Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

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L 000	Initial Comments An licensure survey was conducted January 11, 2011 through January 19, 2011. The following deficiencies were based on observations, record review, staff and resident interviews. The sample included 16 residents based on a census of 77 residents on the first day of survey and 61 supplemental residents. An Immediate Jeopardy at CFR 483.25 (H) (I) and (2) Accidents and Supervision was identified on January 18, 2011 at 3:13 PM. The allegation of removal of the IJ situation was received and verified on January 18, 2011 at 6:05 PM and the Immediate Jeopardy was lifted at this time.	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	L 051	1. The Inter Disciplinary Team (IDT) will develop a Care Plan for Resident #5 for the use of multiple anticoagulants. The IDT will initiate a care plan for the potential drug interaction for the use of nine or more medications for Resident #7. The IDT will develop a care plan will for potential adverse drug interactions with the use of nine or more medications for residents #8 The IDT will initiate a care plan for the potential drug interaction for the use of nine or more medications for Resident #12. The Facility will initiate a care plan with appropriate goals and approaches for Resident # E1 who is on C-PAP. The Facility wil initiate a care plan with appropriate goals and approaches for allergies Penicillin and Lisinopril for Resident # E1. 2. All other residents were check that may be affected be this deficient practice and the appropriate care plan will be developed for compliance if needed.	

Health Regulation Administration

Leonard W. Smith Jr.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 2/28/11

Health Regulation Administration

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L 051	Continued From page 1 (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 of four (4) of 16 sampled residents and one (1) supplemental resident, it was determined that the charge nurse staff failed to develop a care plan for four (4) residents for use of nine (9) or more meds, one (1) resident for anticoagulants, and one (1) resident for allergies and CPAP [Continuous Positive Airway Pressure]. Residents #5, #7, #8, #12 and #E1. The findings include: 1. The Charge Nurse failed to develop a care plan with goals and approaches for Resident #5 who is receiving multiple anticoagulants. Review of the "Admission Order Sheet and Physician Plan of Care dated and signed by the physician on November 9, 2010 revealed that the resident was admitted with a Diagnosis of Atrial Fibrillation, CHF (Congestive Heart Failure, Accelerated HTN (Hypertension), Renal Failure, History of gout, History of Cerebral Aneurysmectomy S/P (status post) G-tube placement." Review of the (MAR) Medication Administration Record for the month of December 2010 revealed that Resident #5 was receiving "Aspirin Chewable tab 81 mg once daily for CVA (Cerebral Vascular Accident) and Lovenox injection 60 mg Subcutaneous every day for prophylaxis. Review of the care plans last updated January 6, 2011 failed to include a care plan with goals and approaches for the use of multiple anticoagulants. A face-to-face interview was conducted with Employee #2 on January 11, 2011 at 11:30 AM	L 051	3. The IDT team will monitor weekly to assure that a comprehensive care plan is developed for each resident to include measurable objectives and timetables to me the residents' medical, nursing and mental psychosocial needs that are identified in a comprehensive assessment. 4. Result from this monitoring will be reported at the Quality Assurance meeting monthly. (On going). Any additional issues or concern will be addressed at this meeting.	3/6/2011

Health Regulation Administration

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L 051	Continued From page 2 after review of the above he/she acknowledged the findings. The record was reviewed on January 11, 2011. 2. The Charge Nurse failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #7. A review of the January, 2011 physician's orders signed December 30, 2010 directed, " Ativan, Aspirin, Norvasc, lovenox, Metoclopramide, Prednisone, multivitamin, Ranitidine, Benadryl, Trileptal, Simvastatin, Acular, Lumigan and Alphagan." A review of the plan of care for Resident #7 lacked documented evidence that facility staff developed a care plan with goals and approaches for the potential drug interactions for the use of nine (9) or more medications. A face-to-face interview was conducted on January13, 2011 at approximately 12:21 PM with Employees #7 and #9. They acknowledged that a care plan for the use of nine (9) or more medications was not initiated. The record was reviewed January 12, 2011. 3. The Charge Nurse failed to develop a care plan for potential adverse drug interactions with the use of nine (9) or more medications for Resident #8. A review of the clinical record for Resident #8 revealed a physician's order dated and signed December 30, 2010 that included the following medications: K-Dur, Lactulose, Lexapro, Mirtazepine, Morphine ER, Nizatidine, Ditropan, Senna, Acetaminophen, Abillify and Amantadine.	L 051		

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L 051	Continued From page 3 A review of the care plan that was last updated on September 30, 2010 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #7 at approximately 11:00AM on January 18, 2011 He/she looked at the care plans and acknowledged the finding. The Charge Nurse failed to develop a care plan with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications for Resident #8. The record was reviewed on January 12, 2011. 4. The Charge Nurse failed to initiate a care plan for the potential drug interactions for the use of nine (9) or more medications for Resident #12. A review of the January 2011 physician ' s orders signed December 30, 2010 directed, " Trazadone, Folic Acid, Zocor, Thiamine, Lisinopril, Hydrochlorothiazide, Senna, Colace, Seroquel, Miralax, Multivitamin and Tylenol." A review of the plan of care for Resident #12 lacked documented evidence that facility staff developed a care plan with goals and approaches for the potential drug interactions for the use of nine (9) or more medications. A face-to-face interview was conducted on January 14, 2011 at 1:21 PM with Employee #3. He/she acknowledged that a care plan for the potential drug interactions for the use of nine (9) or more medications was not initiated. The record	L 051		

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L 051	Continued From page 4 was reviewed on January 14, 2011. 5A. The Charge Nurse failed to initiate a care plan with appropriate goals and approaches for Resident #E1, who was on C-PAP [Continuous Positive Airway Pressure]. A review of a pulmonary consult dated and signed July 22, 2010 revealed, " Use CPAP with sleep at 12 cm H20 pressure. " A review of Resident #E1's record revealed a physician's order dated July 22, 2010, directing, "Use C-PAP with sleep at 12 cm H20. " The care plan, last reviewed September 9, 2010, was not updated to include appropriate goals and approaches for the use of a C-PAP machine. A face-to-face interview was conducted with Employee #7 on January 14, 2011 at 10:00 AM. He/she acknowledged that there should have been a care plan for the use of the CPAP machine. The record was reviewed July 14, 2011. 5B. The Charge Nurse staff failed to initiate a care plan with appropriate goals and approaches for allergies to Penicillins and Lisinopril for Resident #E1. The physician's note dated August 27, 2010 revealed, " Allergy- PCN [Penicillin] and Lisinopril." A review of the November and January 2011 Physician ' s Order sheet, signed by the physician on December 29, 2010 and January 12, 2011 revealed, " Allergies: Penicillins, Lisinopril. " The Medication Administration Record [MAR] for	L 051		

Health Regulation Administration

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L 051	Continued From page 5 July 2010 revealed, " Allergies: Penicillins, Lisinopril. " The resident ' s care plan initiated December 2, 2009, last updated September 9, 2010 lacked evidence that a care plan with goals and approaches was developed to address the resident ' s allergies. A face-to-face interview was conducted on January 14, 2011 at approximately 2:00 PM with Employee #7. He/she acknowledged that there was no care plan for allergies for Resident #E1. The record was reviewed on January 14, 2011.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to:	L 052		

