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FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	05/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

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L 000	Initial Comments An annual licensure survey was conducted on May 15 through 19, 2006. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 30 records based on a census of 324 residents on the first day of survey and 17 supplemental residents.	L 000	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the regulatory requirement of responding to these citations and to continue to provide quality resident care.	
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 observation, record review, and staff interview for twelve of 30 sampled residents and seven (7) supplemental resident, it was	L 051	3210.4 Nursing Facilities Resident #29 1. This resident expired at the hospital with a cause of death unrelated to the results of the PT/INR. 2. Any resident on Coumadin and signs and symptoms of bleeding will be cared for according to the facility's emergency policy. 3. The nursing staff was inserviced on the facility's Emergency Care and the need to contact the Medical Director, DON, or Administrator should the PMD not respond in a very timely manner. The House Supervisors and Clinical Managers will monitor the residents needs closely to ensure compliance with the facility policy The results of this monitoring will be forwarded to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee which is chaired by the administrator.	4/18/06 5/19/06 6/30/06 6/30/06

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L 051	Continued From page 1 determined that the charge nurse failed to: assess the physical and/or emotional status and implement interventions as per facility policy for two (2) residents; weigh and/or reweigh six (6) residents as per facility policy; initiate new approaches after a fall for two (2) residents; indicate which approaches were to be used on the psychoactive medication care plan for one (1) resident; initiate new interventions for one (1) resident with agitated behaviors; develop a care plan for one (1) resident on hospice care; and clarify sliding scale insulin orders and Ativan [Lorazepam] orders for six (6) residents. Residents #29, S14, 1, 2, 6, 8, 9, 12, 14, 15, 17, 21, 24, S5, S6, S7, S8, S9 and W5. The findings include: 1. The charge nurse failed to assess Resident # 29's physical status and implement the facility's resident emergency care policy for the resident who was taking Coumadin, an anticoagulant, and had a nosebleed. The resident subsequently died at the hospital on April 18, 2006. The resident was admitted to the facility on March 22, 2006. According to the admission Minimum Data Set (MDS) signed and dated April 14, 2006, the resident ' s diagnoses included: Diabetes Mellitus (DM), Congestive Heart Failure, Hypertension, Cerebrovascular accident (stroke) Hemiparesis, and Depression (Section I). The admission orders dated March 22, 2006 included, "Warfarin Sodium 10mg (Coumadin) 1 tablet GT/PO daily blood thinning (3/21/06-3/28/06). Labs. (1) CBC every 6 months; (2) FBS every month DM." Physician Orders:	L 051	Resident #S14 1. The behaviors noted by the Clinical Manager were related to confusion and not suicidal ideation. The resident was not trying to hang herself or choke herself with the shower hose. She was hallucinating that is was a snake. The resident was sent to the hospital ER to ensure that this was not suicidal ideation. The return diagnosis was acute schizophrenia and to continue present care. 2. All residents with acute disease exacerbations will be promptly cared for and the continued documentation will reflect the results of the hospital visit. 3. The nursing staff was inserviced on assessment and proper documentation. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement	5/30/06 5/31/06 6/30/06 6/30/06

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L 051	Continued From page 2 March 22, 2006 at 10:00 PM, "Obtain PT/INR lab work in 3 days." March 24, 2006 at 12:30 AM, "Obtain U/A C&S (urinalysis with culture and sensitivity) in AM, to R/ O (rule out) UTI (urinary tract infection)." Resident c/o (complained of) burning sensation when urinating. March 24, 2006 at 2:00 PM, "Levaquin 500mg 1 tab po (by mouth) q (every) day for 7 days." [Drug Interactions... Elevations of the prothrombin time in the setting of concurrent Warfarin and levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ration (INR), or other suitable anticoagulation tests should be closely monitored if levofloxacin is administered concomitantly with Warfarin... Manufacturer's [Ortho-McNeil] prescribing information for Levaquin (levofloxacin), August 2005]. March 28, 2006 at 2:00 PM, "Continue Warfarin Sodium 10mg, I tab. Qd (daily) GT/PO - blood thinning. Check PT/INR every month." April 17, 2006 at 7:00 AM "Continue to apply ice compress over bridge of nose. Do CBC (Complete Blood Count) and PT (Prothrombin Time) and INR (International Normalized Ratio) today; notify PMD of results. Hold Coumadin 4/ 18/06." April 17, 2006 at 1:15 PM "Send resident to ER for Coumadin Toxicity." Laboratory Studies: March 28, 2006: coagulation collected 3/28/06 0620 (6:20 AM) PT 27.4 P (Patient) Normal Range 12.2-15.0	L 051	Resident #1 Weight A. Weights 1. Resident #1 cited at the time of the survey for the facility's failure to follow the weight policy was weighed immediately. The Clinical Managers, corporate and facility dietician reviewed the charts and interventions implemented when indicated. 2. A weight audit was conducted in a cooperative effort of the Clinical Managers and Dieticians to address any other residents whose weights were not properly addressed. 3. Nursing staff and dieticians were inserviced on weight collection and a weight collection team per unit was implemented per a new weight policy. The Clinical Managers were inserviced on the accuracy of documentation specific to weight variations as mandated by policy and the MDS. The Clinical Managers will oversee and monitor the weight teams and the documentation of the weights. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Fall B.1. The care plans of the resident #1 cited at the time of the survey have been updated to reflect new approaches after a	6/30/06 7/2/06 6/30/06 6/30/06 6/30/06

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L 051	Continued From page 3 seconds C/T [call to] [name] at 1009 [10:09 AM], RRB (report read back) Protime INR 2.51 Therapeutic range: 2.0-3.0 April 17, 2006 coagulation collected 4/17/06 0900 (9:00 AM) PT 134.4 P Normal Range 12.2-15.0 seconds Protime INR 19.84 Therapeutic range 2.0-3.0. According to the facility's policy "Nursing Emergency Care-Residents - The facility will provide emergency medical care to all residents. Advanced directives will be followed when the emergency is due to the residents condition or diagnosis. A. In case of significant change in resident's condition: 2. Notify attending physician, associate or Medical Director. If no doctor can be reached call Nursing Director or Administrator regarding transfer of resident to the nearest emergency room. D. Epistaxis: 1. Sit resident upright and instruct him to breathe through his mouth 2. Apply pressure on one or both nostrils apply ice over nose; check vital signs 3. If bleeding does not stop within five minutes, notify doctor for further orders. Every change in resident condition, will be written on the nursing 24 hour report, reported to physician and family and documented in detail on nurses notes. " Nurses' Notes: March 28, 2006, at 3:30 PM, " Writer was called by lab regarding PT/INR result, PMD made aware, no new orders given but said to continue	L 051	fall. 2. The care plans of similar residents with falls and agitated behaviors have been reviewed to ensure that updates were recorded as appropriate. 3. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/20/06 6/20/06 6/20/06

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L 051	Continued From page 4 with Coumadin and was noted accordingly." April 16, 2006 at 11:00 PM, "10:00 PM had nose bleed. Small amount. Ice compress applied over bridge of nose. Place a call to PMD [private medical doctor] and left message to the answering machine ... not responded at this time. Vital signs (V/S) B/P (Blood Pressure) 150/86, T (Temperature) 98.3, P (Pulse) 78, and R (Respiration) 20." April 17, 2006 at 7:35 AM, "Continue to have small amount of nose bleeding. Continue to apply ice compress over bridge of nose and nose packed with gauze. PMD responded and made aware of the medical problem. Ordered to continue to apply ice compress and to do CBC, PT/INR today and to report result to PMD. Hold Warfarin until result of PT/INR arrives. Will endorse to oncoming nurse." April 17, 2006 at 2:30 PM, "V/S 97.8 (T), 72 (P), 22 (R), 144/80(B/P). Resident was noted with a nose bleed, PT/INR result received. Pt. 134.4, INR 19.89. Family and MD notified order given to send resident to ER. Resident picked up at 2:00 PM. No acute distress on departure." On May 19, 2006 at 9:45 AM a face-to-face interview was conducted with the Assistant Clinical Manager who indicated, "Residents who receive anticoagulant medications are to be monitored for bruising and bleeding. Blood tests are to be drawn monthly. The physician was to be called to report the results. Adjustments to the medication might be needed depending on the results if they are high or low. I remember that the resident was transferred to the hospital because of a nose bleed."	L 051	Resident #2 Fall A. 1. The care plans of the resident #2 cited at the time of the survey have been updated to reflect new approaches after a fall. 2. The care plans of similar residents with falls and agitated behaviors have been reviewed to ensure that updates were recorded as appropriate. 3. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Drug Order B. 1. The orders for resident #2 was clarified with the residents' attending physicians. 2. The pharmacy is performing a 100% audit of all PRN medications to ensure that those with the same therapeutic effect for any given resident have a clarification order documenting the order in which these medications should be given. 3. The consultant pharmacist will monitor	6/30/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06 6/30/06

