 2008.	L 051	**#4** The Unit Managers, Q.I. Director and Director of Nursing will conduct random audits and report findings to Q.I. Committee on a monthly basis. The Director of Nursing and the Medical Director will monitor monthly.	July 14, 2008 & ongoing
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on the tour of the main kitchen and unit pantries, it was determined that facility staff failed to: separate stored expired and non-expired nutritional supplements and date and label foods in pantry refrigerators. These observations were	L 099		

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L 099	Continued From page 12 made in the presence of Employees #5, 6, 21 and 22 on May 27, 2008 between 8:40 AM and 10:45 AM and on May 28 between 9:00 AM and 10:05 AM. The findings include: 1. Facility staff failed to separate expired and non-expired nutritional supplements. 12 cases of renal nutritional supplement were observed with the following expiration dates: October 16, 2006 - One (1) case October 1, 2007 - One (1) case November 21, 2007 - Three (3) cases May 3, 2008 - One (1) case May 11, 2008 - Five (5) cases May 28, 2008 - One (1) case The above expired nutritional supplements were stored on shelves that contained approximately 20 cases of non-expired nutritional supplement. Employees #21 and 22 acknowledged the findings at the time of the observation. 2. Two (2) of three (3) unit pantry refrigerators contained unlabeled and undated food. An undated and unlabeled container with a strong odor of fish was observed in the 5th floor unit pantry refrigerator. Employee #6 acknowledged the findings at the time of the observations. An undated and unlabeled container of pineapple slices and a bag containing a sandwich and banana were observed in the 6th floor pantry refrigerator. Employee #5 acknowledged the findings at the time of the observations.	L 099	**#1** 1. Although expired and non-expired nutritional supplements were observed, no residents were identified as being affected by this deficient practice. The expired nutritional supplement were discarded. **#2** To identify other residents that may be affected, nutritional supplements are delivered 3 times a week to nursing center floors, dates of supplements will be checked prior to being taken to the floors **#3** We have put a system in place to perform daily checks for expired supplements. Staff was inservice on the First In First Out (FIFO) method. When new deliveries are brought in the FIFO method will be practiced. **#4** Food Service Manager, supervisors, clinical dietitians, and diet aide will monitor nutritional supplements daily as part of daily checklist and will report findings monthly to the Q.I. Committee. **#1** 2. The unlabeled and undated food have been discarded. **#2** To identify other residents or equipments that may be affected, we have checked all pantry refrigerators in 4th, 5th, 6th floors, discarding any unlabeled or undated food observed.	May 30, 2008 June 9, 2008 & ongoing June 23, 2008 & ongoing July 14, 2008 & ongoing May 30, 2008 May 30, 2008

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L 108	Continued From page 13		Continued From page 13	
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations, interview and record review, it was determined that facility staff failed to maintain hot foods above 140 degrees Fahrenheit (F) and cold food below 45 F at the point of service to residents. The findings include: According to 22DCMR 3220.2, "The temperature for cold foods shall not exceed forty-five degrees Fahrenheit and for hot foods shall be above one hundred and forty degrees Fahrenheit at the point of delivery to the resident." A test tray left the kitchen at 1:10 PM and arrived on the unit at 1:12 PM. All residents were served and eating or being assisted with their meal at 1:30 PM. The following food temperatures were measured at 1:30 PM in the presence of Employee #20: Chicken breast - 127 F Pureed liver - 143 F Chopped liver - 126.6 F Liver - 119.3 F 2% Milk - 46.9 F Chocolate pudding - 49.8 F Employee #20 acknowledged the findings at the time of the observations.	L 099 L 108	**#3** The Director of Nursing will issued a memorandum to the nursing staff, informing them that resident's food must be labeled and dated before placed in pantry refrigerators. This system will be monitored by both Food Services and nursing staff. This information will be reinforced monthly at Resident Council meetings. **#4** In order to sustained our corrective action plan, the Q.I. Director, Director of Nursing, and Unit Managers will monitor for compliance. **#1** Food temperatures will be checked and food trays will be distributed to residents as soon as food carts are delivered to the units. **#2** To identify residents that may be affected, test trays will continue to be done on a weekly basis. **#3** The process of tray set up from tray-line to delivery truck to resident floors will be monitored daily. Staff was in serviced on proper procedures to get meals out in a timely manner Food Service Manager, supervisors, clinical dietitians will conduct daily test trays for one month to monitor temperatures.	July 14, 2008 July 14, 2008 & ongoing June 26 2008 & ongoing June 26 2008 & ongoing July 14, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 128	Continued From page 14	L 108	**#4** Findings will be reported in monthly QI meetings. The Food Service Manager and Director, Q.I. Director, and Administrator will monitor for compliance.	July 14, 2008 & ongoing
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 record review and staff interview for two (2) of 24 sampled residents, it was determined that the pharmacist staff failed to recommend a dose reduction for one (1) resident on Seroquel for six (6) months. Resident #14. The findings include: A review or Resident #14's record revealed the following psychiatrist's orders: October 10, 2007: "Increase Seroquel 75 mg po	L 128	**#1** The Psychiatrist has reviewed Resident #14 chart. **#2** We continue to review charts of residents in collaboration with the Pharmacist consultant to identify residents that may be affected. **#3** The Medical Director has put a system in place of regular written communication to attending and consulting Physicians. The Medical Director has also issued a memorandum to the Psychiatrist, addressing the need to review resident's behavior history prior to increasing the dosage of an antipsychotic medication. In addition, licensed nurses will be re-inservice on documentation of abnormal behaviors exhibited by residents, to ensure that these behaviors are clearly documented in the Nurses Notes and/or the Behavioral Monitoring Flow sheet.	June 25, 2008 June 25, 2008 & ongoing June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing