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L 052	Continued From page 6 (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations, record review and staff interviews for one (1) of 16 sampled residents and five (5) of 61 supplemental residents, it was determined that sufficient nursing time was not given to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed. Residents #16, F1, F2, F3, SAM1 and SAM2. An Immediate Jeopardy at CFR 483.25 (H) (I) and (2) F323 Accidents and Supervision was identified on January 18, 2011 at 3:13 PM. Facility staff failed to ensure that each resident receives adequate supervision to prevent accidents as evidenced by failing to complete	L 052		

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L 052	Continued From page 7 elopement risk assessment on residents that have been identified as being at risk for elopement and failure to update risk assessment as needed after a resident had eloped from the facility and had not yet been found. An additional review of charts for all residents currently in the facility was conducted on January 18, 2011. The review revealed "Elopement Risk Assessments" were not completed and/or updated on 74 of 77 of the residents. The allegation of removal of the IJ situation was received and verified on January 18, 2011 at 6:05 PM and the Immediate Jeopardy was lifted at this time. The findings include: Policies The policy entitled, " Care of the Wandering Residents" effective 12/01/08 stipulated, "Purpose: To ensure the safety of the residents, who have exhibited wandering behavior, the following protocol shall be implemented ...2. Place the resident in a room near the nurse's station when possible for close monitoring of the resident's activities. Place green dot on resident ' s ID [identification] band (code for wanders). Inform security at the front desk to watch out for wandering residents, (picture ID of the resident should be given to security). " The policy entitled, "Resident Elopement " effective 12/01/08 stipulated, "Procedure: Determining Elopement Risk: 2. The Elopement Risk Assessment is completed by the nursing staff for all residents within 48 hours of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement. " A review of the Elopement Risk Assessment revealed that there were no guidelines for facility staff to follow after completing the risk	L 052	1. Resident # 16 was found and returned safely to the Nursing Center on 01/20/11. The resident was discharged to the hospital (United Medical Center) at the time of return. Elopement Risk Assessments were completed immediately on residents F1, F2, F3, SAM1, and SAM2 on 01/19/2011. The Security Department was in-serviced on elopement and updated with names and photographs of residents that are potential elopement risk. The portable electric heater that was store directly on the floor of room# 758 was removed. The filters were cleaned in the dryer in the residents' laundry and it no longer leaks. The oxygen rooms on the 6th and 7th floor are now locked and the key is kept with nursing supervisor. All oxygen tanks are secured and stored in carriers in both oxygen rooms 2. Elopement Risk Assessments were given to all Residents in the Nursing Center and completed on 01/24/2011. These residents found to be elopement risk were places under elopement precautions per the facilities elopement policy and the Security Department was notified. All resident rooms and common areas were check to assure that the environment is free from accident hazards	

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L 052	Continued From page 8 assessment to aide in the determination of the resident being at risk for elopement. On January 11, 2011 approximately 9:00 AM during tour of the facility on the 6th floor unit Employee #33 stated, "Is it not a shame that Resident # 16 eloped from the facility since the weekend and they have not found him/her as yet. " Further investigation revealed: 1. Resident #16 was admitted to the facility on August 13, 2010. A review of the nursing notes revealed the following: August 24, 2010 at 11:00 PM, "monitor for elopement per order. " August 27, 2010 at 11:00 PM, "...continue monitoring for elopement... " November 28, 2010 at 4:00 PM, "monitored qhr [every hour] for elopement " January 2, 2011 at 3:45 PM revealed, " On rounds at 7:00 AM, received in day room watching TV[television]. Alert and verbally responsive. All 10 AM meds [medication] given and tolerated well. Ambulate on the hallway without difficulty . Rounding [unable to read] given. At 2:15 PM received a call from resident in Room 655A, Stated: "patient seen walking toward metro station. Nursing supervisor notified. Myself and another staff member went out in search for resident at the metro area and around the area close by street. Placed a call to the unit spoke to DON who advised us to return back to the unit. Then DC Police came for report. Please follow-up Nursing supervisor. [Notified] the responsible party at 2:25 PM. At this time resident	L 052	3. Per the Nursing Centers Elopement policy, the Social Worker or designee will complete an Elopement Risk Evaluation on all residents on admission, readmission and change of condition. With the use of the elopement risk evaluation tool, if a score of 10 or greater is achieved than preventive strategies will be implemented. The elopement books located with UMC Security Department will be updated with a photograph, floor and room numbers of the residents at risk. When updating the Elopement book we will document the dates on each new residents photograph. The elopement book will be updated quarterly to reflect any changes in physical appearance, change of risk status and health condition of the resident. All other interventions and/or strategies will be followed according to the Resident Elopement Risk and Wandering policy. The DON or designee will audit the elopement procedures for compliance weekly. The Administrator or designee will make weekly environmental round to assure that the environment is free from accident hazards 4. The DON or designee will present the findings from these audits/rounds to the Quality Assurance Committee monthly (on going) starting March 2011.	3/6/2011

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L 052	Continued From page 9 has not returned back to the unit ... " A review of the "Elopement Risk Assessment " was last completed on August 18, 2010. There was no evidence in the clinical record that an "Elopement Risk Assessment" was updated after August 18, 2010. The December 2010 and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #16 was being monitored for roaming around. Additionally, Resident #16 was not on a schedule to be checked on an hourly bases. The record was reviewed as a closed record because the resident had not returned to the facility at the time of the survey. On January 13, 2011 at 10:30 AM a face-to-face interview was conducted with Employee #28 in the main lobby security desk. He/she stated, "We do not have any pictures of any residents [posted at the main desk]. " On January 14, 2011 at 11:38 AM a face-to-face interview was conducted with Employee # 15. He/she stated, "We don't know until they notify us of a missing resident. We don't know in advance who the elopers are. We have never known who the residents are that may elope. We never had any pictures of any residents downstairs [at the security desks]. After they [residents that may have eloped] leave we are notified and we get a picture. We search the grounds and we notify Metropolitan Police Department and give them a report. We checked the cameras yesterday (January 13, 2011). It was around 1:34 PM on January 2, 2011, the resident was seen exiting the front elevator. He/she sits in the lobby area doing something with his/her shoe. He/she talks to the security officer at the desk in the main lobby and then exits the building. Had the security officer known that the resident was and	L 052		

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L 052	Continued From page 10 eloper, the officer would have escorted the resident back upstairs. " On January 14, 2011 at 6:40 PM a face-to-face interview was conducted with Employees #23 and 24 in the main lobby. They showed the SA representative pictures of the resident's that were potential elopers. And they stated that they were inserviced by the previous officer on duty." A review of clinical records was conducted for other residents identified by the facility to be at risk for elopement and wanders. 2. Resident #F1's clinical record revealed that the " Elopement Risk Assessment " was completed on admission and not updated as necessary, and with any change in behavior, which would place the resident at risk for elopement. The November and December 2010 and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F1 was being monitored for wandering. The Elopement Care Plan was initiated on August 15, 2010 and last updated on December 26, 2010. The nursing notes revealed, "December 5, 2010 at 4:00 PM RT ' s [resident ' s] condition remains stable. Continues pacing along the hallway. Needs constant re-directing and encouragement ...Closely monitored for elopement risk." According to the "Hourly Round" sheets for December 2010 and January 2011, Resident #F1 was monitored hourly. There was no evidence in the clinical record that an " Elopement Risk Assessment " was completed on admission and as necessary, and with any change in behavior, which would place the resident at risk for elopement. . 3. Resident #F2 ' s clinical record revealed that the " Elopement Risk Assessment " was not updated as necessary, and with any change in behavior, which would place the resident at risk	L 052		