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L 051	Continued From page 5 A review of the "Physician's Discharge Summary " dated April 25, 2006, under "Course of Diseases and Treatment" indicated: "Patient had started bleeding from the nose on 4/17/06. Nose bleeding was treated unsuccessfully with ice pack on the nasal bridge. PT/INR =134.4/19.84. [He/ she] was transferred to the ER for treatment. Reason For Discharge (Including cause of death if applicable): Nose bleed and Coumadin toxicity." The charge nurse failed to follow the facility's resident emergency care policy by not contacting the associate or Medical Director after no response from the resident's primary physician and failure to transfer the resident to the emergency room for over nine (9) hours. The record was reviewed on May 17, 2006. 2. The charge nurse failed to follow the "Suicidal Residents" policy for Resident S14. A review of Resident S14's record revealed a nurse's note dated March 15, 2006 at 7:30 AM, "...At 6:15 AM, resident pulled fire alarm on wing " A" . Resident stated "I did it, I pulled it. I don ' t care. I want to get out of here." Resident was helped out/away from fire alarm to [his/her] room. Fire safety was observed. Then staff went back to see resident. Found resident in the bath room using/getting shower head hose to wrap it around [his/her] neck. When asked resident why? Or what [he/she] was doing with it, resident said, "I was observing it looks like a snake." Resident was brought to the nursing station for close monitoring ..." According to a nurse's note dated March 15, 2006 at 2:40 (PM), "Resident on hourly watch. [Attending physician] was phoned at 8:35 AM about incident this AM with resident. Telephone	L 051	the orders for the PRN medications to ensure compliance. She will work directly through the DON and physicians when clarification orders are needed. 4. She will report the findings of her monitoring at the quarterly Quality Improvement Committee which is chaired by the administrator. Resident # 6 1. The care plan cited at the time of the survey for Resident #6 has been updated to reflect approaches for psychoactive medications. 2. All residents with psychoactive medications will have their care plan approaches checked for completeness. 3. The Clinical Managers will monitor this issue for accuracy and completeness. They will report their findings to the Director of Nurses. 4. The Director of Nurses will oversee this monitoring process and report on it with any action plans for improvement at the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06 5/19/06 6/30/06 6/30/06 6/30/06

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L 051	Continued From page 6 order of Haldol 2 mg po (orally) QID PRN (four times daily as needed) for agitation. Psyc (psychological) consult with [psychiatrist] and hourly monitoring. RP (responsible party) was notified of the incident. At 9:45 AM [psychiatrist] was phoned and telephone order of Haldol 2 mg po QID (four times daily) routine for agitation. Continue hourly monitoring. Psyc consult for 3/16 /06. Collect [urine for] UA and C&S (urinalysis and culture and sensitivity). Resident received Haldol at 8:30 AM and 1 PM. Resident is now sleeping." According to the facility's policy, "Nursing Suicidal Resident," policy #1404480A.000, dated September 1998, under, " Procedure - #3. Assign a staff member for one to one observation and to stay within the distant of an arm length of the resident until determination of the course of treatment has been made by a physician ...#7 (c) Obtain physician order for transfer or if the resident is to remain in the facility an order for an emergency psychiatric consult. The psychiatrist should recommend the frequency and length of observation period." A face-to-face interview was conducted with the clinical manager and the charge nurse on May 19 , 2006 at 10:55 AM. The clinical manager stated, "When we found (the resident) with the shower hose around (his/her) neck, [Resident S14] was confused. The resident was brought out to the nurse ' s station and then a little later put back to bed. Then we called the doctor (attending physician) to tell [him/her] what happened." The charge nurse stated, " The resident pulled the fire alarm and was very confused. We called [attending physician] and the psychiatrist. When the Director of Nursing found out what was going	L 051	Residents #8, 9 and 12 Weights 1. Residents #8, 9 and 12 cited at the time of the survey for the facility's failure to follow the weight policy were weighed immediately. The Clinical Managers, corporate and facility dietician reviewed the charts and interventions implemented when indicated. 2. A weight audit was conducted in a cooperative effort of the Clinical Managers and Dieticians to address any other residents whose weights were not properly addressed. 3. Nursing staff and dieticians were inserviced on weight collection and a weight collection team per unit was implemented per a new weight policy. The Clinical Managers were inserviced on the accuracy of documentation specific to weight variations as mandated by policy and the MDS. The Clinical Managers will oversee and monitor the weight teams and the documentation of the weights. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 7/1/06 6/30/06 6/30/06

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L 051	Continued From page 7 on, [Resident S14] was sent out to the hospital." Facility staff failed to assign a staff member for one to one observation for Resident S14 from the time he/she was noted with the shower head hose around the neck after the fire alarm was sounded until the physician was contacted. The record was reviewed May 19, 2006. 3. The charge nurse staff failed to ensure that a weight was obtained for Resident #1 for March and April 2006 and initiate new approaches in the care plan after a fall. A. According to the facility's policy, "Nutritional Services - Weights and Heights" , Policy # 0504060A.00, dated April 2004, under, " Procedure -3. Monthly: (a) Weights will be done according to the facility schedule which indicates the person assigned and the date the weight is to be done ..." According to the, "Vital Sign Flow Sheet" for Resident #1, the area for recording the weight for March and April 2006 was blank. A face-to-face interview was conducted with the clinical manager on May 15, 2006 at 3:35 PM. After reviewing the record, he/she acknowledged that the weights were not done for March and April 2006. The record was reviewed May 15, 2006. B. The charge nurse failed to initiate new approaches in the care plan after a fall for Resident #1. A review of Resident #1's nurse's note dated February 4, 2006 at 10:00 PM documented, " Resident found on the floor in [his/her] room in a	L 051	Resident #14 Agitated behaviors 1. The care plan of resident #14 cited at the time of the survey have been updated to reflect new interventions for a episode of agitated behavior. 2. The care plans of similar residents with agitated behaviors have been reviewed to ensure that new interventions were recorded as appropriate. 3. The Clinical Managers will monitor their unit's care plans for appropriate updates, accuracy and completeness. They will report their findings to the DON. Additionally, inservicing was done for the staff involved in the completion of the residents' care plans to ensure their understanding of the errors and corrections. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee which is chaired by the Administrator.	5/19/06 6/30/06 6/30/06 6/30/06

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L 051	Continued From page 8 side lying position. A pool of blood was noted on the floor around [him/her]. On assessment, [resident] was noted with a big hematoma and a laceration measuring 3 x 1 cm on the left side of the head ... [Resident] left the unit via 911 at 7:30 PM ... " A review of care plan problem #3 on February 4, 2005," Need for safety [due to] limited mobility and blindness" revealed that the above incident was documented under the "Problems" column. However, there were no new approaches initiated as a result of the fall. A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 9:30 AM. He/ she acknowledged that there were no new approaches initiated after the above cited fall. The record was reviewed May 17, 2006. 4. A review of Resident #2's record revealed that the charge nurse failed to update the care plan after a fall and clarify Lorazepam orders. A. The nurse's note dated March 30, 2006 at 2: 50 PM revealed the following: "Resident remains alert and oriented x3. Resident stated that he stood up, close his door to the room, stepped to the bed and fell. I assessed the resident no physical injuries noted ..." The care plan dated December 8, 2005 for " At risk for falls related to decreased mobility, use of psychoactive meds and use of antihypertensive meds" was last updated on March 10, 2006. The facility staff failed to update the falls care plan with goals and approaches after the resident fell on March 30, 2006.	L 051	Residents #15, 17, 21 Weights 1. Residents #15, 17 and 21 cited at the time of the survey for the facility's failure to follow the weight policy were weighed immediately. The Clinical Managers, corporate and facility dietician reviewed the charts and interventions implemented when indicated. 2. A weight audit was conducted in a cooperative effort of the Clinical Managers and Dieticians to address any other residents whose weights were not properly addressed. 3. Nursing staff and dieticians were inserviced on weight collection and a weight collection team per unit was implemented per a new weight policy. The Clinical Managers were inserviced on the accuracy of documentation specific to weight variations as mandated by policy and the MDS. The Clinical Managers will oversee and monitor the weight teams and the documentation of the weights. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 7/2/06 6/30/06 6/30/06