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L 128	Continued From page 15 bid (orally twice a day) for agitated behavior." May 21, 2008: "Increase Seroquel 100 mg po bid for agitated behavior." The pharmacist reviewed the drug regimen on the following dates: November 8, 2007 December 4, 2007 January 5, 2008 February 7, 2008 March 10, 2008 April 26, 2008 May 23, 2008 There was no evidence that the pharmacist recommended an attempted dose reduction of Seroquel on the aforementioned dates. A face-to-face interview with Employee #5 was conducted on May 29, 2008 at 1:00 PM. He/she acknowledged that there was no evidence that the pharmacist recommended an attempted dose reduction for Seroquel. The record was reviewed May 29, 2008.	L 128	**#4** To ensure that our plan is sustained, we will monitor for compliance. The Medical Director, Pharmacist, Q.I. Director, Director of Nursing and Unit Managers will continue to monitor for compliance monthly.	July 14, 2008 & ongoing
L 157	3227.8 Nursing Facilities Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. This Statute is not met as evidenced by: Based on observation and staff interview for three (3) of four (4) medication refrigerator, it was	L 157		

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L 157	Continued From page 16 determined that facility staff failed to store drugs and biologicals under proper temperature controls. The findings include: The facility's policy 5.3 "Storage and Expiration Dating of Drugs, Biological Syringes and Needles "stipulates, (8.) " Drugs and biological are stored at their appropriate temperatures. (8.2) Refrigeration: 36 - 46° Fahrenheit (F) or 2 - 8° Celsius." On May 29, 2008, between 4:00 PM and 5:00 PM, the medication refrigerators were inspected. . The thermometer in the medication refrigerator on the 5th floor measured 47 F. The thermometer used by the surveyor measured 57° F. The thermometer in the medication refrigerator on the 6th floor measured 32° F, and the thermometer used by the surveyor measured 59.4° F. A face-to-face interview was conducted after each observation with Employees #17 and 18 on the 5th floor and Employees #5 and 17 on the 6th floor. They acknowledged that the refrigerator temperatures were out of range.	L 157	**#1** The refrigerators on the 4th, 5th & 6th floors will be replaced for proper and required temperature. **#2** The Unit Secretaries/Unit Managers will check temperatures in the refrigerators on a daily basis, to verify temperatures are in compliance. **#3** Licensed staff will be reeducated on the normal temperatures for refrigerators storing drugs and biologicals. They will also be educated on the protocol in the event that the refrigerator is out of range to contact Maintenance immediately. **#4** Daily findings will be reported to the Q.I. Committee monthly and the Director of Nursing will monitor.	July 14, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by:	L 168		