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L 052	Continued From page 11 for elopement. The December 2010 and January 2011 Psychoactive Medication Monthly Flow Records revealed that Resident #F2 was being monitored for non-compliant. The Elopement Care Plan was last updated on December 30, 2010. A physician ' s order dated December 21, 2010 at 7:30 AM directed, " D/C [discontinue] every hourly monitoring for elopement. Start to monitor resident for elopement every four (4) hours times two (2) weeks, then every shift. " The nursing notes revealed, " December 20, 2010 at 12:30 PM, " Remain on hourly rounds 2nd to elopement risk and no attempt noted ...Out of bed to w/c [wheel chair] and propel self around the unit. The nursing notes revealed, " December 21, 2010 at 3:00 PM, " Started on Q4 hr [every four hour] rounds. Monitor for elopement risk. No attempt noted ... " According to the " Hourly Round " sheets for December 2010 and January 2011, Resident #F2 was monitored hourly. A review of the " Elopement Risk Assessment " was last completed on July 29, 2010. There was no evidence in the clinical record that an " Elopement Risk Assessment " was updated as needed after July 29, 2010 and after the physician ' s order on December 21, 2010. 4. Resident #F3 ' s clinical record revealed that the " Elopement Risk Assessment " was not updated of admission, as necessary, and with any change in behavior, which would place the resident at risk for elopement. The November 2010 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for agitation and psychiatric disorder; and January 2011	L 052		

Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER UNITED MEDICAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032		

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L 052	Continued From page 12 Psychoactive Medication Monthly Flow Records revealed that Resident #F3 was being monitored for anxiety and agitation. The Elopement Care Plan was last updated on December 23, 2010. The nursing notes revealed, " November 9, 2010 at 11:00 PM, " ...Patient collected his/her bag, [stated] that his/her room is on [the] 1st floor. All attempts [made] for him/her to go back to his/her room [was] to no avail. Attempted to get to the elevator, security called and was sent back to his/her room ... " The record lacked evidence that hourly rounds and the elopement risk assessment was completed after the aforementioned episode. The Treatment Administration Record dated December 21, 2010 directed, " Every four (4) hours Round monitoring 2nd to elopement risk times two (2) weeks, then every shift. " There was no documentation in the clinical record to support why this order was initiated. According to the " Hourly Round " sheets for December 2010 and January 2011, Resident #F3 was monitored hourly. A review of the " Elopement Risk Assessment " revealed that it was last completed on May 20, 2010. There was no evidence in the clinical record that an " Elopement Risk Assessment " was updated after May 20, 2010. On January 14, 2011 at approximately 10:45 AM a face-to-face interview was conducted with Employee # 7. He/she acknowledged that there was no elopement risk assessment completed for Resident ' s #F1, F2 and F3. 5. Facility staff failed to assess the resident for elopement risk on admission and to identify behaviors which would place the resident at risk for elopement. Resident #SAM1. Record review revealed that resident was admitted to the facility on November 11, 2010	L 052		

Health Regulation Administration

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L 052	Continued From page 13 with diagnoses of : history of Schizophrenia, Hypertension, status post CVA [Cerebral Vascular Accident] and Dementia. Nurse ' s note dated November 13, 2010 at 2:00 AM " Due to resident continuously walking in hallway and refusal to stay in bed, given one tablet po [by mouth] of 50 mg Trazodone. ' Resident states what time does the bus come? "Reassured him/her about place and time and escorted him/her back to his/her room. " Nurse ' s note dated November 13, 2010 at 4:00 AM " Resident continues to walk the hallways and enter other residents ' rooms. Requires constant monitoring. Nursing documentation from November 13, 2010 through December 27, 2010 reveals that the resident is constantly walking the unit hallways and entering other resident rooms. Resident with aggressive behaviors toward staff and other residents. Nurses note dated December 27, 2010 at 4:45 PM Resident alert , OOB [out of bed] ambulating, verbally [with] the staff tried to get the elevator today ... " Nurses note dated January 15, 2011 at 8:00 AM Resident was seen in the back elevator @ [at] 5:00 AM by a nurse. Resident was re directed back to his/her room. Copies of resident ' s picture sent to security. Responsible party [name] made aware..MD also made aware. Hourly monitoring in progress for elopement risk. Physician ' s order January 25, 2011 " Hourly monitoring for resident when ...[unable to read word] 2/2 Elopement risk Q[every] shift. " A review of the clinical record lacked evidence that an Elopement Risk Assessment had been completed on the resident on admission or with behaviors that indicate the resident was an elopement risk. A face-to-face interview was conducted on	L 052		

Health Regulation Administration

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L 052	Continued From page 14 January 18, 2011 at 11:30 AM with Employee # 3 who reviewed the record. He/she was unable to locate an Elopement Risk Assessment on the record. 6. Facility staff failed to assess the resident for elopement risk following the resident ' s verbalization he/she wanted to leave the facility. Resident #SAM2. Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included Diabetes Mellitus, Essential Hypertension, and Osteomyelitis of Right foot, The resident had previously resided at a Mental Health Group Home since 1995 prior to requiring acute care and subsequently being admitted to the long term care Facility. Nursing note dated and signed on December 13, 2010 at 10:30 AM indicated: " ...resident states: I am going. There will be no more treatment for me. I[am] no longer staying here. " The record lacked evidence that an Elopement Risk Assessment was completed or that care plan was implemented for elopement risk. Psychiatrist Consult note completed December 13, 2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home " Okay to discharge to [mental health group home] home with recommended Medications. Physician ' s order dated and signed December 13, 2010 at 12:20 PM directed, "Psych. Resident may be disch. [discharged] Home-(self care) resume Anchor Health Medical Center." Physician ' s order dated and signed December	L 052		

Health Regulation Administration

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L 052	Continued From page 15 15, 2010 at 1910, directed, "Discharge to home in the AM". Physician ' s order dated December 28, 2010 and signed December 30, 2010 directed, "Hold resident ' s Discharge/Planning secondary Anchor Health team unable to secure resident a house". Resident refused Insulin therapy [sliding scale coverage and /or finger sticks] between January 2, 2011 and January 14, 2011. Record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy. A review of the clinical record lacked evidence that an " Elopement Risk Assessment " was completed upon admission and up-dated as needed for Resident #SAM2. A face-to-face interview was conducted with Employee #7 at approximately 4:30 PM on January 18, 2011. He/she acknowledged that the record lacked documented evidence that an elopement risk assessment was completed on the Resident until January 14, 2011 when the elopement protocol was implemented due to resident's refusal of insulin therapy. The record was reviewed on January 18, 2011. B. Based on observations and staff interview for two (2) of 16 sampled residents, it was determined that sufficient nursing time shall be given to protect the resident from infection during trach care according to accepted standards of clinical practice. Residents #2 and #3. The findings include: 1.Sufficient nursing time was not given to protect	L 052		