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L 051	Continued From page 9 B. A review of Resident #2's record revealed that the charge nurse failed to clarify orders for Lorazepam. The May 2006 Physician's Order Form included the following orders: "12/18/05, Lorazepam ½ ml (1 mg) intramuscularly (IM) every 4 hours as needed for agitation" ; and " 12/18/05, Lorazepam 1 mg 1 tablet by mouth every four hours as needed for agitation. " There was no information included with the orders that would determine which route, IM or po, would be used. A face-to-face interview was conducted on May 15, 2006 at 1:02 PM with the charge nurse. He/ She stated, "He gets po (by mouth)." The record was reviewed on May 15, 2006. 5. A review of Resident #6's record revealed that the charge nurse failed to indicate which approaches were to be implemented on the care plan for psychoactive medications. The care plan "On psychoactive medication secondary to agitation" dated March 17, 2005 and most recently updated April 2006 listed ten approaches. The ten approaches had boxes in front of them. Approaches to be used by the facility would be indicated by a check mark in the box. There were no check marks in any of the boxes. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:16 AM. He/ She acknowledged that there were no approaches checked for this care plan. The record was reviewed on May 16, 2006. 7. The charge nurse failed to ensure that a weight was obtained for Resident #8 for February 2006.	L 051	Resident #24 Hospice Care Plan 1. The hospice care plan was initiated immediately upon discovery and integrated into the facility's care plan by the Clinical Manger on that unit. 2. The care plans of any other residents on Hospice were evaluated to ensure that the Hospice program's care plan was integrated with the facility's care plan. 3. The Clinical Managers were inserviced on ensuring current and accurate updates of the residents' care plans. The Clinical Managers will monitor their unit's care plans for accuracy and completeness. They will report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 5/19/06 6/30/06 6/30/06

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L 051	Continued From page 10 According to the, "Vital Sign Flow Sheet" for Resident #8, the area for recording the weight for February 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:30 AM. After reviewing the record, he/she acknowledged that the weight was not done for February 2006. The record was reviewed May 16, 2006. 8. A review of Resident #9's record revealed that the charge nurse failed to ensure that a reweight was obtained according to facility policy. The "Vital Sign Flow Sheet" included the following weights: Date Weight 1/11/06 131 2/14/06 123.5 3/13/06 131 4/6/06 121 4/14/06 117 5/9/06 113 A face-to-face interview was conducted with the clinical manager on May 15, 2006 at 3:12 PM. He/She acknowledged that a reweight was not obtained in February, March and April 2006 according to policy. The clinical manager was asked to weigh the resident. He/She later said that the resident's weight was 115 pounds. Facility Policy #0504060A.000, Nutritional Services Weights and Heights included the following: "...Monthly: b. check the previous weights for changes. If there is a change of + or - 5% in 30 days, 7.5% in 90 days ..., schedule resident to be reweighed within 24 hours ..."	L 051	Residents #S5, S6, S7 and S8 Sliding scale insulin 1. All residents identified at the time of the survey having sliding scale insulin orders which required the nurse to notify the physician when the blood glucose level was over 750 were clarified. The glucometers used by the facility reads blood glucose levels up to 600. Orders were changed to notify the physician when the levels reached 500. No harm came to any resident. 2. All sliding scale insulin orders were reviewed for similar issues and adjustments made when necessary. 3. Staff was inserviced on the upper limits reading of the facility's glucometer and the need to clarify physician The Clinical Managers on the units will monitor the residents' sliding scale insulin orders for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee.	5/19/06 5/19/06 6/20/06 6/20/06

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L 051	Continued From page 11 There was over a 5% weight decrease from January to February 2006, there was over a 5% increase in weight from February to March 2006 and there was over a 7% decrease in weight from March 13 to April 14, 2006. The facility failed to reweigh the resident. The record was reviewed on May 15, 2006. 9. A review of Resident #12's record revealed that the charge nurse failed to ensure that the resident was weighed monthly according to facility policy. The "Vital Sign Flow Sheet" included the following weights: Date Weights 12/15/05 148 1/14/06 152 4/2006 148 There were no weights in the record for February and March 2006. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 2:38 PM. He/ She acknowledged that the weights for February and March 2006 were not in the record. The record was reviewed on May 16, 2006. 10. The charge nurse failed to initiate new interventions for Resident #14 for agitation and verbal abuse. A review of Resident #14's record revealed a nurse's note dated March 15, 2006 at 3:00 PM, " Resident involved in an explosive verbal altercation with another resident ..." Care plan #12 dated April 21, 2004 and updated on November 14, 2005, "Period of agitation with use of abusive language" listed under "Problems	L 051	Resident #S9 1. The orders for resident #S9 was clarified with the residents' attending physicians. 2. The pharmacy is performing a 100% audit of all PRN medications to ensure that those with the same therapeutic effect for any given resident have a clarification order documenting the order in which these medications should be given. 3. The consultant pharmacist will monitor the orders for the PRN medications to ensure compliance. She will work directly through the DON and physicians when clarification orders are needed. 4. She will report the findings of her monitoring at the quarterly Quality Improvement Committee which is chaired by the administrator.	7/2/06 7/2/06 6/30/06 6/30/06

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L 051	Continued From page 12 " a verbal altercation with another resident that occurred November 14, 2005. The above cited incident was not listed under "Problems." There were no interventions initiated after the March 15, 2006 episode. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 3:15 PM. He/ she acknowledged that the care plan was not reviewed after the above cited incident. The record was reviewed May 16, 2006. 11. A review of Resident #15's record revealed that the charge nurse failed to ensure that a reweight was obtained on the resident after readmission to the facility. Facility Policy #0504060A.000, Nutritional Services Weights and Heights included the following: " All residents will be weighed within 24 hours of admission/readmission, again after one week and then monthly, unless ordered more frequently ... 1. On Admission: Weight team member will measure the resident's weight and height within 24 hours of admission ... 3. a. weights will be done according to facility schedule ...When feasible 1-2 days each month will be designated for all monthly weights." The resident was readmitted to the facility on February 23, 2006. The nurse's readmission progress note included the following: " ...Wt (weight) 122 lbs ... " The "Vital Sign Flow Sheet [form SM-67)" included the following weights: Date Weight 12/11/05 147.5 1/11/06 148 2/14/06 147	L 051		

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L 051	Continued From page 13 3/16/06 147 4/no day/06 125 4/14/06 125 - - The readmission weight was not included on this form. The record lacked evidence of a reweight one (1) week after readmission and a reweight when the resident's weight was determined to be 147 pounds on March 16, 2006 [increase of 25 pounds in 21 days]. The record was reviewed on May 16, 2006. 12. The charge nurse failed to ensure that a weight was obtained for Resident #17 for March 2006. According to the, "Vital Sign Flow Sheet" for Resident #17, the area for recording the weight for March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 12:30 PM. After reviewing the record, he/she acknowledged that the weight was not done for March 2006. The record was reviewed May 17, 2006. 13. The charge nurse failed to ensure that a weight was obtained for Resident #21 for January, February and March 2006. According to the, " Vital Sign Flow Sheet" for Resident #21, the area for recording the weight for January, February and March 2006 was blank. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 7:30 AM. After reviewing the record, he/she acknowledged that the weights were not done for January, February and March 2006. The record was reviewed May	L 051		

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L 051	Continued From page 14 17, 2006. 14. The charge nurse failed to initiate a Hospice care plan for Resident #24. A review of Resident #24's record revealed a physician's order dated May 3, 2006, " [Hospice] to evaluate resident for hospice care secondary to decline in medical condition. " The initial Hospice visit was May 5, 2006. Subsequently, Hospice staff visited May 8, 12 and 15, 2006. A review of the resident's care plan revealed that there was no problem with appropriate goals and approaches for Hospice care. A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 10:30 AM. He/she acknowledged that the care plan lacked a problem with goals and approaches for Hospice care. The record was reviewed May 17, 2006. 15. The charge nurse failed to clarify sliding scale insulin orders for Resident S5. According to the manufacturer's recommendations for the blood glucose monitoring meter currently used by the facility, a " Hi " message on the meter indicates blood glucose over 600. A review of Resident S5 ' s record revealed a physician's order dated May 2, 2006, directing, " (blood glucose) 551-650 give 14 units (of insulin)..If greater than 651 call MD. " Since the blood glucose meter registers " Hi " for blood glucose over 600, facility staff would be unable to determine if the blood glucose level	L 051		