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L 168	Continued From page 17 Based on observations and staff interview, it was determined that facility staff failed to date and initial 12 of 14 multi-dose medication vials and/or bottles when first opened. The findings include: On May 29, 2008 between 11:30 AM and 2:30 PM, during the inspection of the medication carts the following multi-dose medication vials and/or bottles were not initialed or dated when first opened: 4th floor Unit Xalatan Ophthalmic drops vial Lidocaine 1% vial 20 ml Heparin 5,000 unit vial 10 ml Heparin 5, 000 unit vial 20 ml x 3 Miacalcin 30 dose vial 3.7 ml x 2 5th Floor Unit Heparin 5,000 unit vial 10 ml Morphine Sulfate Concentrate 20mg/ml Solution (30 ml) x 2. Written on the outside of the package was "Discard after 90 days after opening." 6th Floor Unit Amoxicillin suspension 250mg/ml 150 ml. Written on the outside of the package was "Discard 14 days after opening." During a face-to-face interview conducted at the time of the observations, Employees #1, 4 and 5 acknowledged that the vials and/or bottles listed above were not dated and initialed at the time of the observation.	L 168	All undated multi medication vials and/or bottles have been discarded. A completed audit of all multi-dose vials on all units revealed no other deficiencies. Daily, the licensed nurses and night supervisor will check all medication carts and medication refrigerators to ensure that vials/bottles are dated and initialed. An audit tool has been implemented to track and monitor compliance. Staff will be reeducated on the policy relating to labeling and initialing multi dose vials. An analysis of the audits will be presented on a monthly basis to the QI Committee.	May 29, 2008 June 26, 2008 July 14, 2008 & ongoing July 14, 2008 & ongoing
L 235	3236.4 Nursing Facilities	L 235		

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L 235	Continued From page 18 The temperature of hot water of each fixture that is used by each resident shall be automatically controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F). This Statute is not met as evidenced by: Based on observations during the environmental tour conducted on May 27, 2008 from 10:40 AM through 3:30 PM and random observations conducted throughout the survey period, it was determined that facility staff failed to maintain valves that effected water temperatures as evidenced by fluctuating water temperatures in residents' rooms. These observations were made in the presence of Employees #10, 11 and 12. The findings include: Temperatures were measured at the sinks [in resident rooms] in degrees Fahrenheit (F) as follows: Room 4110 May 27, 2008 at 2:00 PM - 95 F May 28, 2008 at 9:00 AM - 69.7 F Room 4115 May 27, 2008 at 11:00 AM - 71.6 F May 28, 2008 at 9:00 AM - 68.4 F May 29, 2008 at 9:45 AM - 70.4F Room 4129 May 27, 2008 at 11:00 AM - 74.2 F May 28, 2008 at 9:00 AM - 69.1 F Room 4138 May 27, 2008 at 11:00 AM - 67.7 F May 28, 2008 at 9:00 AM - 81.8 F May 29, 2008 at 9:45 AM - 70.3 F	L 235	**#1** The fluctuating water temperature in rooms 4110, 4115, 4129, 4138, 4149, 6130, 6139, 6145, and 6147 has been corrected. The system was repaired on June 6th 2008 with a new check valve and ball valve. The repair immediately improved the water temperature for all resident rooms. With the improvement to the water temperatures some faucets in several rooms require three to five minutes before obtaining 95 degrees or better. **#2** The hot water will continue to be worked on to sustain a threshold of 95 degrees. To identify residents that may have fluctuating hot water, we will do daily checks of the hot water for two months, followed by weekly checks thereafter. The hot water system will be re-evaluated and repaired to eliminate cold water in the hot water system. Weekly temperatures will be monitored on a continuing basis. **#3** The engineering supervisor will conduct (commenced on June 3, 2008) weekly rounds and the out come will be reported at the Q.I. Committee Meetings, using Q.I. tool.	June 6, 2008 June 16, 2008 & ongoing June 3, 2008 & ongoing