Health Regulation Administration

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L 052	Continued From page 16 the resident to ensure that Resident #2 received proper treatment and care for tracheal suctioning. According to " Physician ' s Orders" dated and signed December 19, 2010 directed, "Trach care every shift and prn [as needed], Suction [every] shift and as needed." Employee #10 was observed on January 12, 2011 at approximately 2:25 PM performing trach care to Resident #2. During preparation for trach care, Employee #10 opened one sterile catheter kit and created his/her sterile field. Employee #10 then proceeded to remove a previously opened catheter kit tray with a suction catheter exposed from Resident #2 ' s bedside table. He/she then removed the suction catheter from the previously open tray and placed it on the sterile field. At this point the sterile field was contaminated. Employee #10 failed to maintain sterile technique during preparation for trach care. According to the " 2007 Lippincott ' s Nursing Manual " , under Tracheostomy Care Procedure " revealed for sterile tracheobronchial suction by way of tracheostomy .... Equipment ...assemble the following equipment or obtain a prepackaged suctioning kit: Sterile suction catheters ... " A face-to-face interview was conducted on January 12, 2011 at 2:25 PM with Employees #3 and #4. They acknowledged that Employee #10 should have used a new prepackaged sterile suction kit with a catheter in preparing for Resident #2 ' s trach care. 2.Sufficient nursing time was not given to suction trach according to accepted standards of clinical practice during trach care for Resident #3. On January 14, 2011 at 9:30 AM during trach	L 052	1. The licensed Nurse that failed to provide tracheal suctioning according to accepted standards of clinical practice for residents #2 and 3 were reprimanded and reeducated on correcting that deficient practice. 2. All other licensed Nursing Staff that may do trach care were reeducated on providing tracheal suctioning care. 3. All licensed staff will be given an in service relating to Tracheotomy Care to include Policies on "Suctioning a Tracheotomy Tube and Tracheotomy Care" by the DON or designee. A Competency Validation Tool on Critical Elements for Suctioning will be used. The goal is that all RN/LPN will demonstrate knowledge and skill in suctioning and tracheotomy. Must meet all the critical elements of the procedure and will be checked randomly by the unit manager and nursing supervisors weekly for 3 months until each licensed can demonstrate the procedure times five. 4. Findings from these random checks will be presented to the Quality Assurance Committee Monthly starting March 2011.	3/6/2011

Health Regulation Administration

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L 052	Continued From page 17 care observation Employee #22 washed his/her hands and pulled out a suction care kit out of Resident #3 ' s bedside drawer that consisted of sterile gloves, container for normal saline and suction catheter. He/she then don blue clean gloves on, open sterile packet pull sterile suction catheter out of bag, connected suction catheter to suction tubing and ask resident to hold the suction tubing with the sterile suction catheter attached to it. He/she then removed the blue clean gloves and placed them in garbage bag then without washing his /her hands removed sterile gloves from its container and put them on. He/she opened up the normal saline bottle and poured the saline solution in the sterile container then took suction tubing with the sterile catheter attached back from resident and proceeded with suctioning resident trach. After trach suctioning she voiced that the trach care was already done by respiratory. He/she removed all used supply and placed them in garbage bag then cleaned resident table discard trash in biohazard container in soiled utility room and then he/she washed hands. During observation facility staff failed to use " Professional Standard of Quality " to suction trach during trach care. " Wash hands with antimicrobial soap. Opens equipment and sets up sterile field. Fill the two basins provided in kit with Normal Saline or sterile water. Dons face mask, gown, and goggles (if splashing is anticipated). Dons sterile gloves provided in suction catheter kit. Designate one hand as contaminated for disconnecting, bagging, and working the suction control. Usually the dominant hand is kept sterile and will be used to thread the suction catheter. Use the sterile hand to remove carefully the suction catheter from the package, curling the catheter around the gloves fingers. Connect suction source to the	L 052		

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L 052	Continued From page 18 suction fitting of the catheter with the contaminated hand. Using contaminated hand disconnect the resident from the ventilator. Suction inner cannula. Gently insert suction catheter as far as possible into the artificial airway without applying suction, withdraw catheter 2 to 3cm and apply suction. Quickly rotate the catheter while it is being withdrawn. Limit suction time to no more than 10 seconds. Instill 3-5ml sterile normal saline into the artificial airway during spontaneous inspiration if secretions are tenacious. Rinse catheter between suction passes by inserting tip in cup of sterile water and applying suction. Continue making suction passé, bagging the resident between passes, until the airways are clear of accumulated secretions. Give the patient four to five " sigh " breaths with ambu bag. Return the resident to ventilator. " Tracheostomy Care Procedure, Fundamentals of Nursing Made Incredibly Easy (2007) Lippincott www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Nursing/T-25.pdf <http://www.sh.lsuhsc.edu/policies/policy_manuals_via_ms_word/Nursing/T-25.pdf> A face-to-face interview was conducted on January 14, 2011 at 9:40 AM with Employees #7, #9 and #22. He/she acknowledged that trach suctioning was not provided according to professional standard of practice. The record was reviewed on January 14, 2011. C. Based on record review and staff interview for one (1) of 16 sampled residents, it was determined that sufficient nursing time was not given to ensure that medication was received from the pharmacy and available to be administered to the resident. Resident #11. The findings include:	L 052		

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L 052	Continued From page 19 A review of Resident #11 ' s record revealed a physician ' s order signed January 6, 2011 directed: "Ambien 10 mg by mouth every at bedtime for Insomnia. " A review of the Medication Administration Record for January 2011 revealed that the facility identified that the Ambien was to be administered at 10:00 PM. Reviews of the January 2011 Medication Administration Record (MAR) revealed that Resident #11 was not administered on January 11 and 12, 2011. The reason written on the reverse side of the January 2011 MAR was "Not available, not given ". A face-to-face interview was conducted with Employee #7 on January 18, 2011 at approximately 3:00 PM. He/she stated that the medication had not been delivered from the pharmacy, and the ambien was not given to the resident. The was no evidence that the facility ensured that Ambien was received from the pharmacy in a timely manner to be administered to the resident in accordance with the physician's order. The record was reviewed January 18, 2011. D. Based on observations and staff interview of one (1) of 10 supplemental residents, it was determined that sufficient nursing time was not given to help prevent the development and transmission of disease and infection as evidenced by an employee was observed using his/her bare hands to assist one (1) resident with lunch. Resident #E3.	L 052	1. No resident was negatively affected by this deficient practice. Resident #2, 5 an 6 were weighed according to the Physicians Orders. 2. All other resident were checked that may be affected by this deficient practice to assure that their weights have be taken according to the Physicians order. Those that were found to be out of compliance were weighed. 3. All residents monthly and weekly weights will be monitored by the Unit Manager and the Charge Nurses. The Monthly and /or weekly weight variance report is discussed in the weekly risk meeting. A weight monitoring log has been developed to record weights taken on admission audited weekly. 4. Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May 2011. 3B 1. Resident # 6 was not negatively affected by the deficient practice. 2. All other resident were checked that may be affected by this deficient practice if their medication was found not to available at that it was immediately ordered from the pharmacy. 3. A controlled substance procedure to overview C2-C5 medications has been developed. An Emergency Narcotic Box has been in placed to ensure C2 medications are being given as ordered by the physician. An in service was conducted by the Pharmacist to the LPN/RN and C2-C5 overview is part of the new employee orientation. The DON or designee will be auditing the controlled substance procedure weekly. 4. Findings from these weekly audits will be reported at the Quality Assurance Committee monthly times three March, April and May 2011	3/6/2011