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L 051	Continued From page 15 was over 650. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 2:30 PM. He/ she stated, I never really looked at the order because [Resident S5's] blood glucose never was that high." The record was reviewed May 19, 2006. 16. The charge nurse failed to clarify sliding scale insulin orders for Resident S6. A review of Resident S6's record revealed a physician ' s order dated April 11, 2006, directing, " (blood glucose) 551-650 give 8 units (of insulin). If greater than 651 give 10 units ...if greater than 651 call MD. " Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 650. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 2:45 PM. Residents S6, S7 and S8 resided on this unit. The charge nurse was asked if he/she was aware of the sliding scale insulin order. He/she stated, " The [blood glucose] meter registers " Hi " above 600. I would call the doctor if I got a reading like that. There is no way to tell how high the blood glucose is if it is above 600. I ' ve never had a reading that showed " Hi. " The record was reviewed May 19, 2006 17. The charge nurse failed to clarify sliding scale insulin orders for Resident S7 . A review of Resident S7's record revealed a physician's order dated April 11, 2006, directing,	L 051		

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L 051	Continued From page 16 "(blood glucose) 551-650 give 10 units (of insulin)..Over 651 notify MD." Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 650. The record was reviewed May 19, 2006. 18. The charge nurse failed to clarify sliding scale insulin orders for Resident S8 . A review of Resident S8's record revealed a physician's order dated March 14, 2006, directing, " (blood glucose) 551-650 give 10 units (of insulin)..551 - 750 give 12 units ...Call MD if greater than 750. " Since the blood glucose meter registers "Hi" for blood glucose over 600, facility staff would be unable to determine if the blood glucose level was over 750. The record was reviewed May 19, 2006. 19. The charge nurse failed to clarify the use of oral or injectable Ativan for Resident S9. A review of Resident S9's record revealed a physician's order dated March 14, 2006, "Ativan 1 mg po (orally) or IM (intramuscularly) every 4 hrs PRN (as needed) for anxiety." There was no evidence that the charge nurse attempted to clarify when to use the oral form or the injectable form of the Ativan. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:30 PM. The surveyor asked when each form of the Ativan would be used. The charge nurse stated, "If the	L 051		

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L 051	Continued From page 17 resident is very agitated and won't take the pill, we would give him the injection. "The record was reviewed May 19, 2006. 20. A review of Resident W5's record revealed that the charge nurse failed to clarify an order for sliding scale insulin coverage. The Physician Order Sheet and Interim Plan of Care dated May 11, 2006 included the following order: " Fingerstick blood sugar (BS) TID (three times a day) with sliding scale coverage with Regular Insulin - <60 - Facility protocol; 200-249-o; 250-350-2 units; 351-450-4 units; 451-550-6 units; 551-650-8 units; If BS >651 Notify MD." A face-to-face interview was conducted with the charge nurse on May 18, 2006 at 7:00 AM. He/ She stated, "The glucometer goes up to 600 and gives a reading of "high" after that. We call the MD if it reads high." The May TAR (Treatment Administration Record) did not include any blood sugar levels of 600 or higher. The record was reviewed on May 18, 2006.	L 051	**3211.1 Nursing Facilities** Pulse Resident #4 1. Resident identified as not having a pulse taken prior to the administration of Clonidine has had her medical record reviewed and corrected immediately. There was no identified harm to the resident. 2. All other residents on similar medications requiring a pulse prior to administration have had their MARs reviewed and corrections done when necessary. 3. Staff were inserviced on the requirements of some hypertensive medications to have the pulse taken. MARs reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for consistency of taking and recording the pulse. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee.	5/19/06 5/19/06 6/30/06 6/30/06
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:	L 052		

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L 052	Continued From page 18 (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, interviews and record review for five (5) of 30 sampled residents and nine (9) supplemental residents, it was determined that sufficient nursing time was not	L 052	Resident #6 A. 1. The nurse who did not sign off this resident's 10 AM medications as administered has been counseled . The MAR was reviewed with no further correction needed. No harm was identified to the resident. 2. All MARs are consistently reviewed by the units to ensure that medications are documented as given. 3. Staff were inserviced on the requirements of documenting the administration of medications at the time they are given to the resident. MARs were also reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for consistency of documentation. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. B. 1. The resident identified at the time of the survey that was not afforded proper insulin coverage was reviewed. No actual harm was identified. The nurses involved were educated and counseled. 2. All sliding scale insulin orders were reviewed to ensure proper coverage was afforded the residents. 3. Staff were inserviced on the requirements of sliding scale insulin orders and the importance of ensuring	5/2/06 5/31/06 6/30/06 6/30/06 5/19/06 5/19/06 6/30/06

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L 052	Continued From page 19 given to ensure that facility staff: assessed one (1) resident's pulse rate prior to administration of a antihypertensive medication; administered five (5) oral medications and sliding scale insulin as per physician's orders for one (1) resident; obtained laboratory blood work as ordered by the physician for seven (7) residents; and followed up on ordered laboratory values, followed physician's orders for the use of heel protectors and Ted stockings and positioned the Foley catheter tubing to prevent an urinary tract infection for one (1) resident; administered wound treatments according to physician orders for one (1) resident; placed bedside mats beside two (2) residents' beds; and connected a chair alarm to one (1) resident's chair. Resident #4, 6, 10, 21, 24, S1, S 2, S3, S11, S12, W1, W2, W4 and W5. The findings include: 1. Facility staff failed to assess the pulse rate for Resident #4 according to physician orders. A review of physician orders dated December 12, 2005 indicated, "Clonidine 0.2 mg by mouth twice daily for hypertension. Hold for systolic blood pressure less than 100. Notify physician if systolic blood pressure is more than 160 or less than 100. Notify physician for pulse rate less 50 or more than 120." A review of the Medication Administration Record for March 2006 showed no evidence that the pulse rate was assessed prior to administration of Clonidine 0.2mg as ordered. A face-to-face interview was conducted with the Assistant Clinical Manager on May 15, 2006 at 11 :00 AM. He/she said, "The nursing staff should have assessed the pulse rate prior to the	L 052	accurate coverage. MARs reviewed with the nursing staff. The Clinical Managers on the units will monitor those MARs for accuracy of insulin coverage on sliding scale orders. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #10 BMP 1. BMP due for this resident was completed on 3/28/06. The results were located in the overflow file. The FBS was due on 4/28/06. The resident went to the hospital on 4/17/06, readmitted on 4/19/06 with the order for the FBS discontinued. Instead, an HgA9C every 3 months was ordered on the 4/19/06 admission. 2. A lab audit was done on all charts to ensure accuracy and completeness of the orders and results. 3. Staff were inserviced on the requirements of laboratory ordering and a new procedure was developed. The Clinical team met with the Director of the Southern Maryland Hospital lab to ensure accuracy of communications. The Clinical Managers on the units will monitor the residents' lab orders for consistency and accuracy. 4. The Director of Nursing will oversee	6/30/06 3/28/06 6/30/06 6/30/06 6/30/06

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L 052	Continued From page 20 administration of clonidine 0.2 mg as ordered. The record was reviewed May 15, 2006. 2. A review of the record for Resident #6 revealed that facility staff failed to administer five (5) medications as per physician's orders and administer the correct sliding scale insulin dose according to the physician's order A. Facility staff failed to administer five (5) medications as per physician's orders. The April 2006 MAR (Medication Administration Record) included the following medications: Docusate Sodium 100 mg capsule by mouth twice daily for bowel regimen; Lisinopril 10 mg tablet by mouth every day for hypertension; Megestrol Acetate 10 ml (400 mg) by mouth every day for weight loss; Senna 8.6 mg tablet by mouth every day for bowel management; and Sorbitol 70% solution 30 ml by mouth once daily for constipation. The licensed nurse failed to initial [indicating that the medication was administered] for the 10 AM dose of the above cited medications for April 30, 2006. A face-to-face interview was conducted with the charge nurse on May 16, 2006 at 10:16 AM. He/ She acknowledged that the five (5) medications were not initialed as being administered on the MAR for the 10:00 AM dose on April 30, 2006. B. Facility staff failed to follow physician's orders for the administration of sliding scale insulin. The May 2006 Physician's Order Form included the following order: Initial order date of January 3 , 2006, " Humalog vial - ins [insulin] Fingerstick	L 052	the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. **Resident #21** A. 1. The resident identified with a missing lab had the test repeated at the time of its discovery. There was no harm to the resident. 2. A lab audit was done on all charts to ensure accuracy and completeness of the orders and results. 3. Staff were inserviced on the requirements of laboratory ordering and a new procedure was developed. The Clinical team met with the Director of the Southern Maryland Hospital lab to ensure accuracy of communications. The Clinical Managers on the units will monitor the residents' lab orders for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. B. 1. The resident identified at the time of the survey had heel protectors and Ted stockings applied when ordered at the time of the discovery. There was no harm to the resident. 2. A 100% review of physician's orders	5/19/06 6/30/06 6/30/06 6/30/06 5/19/06 6/30/06