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L 235	Continued From page 19 Room 4149 May 28, 2008 at 9:00 AM - 77.5 F May 29, 2008 at 9:45 AM - 69.2 F The 5th floor had no fluctuating water temperatures at the time of survey. Room 6130: May 28, 2008 at 9:30 AM - 70.1 F May 29, 2008 at 11:30 Am - 88.2 F Room 6139 May 27, 2008 at 10:00 AM -66.7 F May 29, 2008 at 11:30 AM - 69.6 F Room 6145 May 27, 2008 at 10:00 AM -67.4 F May 29, 2008 at 11:30 AM - 87.3 F Room 6147 May 27, 2008 at 10:00 AM - 68.0 F May 29, 2008 at 11:30 AM - 82.0 F A review of maintenance water temperature logs revealed that hot water temperatures were recorded on the following dates on the 4th, 5th, and 6th floors: 4th Floor January 14, 2008 - 10 rooms had water temperatures between 56 F and 90 F. February 22, 2008 - 25 rooms had temperatures between 50.3 F and 77.3 F. May 13, 2008 - 14 rooms had temperatures between 66.3 F and 93.2 F. 5th Floor January 14, 2008 - Six (6) rooms had temperatures between 55 F and 70 F. February 1, 2008 - 12 rooms had temperatures between 68 F and 94 F.	L 235	**#4** To ensure that our action plan is effective, we will monitor the daily checks for two months ongoing and monitor weekly thereafter. If the Facility Diretor and Administrator determines that there is a need for further corrective actions based on the analysis of our monitoring, we will modify our plan with notification to the Department of Health. The Engineering Supervisor, the Administrator and the Facility Director will continue to monitor daily for two months and weekly thereafter.	July 14, 2008 & ongoing

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L 235	Continued From page 20 February 22, 2008 - 19 rooms had temperatures between 57.2 F and 91.2 F. March 7, 2008 - Three (3) rooms had temperatures between 51 F and 66 F. March 21, 2008 - Al rooms were between 95 F and 110 F. May 15, 2008 - 10 rooms had temperatures between 69.3 F and 94.6 F. 6th floor January 14, 2008 - Five (5) rooms had temperatures between 60 F and 89 F. February 1, 2008 - All rooms were between 95 F and 110 F. February 22, 2008 - Seven (7) rooms had temperatures between 49 F and 65 F. March 7, 2008 - Two (2) rooms had temperatures of 62 F and 78 F. March 14, 2008 - All rooms were between 95 F and 110 F. March 21, 2008 - Nine (9) rooms had temperatures between 87 F and 94 F. March 28, 2008 -10 rooms had temperatures between 58 F and 94 F. May 15, 2008 - 12 rooms had temperatures between 64.3 F and 93.6 F. A face-to-face interview was conducted with Employees #9, 10 and 11 on May 28, 2008 at 5:00 PM. Employee #10 stated, "This is an old building and we have had problems with hot water temperatures for years. The hot water temperature is not predictable. From day-to-day, even hour-to-hour, the temperature of the hot water in any one room fluctuates. At first, the plumber thought that the shower valves in the rooms needed to be replaced because the valve interfered with hot water temperatures. We replaced several shower valves (10) from January (2008) right up through last month (April	L 235		

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L 235	Continued From page 21 2008) based on the evaluation of the plumber from November (2007). That did not solve the problem. We called the plumber again and he will be here tomorrow (May 29, 2008)." A follow-up interview was conducted with Employee #10 on May 29, 2008 at 4:45 PM. He/she stated, "The plumber suggested replacing the check valve, gate valve and gasket. Then he will test the hot water circulating pump. That may or may not work. Since we have to shut off the water for about 2 hours, we will schedule the work for early Tuesday (June 3, 2008) morning. If that doesn't work, then the plumber will have to trace the water lines throughout the whole building."	L 235		
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 safe, clean and sanitary environment as evidenced by: damaged/soiled/marred doors, walls, wallpaper, floors, baseboards, corners, and sinks; dusty beds and over bed lights; broken/damaged furniture; light in resident rooms and bathrooms not working; and non-functional bathroom exhaust vents. These observations were made in the presence of Employees #10, 11 and 12 during the environmental tour on May 27, 2008 from 10:40 AM through 3:30 PM.	L 410		

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	095027	A. BUILDING _____ B. WING _____	05/30/2008