Health Regulation Administration

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L 052	Continued From page 20 The findings include: Sufficient nursing time was not given to ensure that proper infection control practices were followed to prevent the spread of infections during the lunch meal for Resident #E3. Resident #E3 was observed during lunch in the dining room on the seventh floor January 14, 2011 at approximately 12:35 PM. Employee #12 was observed cutting the residents fish sandwich with his/her bare hands. Facility staff failed to ensure proper infection control practices were followed prior to cutting resident ' s fish sandwich. A face-to-face interview was conducted with Employee #3 on January 14, 2011 at approximately 1:20 PM. He/she acknowledged that Employee #12 should have gloves on before cutting resident ' s fish sandwich and was discussed with Employee #12. The observation was made on January 14, 2011.	L 052	1. There are no residents that were negatively affected by these deficient practices. The clean linen carts observed uncovered in a cart from room #606 and in the clean room on the seventh floor were covered at the time of the survey. Employee # 12 was reprimanded for not using the proper infection control practices (using gloves) prior to cutting a resident's fish sandwich. 2. All other linen carts were check for covers. If others were found, they were cover immediately. 3. The DON or designee will reeducate the nursing staff on the proper infection control practices of keeping the linen carts covered and handle resident's food. The DON or designee will monitor this for compliance weekly. 4. The DON or designee will report the findings of this monitoring at the Quality Assurance meeting monthly times three March, April and May 2011.	3/6/2011
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: A. Based on observations made during the environmental tour of the facility on January 11 thru January 18, 2011, it was determined that the facility failed to provide a safe, sanitary and	L 091		

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L 091	Continued From page 21 comfortable environment as evidence by: facility staff failed to decrease the spread of infection by failure to keep clean linen covered in two (2) of two (2) observations and failed to maintain fall mats in accordance with facility policies and procedures. The findings include: 1. Facility failed to keep clean linen covered in two (2) of two (2) observations. Clean linen was observed uncovered in a cart across from room #606 and in the clean utility room on the seventh floor. 2. Facility failed to maintain fall mats in accordance with facility policies and procedures. Staff member was observed standing on the floor mat in room #606 and medical equipment was seen stored on the floor mat in room #750. These observations were made in the presence of Employees #1 and #19 who acknowledged these findings during the survey.	L 091	1. There are no residents that were negatively affected by these deficient practices. The clean linen carts observed uncovered in a cart from room #606 and in the clean room on the seventh floor were covered at the time of the survey. Employee # 12 was reprimanded for not using the proper infection control practices (using gloves) prior to cutting a resident's fish sandwich. 2. All other linen carts were check for covers. If others were found, they were cover immediately. 3. The DON or designee will reeducate the nursing staff on the proper infection control practices of keeping the linen carts covered and handle resident's food. The DON or designee will monitor this for compliance weekly. 4. The DON or designee will report the findings of this monitoring at the Quality Assurance meeting monthly times three March, April and May 2011.	3/6/2011
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, interviews and record reviews on January 11 thru January 14, 2011, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by one (1) of one (1) cook-chill bag of cheesy grits, one (1) of one (1) cook-chill bag of chicken gravy, one (1) of one (1) cook-chill bag of chicken broth and two (2) of two (2) bags of meat sauce that were stored beyond their expiration	L 099	1. Food items that were stored beyond their expiration date in the walk-in 1 refrigerator including: one cook- chill bag of cheesy grits with a expiration date of 01/05/11, one cook-chill bag of chicken gravy expired 11/22/10, one cook –chill bag of chicken broth (01/03/11) and two bags of meat sauce were disposed of at the time of the survey.	

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L 099	Continued From page 22 date; two (2) of three (3) garbage disposals and one (1) of two (2) walk-in freezer that were out of order; one (1) of two (2) walk-in freezer that was unable to sustain required temperatures; one (1) of two (2) refrigerators with a broken door handle and a torn gasket; 30 of 30 soiled, dented and damaged full sheet pans and five (5) of seven (7) soiled pizza pans; 15 of 15 expired loaves of bread; prematurely recorded entries on the pots and pans log and the dishwashing machine logs; out of range temperatures on hot and cold foods from the test tray and approximately 100 of 100 serving trays that were inappropriately stored. The findings include: 1. Food items were stored beyond their expiration date in the walkin1 refrigerator including: one cook-chill bag of cheesy grits with an expiration date of 1-5-11, one cook-chill bag of chicken gravy expired 11-22-2010, one cook-chill bag of chicken broth (1-3-2011) and two bags of meat sauce (1-10-2011). 2. Essential equipment such as two (2) of three (3) garbage disposals and one (1) of two (2) walk-in freezers were not functioning and had been inoperative for 30 to 60 days. 3. Walking freezer #2 was not maintaining the expected temperatures of zero to -10 degrees F due to a broken latch at the entrance door. 4. The entrance door to the walkin1 refrigerator would not completely close due to a broken door handle and a torn door gasket. 5. 30 of 30 full sheet pans were soiled, dented and damaged and needed to be replaced. 6. Five (5) of seven (7) pizza pans were soiled with food residue. 7. Fifteen loaves of bread with an expiration date of October 2010 were stored in the walk-in freezer #1. 8. The pots and pans sanitizing log entries and	L 099	Essential equipment such as two of three garbage disposals and one of two walk-in freezers that were not working was repaired. The walk-in freezer#2 that was not maintaining the expected temperatures of zero to ten degrees F due to a broken latch at the entrance door was repaired. The entrance door to the walk-in 1 refrigerator that would not completely close due to a broken door handle and a torn door gasket was repaired. The 30 full sheet pans that were soiled, dented and damaged were discarded and replaced. The 5 pizza pans that were soiled with food residue were cleaned at the time of the survey. Fifteen loaves of bread with an expiration date of October 2010 in the walk in freezer #1 was discarded at the time of the survey. The dietary staff was reprimanded for prerecording the pot and pans sanitizing log and the dishwashing machine log entries. Re educate staff on proper documentation. The dietary staff examined the process used in the kitchen for keeping hot foods hot 140F> and Cold food s cold <40F. Re educate staff on process. The 100 serving trays that were found wet and stacked on top of each other were rewashed and dried. 2. All other areas in the kitchens that would pertain to these deficient practices stated above we check and corrected if needed. 3. The Dinning Service director or designee will monitor compliance of the cited deficient practices weekly. 4. The findings from the audit will be presented at the quality Assurance meeting monthly times three March, April and May 2011.	3/6/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 23 the dishwashing machine log entries for 1-11-2011 were pre-recorded. Copies of both logs were presented to this surveyor at 10:15 am on January 11, 2011 and the afternoon and evening entries had already been documented. 9. Test tray hot foods such as roasted red potatoes (131 degrees F), puree carrots (136 F) and fish (137.5 F) were measured at temperatures below 140 F and cold foods such as milk (59 F), yogurt (58F), canned peaches (59 F) and iced tea (57 F) were below the expected cold food temperature of 41 F. 10. Approximately 100 of 100 serving trays were stacked wet, on top of each other. These observations were made in the presence of Employee # 16 who acknowledged these findings during the survey.	L 099		
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	L 128		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/19/2011
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L 128	Continued From page 24 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 of one (1) of 16 sampled residents, it was determined that the supervising pharmacist failed to review the drug regimen monthly and report any irregularities for Resident #5. The findings include: Review of the Physician ' s Order dated and signed by the Physician on January 12, 2011 for Resident #5 revealed that the resident was prescribed eight (8) medications: Allupurinol 100mg, Aspirin 81mg, Clonidine 0.1mg, Digoxin 0.05mg/ml, diltiazem 30 mg, Diovan 320mg, Lovenox injection 60mg/0.6ml, Simvastatin 40mg. A review of the " Chronological Record of Medication Review " form was last dated November 26, 2010. A face-to-face interview was conducted with Employee # 2 on January 12, 2011 at 12:13 PM. After review of the medication regimen for Resident #5 he/she acknowledged the findings and indicated that he/she will inform the pharmacist. The record was reviewed on January 12, 2011.	L 128	1. Resident # 5 was not affected negatively by this deficient practice.. 2. The licensed pharmacist was called to review the medication regimen of all residents of the facility. 3. The Pharmacy has communicated to the Administrator of the facility that a licensed pharmacist will review the medication regimen of all the residents in the facility monthly. Should there be an occasion when the regularly assigned licensed pharmacist is not available then the pharmacy will send an alternate replacement. The administrator or designee will monitor the pharmacy for compliance monthly. (on going) 4. Finding from this monitoring will be shared at the Quality Assurance Meeting Monthly.	3/6/2011
L 182	3229.4 Nursing Facilities In conjunction with the resident's admission, stay, and discharge, the functions of the social services program shall include the following:	L 182		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