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L 052	Continued From page 21 blood sugar three times daily before meals inject subcutaneously with sliding scale coverage: 140-200 = 4 units, 201-280 = 6 units, 281-340 = 8 units, 341-400 = 10 units. Call MD if blood sugar less than 60 or greater than 400." The April MAR revealed the following insulin sliding scale coverage: Date / Blood Sugar / Coverage 4/7/06 at 4 PM / 215 / 4 units 4/9/06 at 4 PM / 127 / 4 units According to the physician ' s order the resident should have received 6 units of insulin on April 7 and no insulin coverage on April 9, 2006. The record was reviewed on May 16, 2006. 3. Facility staff failed to do laboratory studies for Resident #10 according to the physician orders. A review of the physician orders indicated, " Fasting Blood Sugar (FBS) every month; Basic Metabolic Panel (BMP) every six months: March and September." A review of Resident #10's laboratory reports indicated that BMP was not done in March 2006 and FBS was not done in April 2006 as ordered by the physician. A face-to-face interview was conducted with the Assistant Clinical Manager on May 19, 2006 at 10 :00 AM. He/she checked with the laboratory company and said that there was no evidence that the BMP was done in March 2006 and no evidence that the FBS was done in April 2006. The record was reviewed May 15, 2006. 4. Facility staff failed to follow-up on a laboratory value for a Hemoglobin A1C, follow physician's	L 052	for similar protective devices was done with corrective actions made when necessary. 3. Staff were inserviced on the importance of wearing such protective devices and following physician orders. The Clinical Managers on the units will monitor the residents for consistency and accuracy. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee. Resident #21 1. The catheter tubing was positioned correctly immediately upon discovery. 2. A review of the other catheters in the facility was done to ensure the proper positioning of the tubing. 3. Inservicing was done with the nursing staff to ensure their understanding of the importance of the positioning of the catheter tubing. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	6/30/06 6/30/06 5/19/06 5/19/06 6/30/06 6/30/06

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L 052	Continued From page 22 orders for the use of heel protectors and Ted stockings and position the Foley catheter tubing to prevent an urinary-tract infection. A. A review Resident #21's record revealed a laboratory report for a Hemoglobin A1C drawn on April 13, 2006, "Cancelled: Quantity not sufficient for procedure." There was no evidence in the record that the Hemoglobin A1C had been repeated. A face-to-face interview with the charge nurse was conducted on May 17, 2006 at 7:30 AM. He/ she acknowledged that the test had not been repeated. The record was reviewed May 17, 2006. B. Physician's orders for Resident #21 dated April 11, 2006 directed, " Heel protectors on at all times bilaterally when in bed " and "Ted Stockings to right foot/ankle/leg swelling to be worn daily." The resident was observed in bed on May 17, 2006 at 7:40 AM. A Certified Nursing Aide (CNA) removed the bed covers from the resident' feet. The resident was not wearing heel protectors. Additionally, the CNA stated that the resident wore socks daily and not Ted stockings. The CNA searched the resident ' s closet and drawers and neither heel protectors nor Ted stockings were found. Resident #21 was observed on May 15, 2006 at 2 :10 PM, May 16, 2006 at 10:45 AM and May 17, 2006 at 1:15 PM sitting in a wheel chair wearing socks. C. Resident #21 was observed on May 15, 2006 at 2:10 PM with the catheter tubing looped over	L 052	Resident #24 1. The nurse who did the wound dressings but failed to sign the Treatment Administration Record (TAR) was counseled and educated. 2. An audit of the TARs was done to ensure proper documentation. 3. Inservicing was done with the licensed staff to ensure their full understanding of signing each TAR upon completion of the order. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/2/06 6/30/06 6/30/06 6/30/06

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L 052	Continued From page 23 the hand grips of the wheelchair causing the urine to flow upwards. According to " Guidelines for prevention of Catheter-associated Urinary Tract Infections," published by the Centers for Disease Control and Prevention, February, 1981, under,"8. Urinary Flow ...4) collecting bags should always be kept below the level of the bladder." A face-to-face interview was conducted with the clinical manager at the time of the observation. He/she stated that the catheter tubing was positioned incorrectly and called the resident's assigned Certified Nursing Aide to re-position the tubing so the urine would flow downward. The record was reviewed May 17, 2006. 5. Facility staff failed to administer wound treatments as ordered by the physician for Resident #24. A review of Resident #24's record revealed physician's orders to treat the left hip wound, left elbow wound, and two (2) wounds on the right shin every three (3) days. According to the Treatment Administration Record for March 2006, March 10, 13, 16, 19, 22, 25, 28 and 31 were identified as days the wound treatments were to be performed. The above cited dates had boxes drawn on the day for the nurse to initial, indicating the wound treatments had been administered. The boxes for the nurse's initials were blank for the left elbow and both shin wounds for March 10, 2006 and all the wounds for March 16, 2006 indicating the wound treatments had not been administered. A review of the nurses' notes from March 10	L 052	Residents #S1, S2 and S3 1. The safety devices (mats and chair alarm) found not in use at the time of the survey were immediately implemented upon discovery. 2. Other residents with similar safety devices were checked to ensure that everything was in use and in place. 3. Inservicing was done with the nursing staff to ensure their complete understanding of the use of safety devices such as fall mats and chair alarms. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 5/19/06 6/30/06 6/30/06

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L 052	Continued From page 24 through March 17, 2006 revealed that the resident was sent to the emergency room on March 13, 2006 at 3:50 AM and returned to the facility the same day at 11:00 AM. On March 17, 2006 at 12:30 PM the resident was sent to the hospital and returned March 22, 2006. There was no evidence in the nurses' notes that wound treatments were administered on March 10 or 16, 2006. A face-to-face interview was conducted with the charge nurse on May 17, 2006 at 10:30 AM. The charge nurse acknowledged that the above cited dates were blank indicating that wound treatments were not administered. He/she had no explanation as to why the wound treatments were not administered. The record was reviewed May 17, 2006. 6. Facility staff failed to ensure that the bedside mat was next to Resident S1's bed. On May 15, 2006 at 9:35 AM, Resident S1 was observed lying his/her bed which was in the low position with the bedside mat standing upright against the wall. The nurse immediately placed the bedside mat on the floor next to the bed and stated that the resident attempts to get out of bed without assistance, but is unable to do so without assistance. The bedside mat is used to prevent injury. 7. Facility staff failed to ensure that the bedside mat was next to Resident S2's bed. On May 15, 2006 at 9:27 AM, the door to Resident S2's room was observed to be closed. After knocking, the surveyor and nurse entered the room. Resident S2 was in bed, the bed was in	L 052	Residents #S11, S12, W1, W2 and W4 Lab tests 1. The residents cited at the time of the survey for not having monthly or bi-weekly PT/INRs, PSA level, urinalysis, dilantin and albumin levels were ordered that lab test. Results were forwarded to the attending physician for review and comment, if necessary. 2. All resident with similar issues had their medical records reviewed and lab tests ordered if necessary. The results were forwarded to the attending physician for review and comment. 3. An inservice was done with the licensed nursing staff regarding the monitoring and ordering of lab tests. A 100% lab audit was performed and adjustments made as necessary. Additionally, the consultant pharmacist was asked to specifically address this issue in her monthly chart audits. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	5/19/06 6/30/06 6/30/06 6/30/06

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L 052	Continued From page 25 the high position. The bedside mat was upright and at the head of the bed. The nurse immediately lowered the bed and placed the bedside mat on the floor next to the bed. The nurse stated that Resident S2 is frequently found on the bedside mat after attempting to get out of bed without assistance. 8. Facility staff failed to ensure that the alarm was connected to Resident S3's chair. On May 19, 2006 at 9:40 AM, Resident S3 was observed in a wheel chair wheeling from the room towards the nurse's station. A chair alarm was present on the back of the wheelchair. The alarm was not connected to the resident. The nurse immediately connected the alarm to the resident and stated that the chair alarm is used because the resident attempts to stand up without assistance and falls. 9. Facility staff failed to obtain a monthly INR (International Normalized Ratio) to measure blood clotting time for Resident S11. A review of Resident S11's record revealed an initial physician's order dated January 5, 2006 and re-ordered February 7 and April 4, 2006 directing," Warfarin (Coumadin) 7.5mg 1 tab by mouth every evening." The most recent INR laboratory value was dated January 13, 2006. According to the, "Long Term Care Pharmacy Policy and Procedure Manual," policy #7.1 " Laboratory Monitoring of Drug Therapy " , effective date August 1, 2002, page 6, "11. INR or assessment of clotting function monthly, if on Warfarin (Coumadin), Dicumarol."	L 052		