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L 410	Continued From page 22 The findings include: 1. Damaged/soiled/marred doors were observed in the following areas: Rooms 4110, 4112, 4115, 4122, 4th floor shower/whirlpool room, and 4119 resident bathroom in six (6) of 14 doors observed. Rooms 5106, 5111, 5116, 5123, and 5th floor fires doors on Hallway B in five (5) of 13 doors observed. Rooms 6115, 6111, 6122, 6145 and 6147 in five (5) of 12 doors observed. 2. Damaged/soiled/marred walls were observed in the following areas: Rooms 4119, 4125, 4133, 4156 in four (4) of 12 rooms observed. Rooms 5106, 5118, 5123, 5129, 5143 and 5147 in six (6) of 12 rooms observed. Rooms 6110, 6111, 6132 and restroom in four (4) of 12 rooms observed. 3. Damaged/soiled/marred wallpaper was observed bathrooms in the following areas: Room 4110 bathroom in one (1) of 12 rooms observed. Rooms 5111, 5116, 5129, 5145 and 5147 in five (5) of 13 doors observed. 4. Damaged/soiled/marred floors were observed in the following areas: Rooms 4115, 4th floor mechanical room with 16 missing floor tiles and 4119 in three (3) of 14 rooms observed.	L 410	**#1** 1. Damaged/soiled/marred doors in: rooms # 4110, 4112, 4115, 4122, 4th floor shower whirlpool room, and 4119 resident bathroom will be repaired. Also rooms 5106, 5111, 5116, 5123, and 5th Floor fires doors on Hallway B will be repaired. Also rooms 6115, 6111, 6122, 6145, and 6147 will be repaired. 2. Damaged/soiled/marred walls in: rooms 4119, 4125, 4133, 4156 will be repaired. Also rooms 5106, 5118, 5123, 5129, 5143, and 5147 will be repaired. Also rooms 6110, 6111, 6132, and restroom will be repaired. 3. Damaged/soiled/marred wallpaper in the bathrooms in room 4110 will be repaired. Also in the bathrooms in rooms 5111, 5116 5129, 5145, 5147 will be repaired. 4. Damaged/soiled/marred floors in Rooms 4115, 4th floor mechanical room with 16 missing tiles, and 4119 will be repaired.	July 14, 2008 & ongoing for 1-9, 11 & 12

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L 410	Continued From page 23 Rooms 5106, 5145, 5147 and 5149 in four (4) of 12 rooms observed. Rooms 6110, 6119, 6132, 6th mechanical room, and 6139 in five (5) of 13 rooms observed. 5. Damaged/soiled/marred baseboards were observed in the following areas: Hallway A 4th floor in one (1) of three (3) hallways observed. Hallway A 5th floor in one (1) of three (3) hallways observed and rooms 5106, 5111, 5118, 5123, 5129, 5130, 5143, and soiled utility room in eight (8) of 13 rooms observed. Hallway A 6th floor in one (1) of three (3) hallways observed and rooms 6110, 6122, 6th floor rest room, 6130, 6139, 6145, 6147 and 6156 in eight (8) of 13 rooms observed. 6. Damaged/soiled/marred corners were observed in the following areas: Rooms 5106, 5111, 5116, 5118, 5123, 5130, 5143 and 5149 in eight (8) of 12 rooms observed. Rooms 6112, 6113, 6115, 6119, 6th floor tub and shower room, 6th floor restroom, 6122, 6130, 6132, 6145 and 6147 in 11 of 13 rooms observed. 7. Damaged/soiled/marred sinks were observed in the following areas: 4th floor clean utility room sink and 4th floor soiled utility room hopper in two (2) of two (2) utility rooms observed. 5th floor hopper in the solid utility room in one (1) of one (1) soiled utility room observed.	L 410	Also rooms 5106, 5145, 5147, and 5149 will be repaired Also rooms 6110, 6119, 6132, 6th floor Mechanical room, and 6139 will be repaired. 5. Damaged/soiled/marred baseboard In: Hallway 4th floor will be replaced. Also Hallway A 5th floor, and in rooms 5106 5111, 5116, 5118, 5123, 5129, 5130, 5143, and soiled utility room will be replaced. Also Hallway A 6th floor, and rooms 6110, 6122, 6th floor rest room, 6110, 6139, 6145, 6147, 6156 will be replaced. 6. Damaged/soiled/marred corners in: Room 5106, 5111, 5116,5118, 5123, 5130, 5143, and 5149 will be repaired. Also room 6112, 6113, 6115, 6119, 6th Floor tub and shower room, 6th Floor restroom, 6122, 6130, 6132, 6145, and 6147 will be repaired. 7. Damaged/soiled/marred sinks in: 4th Floor clean utility room will be scrubbed and cleaned and the 4th floor soiled utility room hopper, will be repaired. Also 5th Floor hopper in soiled utility room will be scrubbed and cleaned. Sinks in 6th floor clean and soiled utility room will be scrubbed and cleaned.	July 14, 2008 & ongoing for 1-9, 11 & 12