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L 182	Continued From page 25 (a)Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b)Advocacy on behalf of residents; (c)Discharge planning; (d)Community liaison and services; (e)Consultation with other members of the facility's Interdisciplinary Care Team; (f)Safeguarding the confidentiality of social service records; and (g)Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 16 sampled and two (2) of 10 supplemental residents, it was determined that Social Worker failed to provide medically related social services and discharge planning to meet residents' needs for two (2) residents, failed to assist one (1) resident with completing an application for Social Security and failed to assist one (1) resident with discharge to a mental health group home. Residents #11,14, P1 and SAM2. The findings include: 1. The Social Worker failed to provide medically-related social services to assist	L 182	1. A qualified Social Worker was hired and started working on 02/14/2011. Medically – Related social services will be provided to assist resident #11 in completing their application for Social Security. The Social Worker will also complete the quarterly social services assessment for Resident #11. Resident #14 was discharged to the community 12/17/2011. Social Services will provide evidence that resident #14 was referred to Community Connection for discharge. Social worker will evaluate and assist resident #P1 in discharge planning and medically related social services. Social worker will evaluate appropriateness and assist resident #SAM2 in discharge planning to go to a mental health group home other medically related social services. 2. All other residents were check that may be affected by this deficient practice and the Social Worker or designee will assist the resident with the appropriate medically related social services for compliance if needed. 3. The new Social Worker will working on bring the facility back in compliance with resident social assessments, MDS, care plans and handling resident medically related social services needs etc. 4. The Social Worker will report their progress at the Quality Assurance meeting monthly.(on going)	3/6/2011

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/19/2011
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L 182	Continued From page 26 Resident #11 in completing his/her application for Social Security. Resident #11 was admitted to the facility on September 11, 2009. A review was conducted of a letter sent from the Social Security Administration dated May 12, 2010, second request. The letter was sent to Resident #11 requesting information necessary to complete his/her application for Medicaid. The letter also stipulated, "It is important that you return the information to us right away so that we can decide if you are eligible. You could lose benefits if you return the information to us after May 24, 2010." A face-to-face interview was conducted with Resident #11 on January 12, 2011 at 11:30 AM. He/she stated, "I have not spoke with a social worker in months; and I have not had my social security paperwork followed up on." The record lacked evidence that information was sent to the Social Security Administration to complete the application process. Additionally there were no ongoing quarterly social service assessments for Resident #11. A face-to-face interview was conducted with Employee #7 on January 14, 2011 at 3:00 PM. He/she acknowledged that there were no social services notes on the resident's clinical record. The record was reviewed on January 14, 2011. 2. Social Worker failed to provide medically-related social services to meet needs for discharging Resident #14. Physician ' s orders dated and signed November 28, 2010, directed " Please follow up at Community Connection with [MD].	L 182		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING B. WING	01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 182	Continued From page 27 A psychiatric consultation note dated December 13, 2010 at 12:25 PM included: "...Zyprexia for Schizophrenia- seeing devil- [decreased for -9-10 months. [Diagnosis] Schizophrenia since 2/10 [February 2010] ... with Community Connections, stays home - apartment with wife... Plan - OK for discharge. Rx - Zyprexia, community connections referral. " An interim telephone order dated December 6, 2010 at [3:18 PM] revealed, " Resident to have discharge planning. " There was no evidence that Resident #14 was refereed to Community Connections. A face-to-face interview was conducted with Employee #2 on January 18, 2011at 12:00 PM. He/She acknowledged that there were no documented social service interventions in the record. The record was reviewed on January 18, 2011. 3. The Social Worker failed to provide medically related social services and discharge planning for Resident #P1. Review of the information documented in the admission history revealed that the resident was admitted to the facility on December 12, 2010 with diagnoses that included: Thalmic Stroke, Diabetes Mellitus, Lt (Left) Below Knee Amputation, Cholecystitis, Obesity and Rt (Right) Hemiparesis. A review of the Social Work Section failed to reveal any documentation. Further review of the record failed to reveal any discharge planning	L 182		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/19/2011
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L 182	Continued From page 28 documentation. A face-to-face interview was conducted with Resident P1 at approximately 10:30AM on January 14, 2011. The resident was queried about his/her plans for discharge and whether he/she had spoken to the social worker. He/she stated, " I have not seen a social worker since I was admitted. I am not sure where I will go after discharge. I came from another facility but I do not want to return there and I do not want to stay here. I hope someone can help me find a good place. " A face-to-face interview was conducted with Employee #2 at approximately 2:00 PM on January 14, 2011. He/she acknowledged that the record lacked social work documentation/intervention. He/she added, " We have not had a social worker for a while but we hired one. He/she will be starting to work soon. However, I have been doing everything I can to meet the residents ' needs. " The record was reviewed on January 14, 2011. 4. The Social Worker failed to provide medically related social services and discharge planning for Resident #SAM2 who was to be discharged to a mental health group home. Review of the information documented in the admission history revealed that the resident was admitted to the facility on September 29, 2010 with diagnoses which included: Diabetes Mellitus, Essential Hypertension, and Osteomylitis of Right foot. The resident had previously resided at a Mental Health Group Home prior to requiring acute care and subsequently being admitted to the long term	L 182		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