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L 052	Continued From page 26 A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:15 AM. He/ she acknowledged that the INR was not obtained after January 2006. The record was reviewed May 19, 2006. 10. Facility staff failed to obtain an INR as ordered by the physician for Resident S12. A review of Resident S12's record revealed an initial physician ' s order dated January 7, 2006 and re-ordered March 14, 2006 directing, " Warfarin (Coumadin) 2.5mg 1 tab by mouth every evening. " A physician's order dated March 14, 2006 directed, "PT/INR every other week - DVT (deep vein thrombosis)." The most recent PT/INR laboratory value was dated March 16, 2006. A face-to-face interview was conducted with the charge nurse on May 19, 2006 at 11:30 AM. He/ she acknowledged that the PT/INR was not obtained after March 2006. The record was reviewed May 19, 2006. 11. A review of Resident W1's record revealed that facility staff failed to ensure that a PSA level and Urinalysis was performed. The Interim Order Form included an order dated May 9, 2006 at 3:40 PM which included: "...(2) PSA (Prostatic Specific Antigen) (3) Repeat U/A (Urinalysis). The laboratory book included a laboratory slip for Resident W1 dated May 11, 2006 with the tests	L 052		

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L 052	Continued From page 27 PSA and U/A checked. The laboratory slip was not signed [indicating that the blood was not drawn] by the laboratory technician. There was no reason on the laboratory slip as to why the blood was not drawn. A face-to-face interview was conducted with the Assistant Director of Nursing on May 17, 2006 at approximately 1:35 PM. He/She acknowledged that the blood work was not performed. The record was reviewed on May 17, 2006. 12. A review of Resident W2's record revealed that facility staff failed to ensure that Dilantin and Albumin levels were drawn. The Interim Order Form included an order dated May 6, 2006 at 12:30 AM which included: " Dilantin and Albumin level in one week (Due 5/12/06)". The record did not include results for Dilantin and Albumin levels for May 2006. A face-to-face interview was conducted with the Assistant Director of Nursing on May 17, 2006 at approximately 1:35 PM. The laboratory was called and indicated that there was no record of blood drawn for Resident W1 on May 12, 2006.. The record was reviewed on May 17, 2006. 13. A review of Resident W4's record revealed that facility staff failed to ensure that weekly PT and INR levels were drawn as per physician's order. The Physician Order Sheet and interim Plan of Care dated March 2, 2006 included the following order: "PT/INR Q (every) week secondary to Coumadin Toxicity ". The Interim Order Form dated May 15, 2006 at	L 052		

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L 052	Continued From page 28 10:00 PM included: "T/O (telephone order) PT/ INR for resident." The record included results for the PT/INR on April 3, 2006 - PT-31.6 and INR-3.0 and May 3, 2006 - PT -16.9 and INR 1.34. The physician's progress note dated April 3, 2006 included the following: " Attending-Blood draw was done on the anterior aspect of the left ankle for PT/PTT, INR, CBC, CMP. Patient is a hard stick and we could not get blood from any other site peripherally. " The physician also had progress notes dated April 17 and 18, 2006. There were laboratory slips in the laboratory book for Resident W4 for PT/INRs to be drawn dated March 3, April 12, May 10 and May 15, 2006. The resident ' s blood was not drawn on any of the aforementioned dates. A face-to-face interview was conducted with the clinical manager on May 17, 2006 at approximately 9:00 AM. He/She acknowledged that there were only two PT/INR levels drawn since the order. He/She stated that the staff and the physician were aware of the technician having difficulties drawing the labs. The PT/INR levels were not drawn weekly as ordered. The record was reviewed on May 17, 2006.	L 052	3211.3 Nursing Facilities 1. The facility strives to attain 3.5 nursing hours per patient day. 2. Each day the staffing is evaluated and adjusted to ensure proper staff for the residents of the facility. 3. The staffing coordinator, ADON and DON will ensure proper staff of nurses and certified nursing assistants are present on the units to attain and maintain the residents' highest level of functioning. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with action plans for improvement, will be presented at the quarterly Quality Improvement Committee which is chaired by the administrator.	5/19/06 5/19/06 5/19/06 6/30/06
L 054	3211.3 Nursing Facilities To meet the requirements of subsection 3211.2, facilities of thirty (30) licensed occupied beds or more shall not include the Director of Nursing Services or any other nursing supervisor employee who is not providing direct resident	L 054		

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L 054	Continued From page 29 care. This Statute is not met as evidenced by: Based on observation, interview, record review and review of staffing sheets for four (4) of five (5) days of the survey period, the facility failed to maintain staffing at 3.5 nursing hours per resident per day. The findings include: According to 22 DCMR, Beginning no later that January 1, 2005, "Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day ." The Nursing Daily Staffing Sheets were requested for May 14 through 21, 2006. The actual staffing schedules were reviewed with the DON for May 14, 15, 16, and 17. Three (3) of the four (4) days reviewed, revealed that the actual staffing was less than 3.5 nursing hours per resident per day. The same days were reviewed again by the DON (Director of Nurses) and ADON (Assistant Director of Nurses) and the result of the staffing schedule indicated: May 14, 2006 3.09 May 15, 2006 3.09 May 16, 2006 3.6 May 17, 2006 3.16. Three (3) of the four (4) days staffing reviewed by the DON and ADON remained below the required 3.5 nursing hours per resident per day.	L 054	3219.1 Nursing Facilities Floor Surfaces, Ceiling tiles, Ice Machine, Meat Slicer, Garbage Disposal, Pans and Muffin pans 1. All issues found at the time of the survey have been addressed and corrected. 2. Sanitation surveys of the entire kitchen are done on a routine basis by the Nutritional Services Staff to ensure on-going compliance. 3. The Nutritional Services Supervisors will monitor the kitchen sanitation issues throughout the month and report their findings to the Director of Nutritional Services.. 4. The Director of Nutritional Services will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator.	7/7/06 6/30/06 6/30/06 6/30/06
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and	L 099		

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L 099	Continued From page 30 served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain dietary services in a safe and sanitary manner as evidenced by: damaged floor surfaces; soiled ceiling tiles, inner surfaces of the ice machine and meat slicer; water to the disposal unit failed to shut off; and hotel and muffin pans were stored wet. These observations were made in the presence of the Director of Dietary Services. The findings include: 1. Floor surfaces were damaged and in disrepair in the cart wash room, nourishment room, walk in freezer and refrigerator, chemical room, tilt skillet area, and under the steam table in seven (7) of seven (7) observations between 8:45 AM and 4:30 PM on May 15, 2006. 2. Ceiling tiles over the food preparation area and serving areas were soiled with food spillage and dust in two (2) of two (2) observations between 8:45 AM and 4:30 PM on May 15, 2006. 3. The interior surfaces of the ice machine were soiled with accumulated mineral deposits and other products in one (1) of one (1) observations between 8:45 AM and 4:30 PM on May 15, 2006. 4. The inner and cutting areas of the meat slicer was not thoroughly cleaned after being used as evidenced by particles of leftover meats on the machine in one (1) of one (1) observation between 8:45 AM and 4:30 PM on May 15, 2006.	L 099		

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L 099	Continued From page 31 5. The water supply to the disposal unit in the pot and pan wash area failed to shut off after the unit had been turned off in one (1) of one (1) observation between 8:45 AM and 4:30 PM on May 15, 2006. 6. The interior of hotel pans (12"x10"x6") were wet and not allowed to dry before placing pans on racks for reuse in five (5) of five (5) observations between 8:45 AM and 4:30 PM on May 15, 2006. 7. Muffin pans stored on a rack in the cook's preparation area were not allowed to dry before placing pans on racks for reuse in 12 of 12 observations between 8:45 AM and 4:30 PM on May 15, 2006.	L 099	3224.3 Nursing Facilities Residents #2 and S9 1. The orders for these residents were clarified with the residents' attending physicians. 2. The pharmacy is performing a 100% audit of all PRN medications to ensure that those with the same therapeutic effect for any given resident have a clarification order documenting the order in which these medications should be given. 3. The consultant pharmacist will monitor the orders for the PRN medications to ensure compliance. She will work directly through the DON and physicians when clarification orders are needed. 4. She will report the findings of her monitoring at the quarterly Quality Improvement Committee which is chaired by the administrator.	5/19/06 6/30/06 6/30/06 6/30/06
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	L 128	Resident #4 1. The drug regime review was done for this resident for May and June 2006 with no particular issues arising or harm. 2. The pharmacy did an audit of the medical records and found no other record with a missing monthly audit. 3. The Consultant Pharmacist will be given an accurate census prior to each of her visits so that she can be assured of the current residents and their room numbers. Business Office coordinator to work with the pharmacist to ensure this is completed. The Clinical Managers will monitor this issue throughout the month and report their findings to the DON. 4. The Director of Nursing will oversee the monitoring. The results of this monitoring, along with any action plans for improvement, will be presented at thequarterly Quality Improvement Committee, which is chaired by the Administrator.	5/31/06 5/31/06 6/30/06 6/30/06