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L 410	Continued From page 24 6th floor clean and soiled utility room sinks in two (2) of two (2) utility rooms observed. 8. Dusty bed frames were observed in the following areas: Room 4119 in one (1) of 12 rooms observed. Room 5116 in one (1) of 12 rooms observed. Rooms 6110, 6122, 6139, 6147 and 6156 in five (5) of 12 rooms observed. 9. Dusty over bed lights were observed in rooms 5111, 5116, 5123, 5129 and 5147 in five (5) of 12 rooms observed. 10. Broken/damaged furniture was observed in the following areas: 4th Floor: 4119 - dresser drawer off track 4115 - torn arms to geri chair 4120 - no handle on closet 4122 - torn geri chair arms 4129 - broken side of nightstand 4157 - missing closet door In six (6) of 12 resident rooms observed. 5th Floor: 5111 - broken side of bedside stand, sink door off hinges, bedside stand drawer off track 5116 - broken side of night stand 5118 - broken side of night stand 5129 - broken side of night stand 5145 - night stand drawer missing 5147 - broken side of bed side stand In six (6) of 12 resident rooms observed. 6th Floor: 6110 - broken side of back of dresser 6111 - sink door off hinges	L 410	8. Bed frames in rooms 4119, 5116, 6110, 6122, 6139, 6147, and 6156 will be dusted and cleaned. 9. Bed lights in rooms 5111, 5116, 5123, 5129, and 5147 will be dusted and cleaned. 10. For broken furniture in rooms 4119, 4115, 4120, 4122, 4129, 4157, 5111, 5116, 5118, 5129, 5145, 5147, 6110, 6111, 6115, 6122, 6139, 6147, and 6146 will be repaired and/or replaced. 11. The light bulbs in rooms 5106, 5111, 5119, 5129 and 6104 will be replaced and are working. 12. Exhaust vents in bathroom 4110, 4119, 5106, 5111, 6104, 6110, 6119, 6156, and 6th floor restroom will be repaired.	July 14, 2008 & ongoing for 1-12

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L 410	Continued From page 25 6115 -foot board missing off bed 6122- broken side of bed side stand 6139 - broken side of bed side stand 6147- broken side of bed side stand 6156 - broken side of bed side stand In seven (7) of 12 resident rooms observed. 11. Light bulbs were observed not working in the following areas: Rooms 5106, 5111, 5119 and 5129 in four (4) of 12 rooms observed Room 6104 in one (1) of 12 rooms observed. 12. Non-functional bathroom exhaust vent were observed in the following areas: Rooms 4110 and 4119 in two (2) of 12 rooms observed. Rooms 5106 and 5111 in two (2) of 12 rooms observed. Rooms 6104, 6110, 6119, 6156 and 6th floor restroom in five (5) of 13 rooms observed. Employees #10, 11 and 12 acknowledged the findings at the time of the observations	L 410	Continued From page 25 **#2** To identify other resident's rooms and common area that may be affected, we have done a walk through of the units and resident's rooms, hallways, shower rooms, and observe furniture. Those areas found to be damaged, soiled or marred will be repaired. **#3** We have put a system in place to provide more frequent and collaborative Environment of Care (EOC) rounds on the units. The Unit Managers, Engineer Supervisor, and Manager of Environmental Service, will do weekly rounds to ensure repairs are carried out. Findings of these rounds will be communicated to the QI Director, Administrator, and Facility Director using standardized tools for all units. We will also observe all furniture during EOC rounds, by the Engineering Supervisor, Unit Managers, and the Housekeeping Supervisor. **#4** EOC rounds will be done weekly by the Unit Managers, the Engineering supervisor, Housekeeping supervisor and Administrator. To sustain compliance the Q.I. Director, the Facility Director, and Administrator will continue to monitor and review the results of the EOC rounds at the monthly Q.I. meetings.	July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing July 14, 2008 & ongoing