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L 182	Continued From page 29 care Facility. Nursing note Dated and signed on December 13, 2010 at 10:30 AM indicated: " ...resident states: I am going. There will be no more treatment for me. I[am] no longer staying here. " Psychiatrist Consult note completed December 13, 2010 at 11:25 AM reveals " refusing treatment & [and] wants to go home " Okay to discharge to [mental health group home] home with recommended Medications. Physician ' s order dated and signed December 13, 2010 at 12:20 PM- Psych. Resident may be disch. [discharged] Home-(self care) Resume Anchor Health Medical Center. Physician ' s order dated and signed December 15, 2010 at 1910 Discharge to home in the AM. Resident remains in facility as of January 18, 2011. A review of the Social Work section revealed a social worker note dated and signed November 12, 2010 was titled an introductory note and lacked documentation of any discharge planning which included the resident being discharged to a mental health group home. This was the only note in the record for the social worker. A face-to-face interview was conducted with Employee #2 at approximately 4:30 PM on January 18, 2011. He/she acknowledged that the record lacked documentation of discharge planning by a social worker. The record was reviewed on January 18, 2011.	L 182		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

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L 194	Continued From page 30	L 194		
L 194	3231.5 Nursing Facilities The medical records shall be completed within thirty (30) days from the date of discharge. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 16 sampled residents, it was determined that facility staff failed to complete a discharge summary within thirty days from the date of discharge for Resident #14. The findings include: Resident #14 was admitted to the facility on November 24, 2010, with a [chief complaint] of [Status Post Blount Trauma]. An interim telephone order dated December 16, 2010 at 10:30 AM directed " May discharge resident home today. " A review of the nurse ' s note dated December 16, 2010 at 3:00 PM revealed, " Resident discharged home this morning per Doctor ' s orders. Resident requested discharge. Evaluated by the psychiatrist on December 13, 2010 and deem fit for discharge. Writer spoke with mother who confirmed resident has a safe place to return to. Physician's Orders received by writer by phone. " The medical record lacked evidence of a discharge summary from the physician for Resident #14 who was discharged on December 16, 2010. A face-to-face interview was conducted with Employee #4 on January 18, 2011. He/She acknowledged that the record lacked a physician discharge summary. The clinical record was reviewed on January 18. 2011.	L 194	1. Resident #14 was not negatively affected by this deficient practice. The resident was discharged on 12/16/2010. 2. The charts were review for all other discharged residents to assure that a signed physician discharge summary had been completed and a documented transition plan for medication was present. If the discharge summery was missing, one will be requested from the resident's physician. 3. The DON or designee will reeducate the Physicians and the license nursing staff on the importance of having the physicians discharge summery present on a discharged residents chart within 30 days of discharge and a medication transition plan. The DON or designee will audit discharged residents charts for physicians discharge summaries and medication transition plans monthly. 4. The DON or designee will report the findings of this audit at the Quality Assurance Meeting Monthly times three (March, April and May 2011)	3/6/2011
L 214	3234.1 Nursing Facilities	L 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0030	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/19/2011
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L 214	Continued From page 31 Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made during the environmental tour of the facility on January 11 thru January 18, 2011, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by an electric heater that was observed on the floor in one (1) of 19 resident ' s rooms, a leaky dryer in one (1) of one (1) resident laundry room, two (2) of two (2) unlocked and accessible oxygen rooms and one (1) of six (6) oxygen tank that was stored upright and unsecured. The findings include: 1. A portable, electric heater was stored directly on the floor of room #758. 2. The dryer in the resident laundry room was leaking. 3. The oxygen rooms on the sixth and seventh floor were not secured and were accessible to residents. 4. One (1) of six (6) oxygen tanks was stored upright and was not secured in the oxygen room on the sixth floor. These findings were acknowledged by Employees # 1 and #19 who were present at the time of observation.	L 214	1. Resident # 16 was found and returned safely to the Nursing Center on 01/20/11. The resident was discharged to the hospital (United Medical Center) at the time of return. Elopement Risk Assessments were completed immediately on residents F1, F2, F3, SAM1, and SAM2 on 01/19/2011. The Security Department was in-serviced on elopement and updated with names and photographs of residents that are potential elopement risk. The portable electric heater that was store directly on the floor of room# 758 was removed. The filters were cleaned in the dryer in the residents' laundry and it no longer leaks. The oxygen rooms on the 6th and 7th floor are now locked and the key is kept with nursing supervisor. All oxygen tanks are secured and stored in carriers in both oxygen rooms. 2. Elopement Risk Assessments were given to al residents in the Nursing Center and completed on 01/24/2011. These residents found to be elopement risk were places under elopement precautions per the facilities elopement policy and the Security Department was notified. All resident rooms and common areas were check to assure that the environment is free from accident hazards	
L 224	3234.10 Nursing Facilties Every habitable room shall contain windows of size, area, and specifications in accordance with the 1996 BOCA National Building Code. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 11	L 224		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 224	Continued From page 32 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to provide effective maintenance services in residents rooms as confirmed by burnt out bulbs were observed in two (2) of 13 resident 's rooms as well as the spa area located in the beauty shop. The findings include: Table lamp bulbs were out in rooms # 636, 728 and the ceiling light was also out in the spa area located in the beauty shop. These observations were made in the presence of Employees #1 and #19 who acknowledged these findings during the survey.	L 224	1. The accumulated dust that was observed on the television sets (room# 606, 635, 644) on the dressers (Rm#728, 724, 718, 706, 701, 758, 750) in the exhaust vents (rm# 728, 724, 718, 706, 701) the laundry room on the 7th floor,(750, 758)on the table lamps (rm#706, 750, 635), on the bed frames in room#706 and the window blinds in room # 724 was removed. The hallway across from the seventh floor laundry room that was cluttered with a mattress, three geri-chairs and one scale, and the hallway by room 644 that was filled with items such as three geri – chairs, one scale, a wheelchair was cleared. The marred walls were repaired. In resident room # 758, the cluttered pictured and painting that were stored on the floor in front of the HVAC unit was removed. The tray table, an electric heater, and a extension cord was also removed. The marred walls were repaired. The malodorous smell that was evident in in room #756 cleaned and removed. The two bottles of eye wash solution that were expired as of 11/06/10 located in the soiled utility room on the seventh floor were replaced with current solution. The wall clock that was broken in room #618 was replaced. The table lamp bulbs that were out in room #636, 728, and the ceiling light that was also out in the spa area located in the beauty shop was replaced. 2. All other resident rooms, hallways and common areas were checked for clutter, burned out light bulbs, dust, odors and marred walls. When these deficient issues were found, they were corrected. 3. The Director of Housekeeping or designee will do weekly environmental round to ensure that these deficient issue do not recur.	
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 made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to provide services necessary to maintain the interior of the facility in a safe, orderly, comfortable and attractive manner as evidenced by two (2) of six (6) cluttered hallways and marred walls. The findings include: 1. The hallway across from the seventh floor laundry room was cluttered with a mattress, three (3) geri-chairs and one (1) scale,	L 410		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 33 2. The hallway by room #664 was cluttered with three (3) geri-chairs, one (1) scale, a wheelchair. 3. The walls in the hallway by room #664 were marred. The observations were made in the presence of Employees #1 and #19 who acknowledged these findings during the survey.	L 410	4. The Director of housekeeping or designee will report the find from the weekly environmental rounds at the Quality Assurance committee meeting Monthly times three March April and May 2011.	3/6/2011
L 413	3256.4 Nursing Facilities Each housekeeping employee shall keep the facility free from offensive odor accumulation of dirt, rubbish, dust, and hazards. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to provide effective maintenance services in residents rooms as confirmed by accumulated dust noted in two (2) of six (6) resident 's rooms on the sixth floor and seven (7) of seven (7) resident ' s rooms on the seventh floor. The findings include: 1. Accumulated dust was observed on television sets (rooms #606, 635, 644), on dressers (rooms #728, 724, 718, 706, 701,758,750), in exhaust vents (rooms #728, 724, 718, 706, 701, the laundry room on the seventh floor, 750, 758), on table lamps (rooms #706, 750, 635), on the bed frames in room #706 and window blinds in room #724. These observations were made in the presence of Employees #1 and #19 who acknowledged these findings during the survey.	L 413	1. The accumulated dust that was observed on the television sets (room# 606, 635, 644) on the dressers (Rm#728, 724, 718, 706, 701, 758, 750) in the exhaust vents (rm# 728, 724, 718, 706, 701) the laundry room on the 7th floor,(750, 758)on the table lamps (rm#706, 750, 635), on the bed frames in room#706 and the window blinds in room # 724 was removed. The hallway across from the seventh floor laundry room that was cluttered with a mattress, three geri-chairs and one scale, and the hallway by room 644 that was filled with items such as three geri – chairs, one scale, a wheelchair was cleared. The marred walls were repaired. In resident room # 758, the cluttered pictured and painting that were stored on the floor in front of the HVAC unit was removed. The tray table, an electric heater, and a extension cord was also removed. The marred walls were repaired. The malodorous smell that was evident in in room #756 cleaned and removed. The two bottles of eye wash solution that were expired as of 11/06/10 located in the soiled utility room on the seventh floor were replaced with current solution. The wall clock that was broken in room #618 was replaced.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