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L 128	Continued From page 32 reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review, and staff interview for three (3) of 30 sampled residents, it was determined that the contract pharmacist failed to report to the physician and Director of Nursing that orders for Lorazapam (Ativan), IM and PO (by mouth), had the same indication for use for two (2) residents and complete a monthly drug regimen review for one (1) resident. Resident #2, 4 and S9. The findings include: 1. A review of Resident #2's record revealed that the pharmacist failed to report to the physician and Director of Nursing that the two (2) orders for Lorazepam, IM and PO, had the same indication for use. The May 2006 Physician's Order Form included the following orders: "12/18/05, Lorazepam ½ ml (1 mg) intramuscularly (IM) every 4 hours as needed for agitation"; and " 12/18/05, Lorazepam 1 mg 1 tablet by mouth every four hours as needed for agitation. " There was no information included with the orders that would determine which route, IM or po, would be used. The drug regimen review was done monthly, December 2005 through March 2006. There were no irregularities for the aforementioned months. The record was reviewed on May 15, 2006. 2. A review of Resident #4's record revealed that	L 128		

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L 128	Continued From page 33 a monthly drug regimen review was not done for April 2006. A face-to-face interview was conducted with the Assistant Unit Manager on May 15, 2006 at 11:00 AM. He/she acknowledged that the drug regimen review for April 2006 was not done. The record was reviewed May 15, 2006. 3. The facility's contract pharmacist failed to report to the physician and Director of Nursing that the order for Lorazapam (Ativan) failed to specify when to use IM or PO. A review of Resident S9 ' s record revealed a physician's order dated March 14, 2006, " Ativan 1 mg po (orally) or IM (intramuscularly) every 4 hrs PRN (as needed) for anxiety. " There was no evidence that the contract pharmacist notified the physician of that to clarify when to use the oral form or the injectable form of the Ativan. The facility's contract pharmacist reviewed the record April 10 and May 11, 2006. "NI" (no irregularities" was circled for both review dates. The record was reviewed May 19, 2006.	L 128	3229.5 Nursing Facilities Social Work Resident #1, 12, 18, 21, 25, and S13 1. Social Work notes and evaluations missing at the time of the survey have been reviewed by the Director of Social Work and corrections were made whenever possible. 2. A 100% audit of all social work notes was done by the Director of Medical Records and the results of that audit were forwarded to the Director of Social Work for correction. 3. Aggressive recruitment to fill 2 vacant social work positions is on-going. The facility signed a contract with Delta-T, an agency which supplies contract workers, and an LICSW has started with an LGSW to begin soon. The Director of Social Work will monitor the timely completion of evaluations and notes. 4. The results of his monitoring and any action plans for improvement will be presented to the quarterly Quality Improvement Committee which is chaired by the administrator.	7/2/09 7/2/09 7/2/09 8/2/09
L 183	3229.5 Nursisng Facilities The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record, reviewed quarterly, and revised as necessary. This Statute is not met as evidenced by: Based on record review and staff interviews for five (5) of 30 sampled residents and one (1) supplemental resident, the social worker failed	L 183		

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L 183	Continued From page 34 write quarterly progress notes for three (3) residents and perform an initial assessment as per facility policy for two (2) residents. Residents #1, 12, 18, 21, 25 and S13. The findings include: 1. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #1. A review of Resident #1's record revealed the last social worker's progress note was written on January 10, 2006. A progress note was due April 2005. A face-to-face interview was conducted with the Director of Social Services on May 16, 2006 at 9: 30 AM. He/she stated, "We know we are behind in the progress notes on all the units. We had a turn over in staff and are trying to catch up. We are trying to address residents with immediate needs first." The record was reviewed May 15, 2006. 2. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #12. A review of Resident #12's record revealed social worker progress notes were written on July 5, 2005 and December 27, 2005. A quarterly progress note was due October 2005. The record was reviewed May 16, 2006. 3. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #18. A review of Resident #18's record revealed social	L 183		

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L 183	Continued From page 35 worker progress notes were written on November 1, 2005 and April 5, 2006. A quarterly progress note was due on February 2006. The record was reviewed May 16, 2006. 4. The social worker failed to write a quarterly progress that included a social assessment and evaluation for Resident #21. A review of Resident #21's record revealed the last social worker's progress note was written on January 17, 2006. A progress note was due April 2005. The record was reviewed May 17, 2006. 5. The social worker failed to do an initial social service assessment for Resident # 25. A review of Resident #25's record revealed that he/she was admitted to the facility on April 27, 2006. At the time of this review there was no initial social service assessment in the record. Resident #25 had been in the facility for 21 days from April 27, 2006 to May 17, 2006. According to the facility's policy, "Social Work Initial History and Assessment," Policy #1702010 A.000, dated May 1997, under "Procedure - #3. The Psychosocial Evaluation will be entered into the resident's medical chart within 14 days of admission. This form will be maintained as part of the resident's medical record. A face-to-face interview was conducted with a social worker on May 17, 2006 at 2:30 PM. He/ she stated, " We have a 14 day window to complete the initial social service assessment for the intermediate units which include [unit where Resident # 25 was admitted]. The initial social service assessment should have been completed ." The record was reviewed May 17,2006.	L 183		

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L 183	Continued From page 36 6. The social worker failed to complete an initial Psychosocial Evaluation for Resident S13. According to the facility's policy, "Social Work Initial History and Assessment", policy #1702010 A.00, dated May 1997, under "Procedure - #3. The Psychosocial Evaluation will be entered into the residents's medical chart within 14 days of admission. This form will be maintained as part of the residents's medical. A review of the clinical record for Resident S13 revealed that the resident was admitted to the facility on February 16, 2006. At the time of this review, there was no social worker's initial Psychosocial Evaluation. The resident had been in the facility 89 days. The record was reviewed May 17, 2006.	L 183	**3234.1 Nursing Facilities** Oxygen concentrators 1. Any oxygen concentrator with an odometer reading over 10,000 hours has been pulled from the unit and replaced with another one. 2. NeighborCare is assisting the facility in developing an aggressive and effective preventative maintenance program for its oxygen concentrators. Logs have been developed for tracking. 3. Inservicing was done by NeighborCare of the Central Supply and Maintenance staff regarding the measuring of oxygen output to ensure therapeutic levels for the residents. Additionally, NeighborCare will provide preventative maintenance on the oxygen concentrators which have reached certain odometer readings. 4. The Director of Maintenance will report on the progress of the PM program for the facility's oxygen concentrators at the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06 7/2/09 7/2/09 6/30/09
L 214	3234.1 Nursing Facilities 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 during the survey period, facility staff failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: lack of service tags for oxygen concentrators; non-functional amplifiers on telephones; failure of elevator indicator lamps to illuminate; and no logs to track preventive maintenance for equipment. These observations were made in the presence of nursing staff and/ or the Directors of Maintenance and Housekeeping.	L 214	Amplifiers and indicator lamps 1. Amplifiers on the public phones and indicator lamps on the elevators missing at the time of the survey have been repaired and/or replaced. 2. All public telephones and elevators were checked to ensure amplifiers and indicator lamps were present. 3. Maintenance aides will monitor the amplifiers and lamps on a monthly basis to ensure compliance. They will report their findings to the Director of Maintenance. 4. The Director of Maintenance will report any action plans for the amplifiers and indicator lights at the quarterly Quality Improvement Committee which is chaired by the	7/2/09 7/2/09 6/30/09 6/30/09