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UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

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L 417	Continued From page 34	L 417		
L 417	3256.8 Nursing Facilities Each resident room shall be cleaned and arranged in an orderly fashion and shall be well ventilated. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to ensure that one (1) of seven (7) resident 's rooms was cleaned and arranged in an orderly fashion: free of clutter. The findings include: Resident room #758 was cluttered with pictures and/or paintings that were stored on the floor in front of the HVAC unit. A tray table, an electric heater and an extension cord were also observed in the room. The walls were marred. This observation was made in the presence of Employees #1 and #19. They both acknowledged the finding during the survey.	L 417	The table lamp bulbs that were out in room #636, 728, and the ceiling light that was also out in the spa area located in the beauty shop was replaced. 2. All other resident rooms, hallways and common areas were checked for clutter, burned out light bulbs, dust, odors and marred walls. When these deficient issues were found, they were corrected. 3. The Director of Housekeeping or designee will do weekly environmental round to ensure that these deficient issue do not recur.	
L 418	3256.9 Nursing Facilities Odor control shall be achieved by cleanliness and proper ventilation. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to ensure odor control in one (1) of seven (7) resident's rooms. The findings include:	L 418	1. The accumulated dust that was observed on the television sets (room# 606, 635, 644) on the dressers (Rm#728, 724, 718, 706, 701, 758, 750) in the exhaust vents (rm# 728, 724, 718, 706, 701) the laundry room on the 7th floor,(750, 758)on the table lamps (rm#706, 750, 635), on the bed frames in room#706 and the window blinds in room # 724 was removed. The hallway across from the seventh floor laundry room that was cluttered with a mattress, three geri-chairs and one scale, and the hallway by room 644 that was filled with items such as three geri – chairs, one scale, a wheelchair was cleared. The marred walls were repaired.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING B. WING	01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

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L 418	Continued From page 35 A malodorous smell was evident in room #756. These observations were made in the presence of Employees #1 and #19. They both acknowledged the findings during the survey.	L 418	In resident room # 758, the cluttered pictured and painting that were stored on the floor in front of the HVAC unit was removed. The tray table, an electric heater, and a extension cord was also removed. The marred walls were repaired. The malodorous smell that was evident in in room #756 cleaned and removed. The two bottles of eye wash solution that were expired as of 11/06/10 located in the soiled utility room on the seventh floor were replaced with current solution.	
L 421	3256.12 Nursing Facilities Each building, each piece of equipment, and the grounds shall be regularly maintained and attended. This Statute is not met as evidenced by: Based on observations made during the environmental tour of the facility on January 11 thru January 18, 2011, it was determined that facility staff failed to maintain essential patient care equipment in safe operating condition including: a broken wall clock in one (1) of 13 resident 's rooms, one (1) of one (1) non-operable bedside scale with a missing pad, loose bed side rail, rusty and leaking city inlet valve in physical plant, and non-functioning pulse oximeter. The findings include: 1. The wall clock was broken and needed to be replaced in room #618.These observations were made in the presence of Employees #1 and #19. They both acknowledged this finding at the time of the observation during the survey. 2. The bedside scale for the sixth and seventh floor was missing a pad and could not be used.	L 421	The wall clock that was broken in room #618 was replaced. 2. All other resident rooms, hallways and common areas were checked for clutter, burned out light bulbs, dust, odors and marred walls. When these deficient issues were found, they were corrected. 3. The Director of Housekeeping or designee will do weekly environmental round to ensure that these deficient issue do not recur.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0030		01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE WASHINGTON, DC 20032

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L 421	Continued From page 36 3. The right side rails were loose and in danger of falling off the resident ' s bed in room #638 and the left side rails were also loose. 4. The city inlet valve in physical plant was steadily leaking, was rusty and needed to be replaced. This observation was made in the presence of Employee #1 and #18 who acknowledged the finding during the survey. 5. Facility staff failed to maintain essential patient care equipment in safe operating condition. Resident #6. Employee #9 was observed monitoring Resident #6's blood pressure and pulse ox prior to performing trach care. He/she was unable to obtain a pulse ox due to the finger pulse oximeter not functioning. The employee retrieved another blood pressure machine with a functional finger pulse oximeter. A pulse ox reading of 99% was obtained on January 14, 2011 at 11:35 AM. A face-to-face interview was conducted with Employees #4 and #9 during the time of the observation. Both acknowledged that the finger pulse oximeter attachment to the blood pressure machine was malfunctioned and the pulse ox could not be obtained and a work order was entered for repair of the equipment. The observation occurred on January 14, 2011 at 11:25 AM.	L 421	1. The missing pad for the bedside scale for the sixth and seventh floor was found during the time of the survey. The loose side rails on the residents' bed in room #638 were tightened. The city inlet valve in the physical plant that was leaking and rusty was replaced. The pulse oximeter that was cited to be non functioning was taken out of service. 2. All other essential patient care equipment was checked for safe operating conditions. Any equipment not found to be in safe operating condition will be taken out of service and or replaced. 3. The DON or designee will in-service the nursing staff on identifying, documenting and taking out of service essential patient equipment not found in safe operating condition. The DON or designee will monitor this process for compliance monthly. 4. The findings from this monitoring will be reported to the Quality Assurance Committee Monthly times three (March, April and May 2011)	3/6/2011
L 431	3258.2 Nursing Facilities First aid supplies shall be readily available on	L 431		

Health Regulation Administration

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	HFD02-0030	A. BUILDING B. WING	01/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 431	Continued From page 37 each unit to each employee. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 11 through January 18, 2011, it was determined that the housekeeping and maintenance staff failed to ensure that unexpired eyewash solution was available to employees in two (2) of two (2) observations. The findings include: Two bottles eyewash solution were expired as of 11-6-2010 in the soiled utility room on the seventh floor. These observations were made in the presence of Employees #1 and #19 who acknowledged these findings during the survey.	L 431		