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L 214	Continued From page 37 The findings include: 1. Oxygen concentrators were observed without service tags and odometer readings in rooms 308 , 316, 337 and 349 in four (4) of four (4) observations on May 15, 2006 between 9:15 AM and 9:45 AM. 2. The amplifiers of public telephones were not functioning on 3 North on May 18, 2006 at 10:15 AM in one (1) of four (4) observations. 3. Elevator indicator lamps failed to illuminate on the main elevator on May 15, 2006 at 8:30 AM. 4. Documentation was not available to show that temperatures/pressure checks, lubrication, coil cleaning and filter changes were performed on HVAC units, hot water boilers, laundry washers, gas dryers, circulation pumps, air handlers and exhaust fans during the survey period.	L 214	administrator. Logs 1. Logs have been developed as evidence that the temperatures, pressure checks, coil cleaning and filter changes were performed on HVAC units, hot water boilers, washers, dryers, circulation pumps, air handlers exhaust fans are being done on a consistent basis. 2. Logs are being kept on all of these areas on an on-going basis as part of the facility's preventative maintenance program. 3. The Maintenance Aides and Director will ensure the documentation of these logs on a routine and consistent basis. 4. The Director of Maintenance will report on the progress of the PM program at the quarterly Quality Improvement Committee which is chaired by the administrator.	6/30/06 6/30/06 6/30/06 6/30/06
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 survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidence by: marred entrance and bathroom doors; soiled HVAC units; marred and damaged wall surfaces; an abundance of personal items in residents' rooms; damaged Venetian blinds; urine odors;	L 410	3256.1 Nursing Facilities Door Jambs 1. The door jambs cited at the time of the survey have been repaired and/or painted. 2. All door jambs have been evaluated and repaired/repainted as needed. 3. The Maintenance Supervisor will evaluate the door jambs on a monthly basis, scheduling repainting or repair as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the	6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 38 accumulated dust in the gas dryer; supplies stored under the sink; soiled and/or torn privacy curtains; soiled and stained ceiling tiles; soiled and damaged baseboards; soiled sprinkler heads; damaged HVAC units; soiled exhaust vents; soiled parallel bars in the Rehabilitation Department; mops and buckets stored on the floor; soiled wheelchairs, straight back chairs and dining room table legs; and worn and torn arm surfaces of geri chairs. These findings were observed in the presence of the Directors of Housekeeping and Maintenance and nursing staff . The findings include: 1. Entrance and bathroom doors and door jams were marred on the frontal and rear surfaces in the following areas: 1 North rooms: 111 and tub room in two (2) of 10 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 106, 110, 122, 146, 160, supply room and shower room in seven (7) of 15 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 209, 211, 215, 233, 237, 245, shower room and pantry in eight (8) of 16 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 212, 232, and 238 in three (3) of eight (8) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305, 313, 323 and 327 in four (4) of nine (9) observations on May 18, 2006 from 8:	L 410	Administrator. HVAC units 1. The HVAC units cited at the time of the survey have been thoroughly cleaned. 2. All HVAC units have been evaluated and cleaned when necessary. 3. The Housekeeping Supervisors evaluate the HVAC units on a monthly basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Wall surfaces 1. The wall surfaces cited at the time of the survey have been repaired and/or painted. 2. All wall surfaces have been evaluated and repaired/repainted as needed. 3. The Maintenance Supervisor will evaluate the wall surfaces on a monthly basis, scheduling repainting or repair as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 39 30 AM to 11:45 AM. 3 South rooms: 312, 326, 340, 348 and tub room in five (5) of nine (9) observations on May 18, 2006 from 1:48 PM to 4:54 PM. Laundry room in one (1) of one (1) observation on May 18, 2006 at 5:50 PM. 2. HVAC units were soiled in the following areas: 1 North rooms: 105, 111, 113, 139, 141, 151, 159 and dining room in eight (8) of 13 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms, 106, 110, 114, 142, 144, and 154 in six (6) of 12 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 North rooms: 203, 209, 215, 225, 233, 245 and 253 in seven (7) of 14 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 2 South rooms: 226, 232, 236 and 238 in four (4) of seven (7) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 309, 313, 327, 335 and 353 in five (5) of 11 observations on May 18, 2006 from 8:30 AM to 11:45 PM. 3 South rooms: 312, 326 and 340 in three (3) of six (6) observations on May 18, 2006 from 1:48 PM to 4:54 PM. 3. Wall surfaces were marred and damaged in the following areas: 1 North rooms: 105, 111, 113, 123, 125, 141, 139 , toilet room, linen room and pantry in 10 of 17	L 410	Committee, which is chaired by the Administrator. Personal Items 1. The abundance of personal items cited at the time of the survey have been organized and/or removed and stored. 2. All residents with an abundance of personal items have been addressed and their items reorganized or stored as needed. 3. The Maintenance Supervisor will evaluate the abundance of personal items on a monthly basis, scheduling the reorganization and/or storing as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Venetian blinds 1. The Venetian blinds cited at the time of the survey have been repaired and/or replaced as needed. 2. All Venetian blinds have been evaluated and repaired/replaced as needed. 3. The Maintenance Supervisor will evaluate the Venetian blinds on a monthly basis, scheduling their repair or replacement as needed. He will report his	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 40 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 106, 114, 116, 122, 132, 142, 146, 154, toilet room and dining room in 10 of 10 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 203, 233 and 237 in three (3) of nine (9) observations on May 17, 2006 from 11: 33 AM to 2:30 PM. 2 South rooms: 210, 212, 220, and tub room in four (4) of seven (7) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 313, 353, hallway on H side and dining room in four (4) of nine (9) observations on May 18, 2006 from 8:30 AM to 11:45 PM 4. An abundance of personal items were in residents' rooms beside the bed and on the floor in the following areas: room 210 and 348 in two (2) of two (2) observations on May 17, 2006 at 2: 38 PM and May 18, 2006 at 1:50 PM. 5. Venetian blinds were damaged in the following areas: 1 North rooms: 111, 113, 123, and 145 in four (4) of 10 observations May 15, 2006 from 11:20 AM to 1:30 PM. 1 South room 106 in one (1) of seven (7) observations on May 17, 2006 from 8:40 AM to 11:30 PM. 2 North rooms: 209, 211, 225, 233 and 245 in five (5) of eight (8) observations on May 17, 2006 from 11:33 AM to 2:30 PM.	L 410	findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Urine Odors 1. The urine odors noticed at the time of the survey have been addressed and eliminated. 2. All areas of the facility have been evaluated for the presence of odors and addressed as necessary. 3. The Nursing, Housekeeping, and Maintenance Supervisors will evaluate the cause of any odors on a monthly basis, scheduling inservices, ventilation repair, or cleaning as needed. They will report their findings to their respective department heads. The facility implemented a new practice of providing disposable (rather than reusable) incontience products to its residents. This was done both for acceptability by the residents and staff as well as odor control. 4. The Directors of Nursing, Maintenance and Housekeeping will oversee the monitoring of the presence of odors. The results of their monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired	6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 41 2 South rooms 226, 232 and dining room in three (3) of 11 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 313, 327, 349, 335 and 353 in five (5) of 10 observations on May 18, 2006 from 8:30 Am to 11:45 PM. 3 South rooms: 326 and 334 in two (2) of five (5) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 6. Urine odors were detected throughout the facility in the following areas during the survey period: first and third floor hallways near the main elevator, second floor hallway by the Rehabilitation Department and residents' rooms 106, 110, 111, 139, 145, 220, 228, 236, 253, 326, 334 and 353. 7. The interior of a gas dryer had accumulated dust in one (1) of one (1) observation on May 18, 2006 at 5:50 PM. 8. Supplies were stored under the sink in the following areas: 3 South janitor's closet, Rehabilitation Department and room 334 in three (3) of 11 observations throughout the survey period. 9. Soiled and/or torn privacy curtains were observed in the following areas: residents' rooms 116, 132, 145, 209, 225, 233 and 313 and the Rehabilitation Department in eight (8) of 26 observations throughout the survey period. 10. Ceiling tiles were soiled and stained in the following areas:	L 410	by the Administrator. Interior of the dryer 1. The interior of the dryer cited at the time of the survey have been thoroughly cleaned. 2. All dryers have been evaluated and cleaned routinely through the day. 3. The Housekeeping Supervisors evaluate the interior of the dryers on a frequent basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Storing of supplies 1. All areas noted at the time of the survey where supplies were inappropriately stored have been cleaned and supplies stored in an appropriate place. 2. Other similar areas have been evaluated for inappropriately stored supplies. The areas were cleaned when necessary and supplies moved to a safe and secure area. 3. The Housekeeping Supervisors evaluate the storage of supplies on a monthly basis, scheduling their cleaning and organization as needed. He will report his findings to the Director of Environmental Services.	5/19/06 5/19/06 6/30/06 6/30/06 5/19/06 5/19/06 6/30/06

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	095022	A. BUILDING _____ B. WING _____	05/19/2006

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L 410	Continued From page 42 1 North rooms: 113, 123, 145, 149, 159, hallway, shower room, toilet room and pantry in nine (9) of 15 observations on May 15, 2006 from 11:20 AM to 1:30 PM, 1 South rooms: 104, 132, 142, 146, 160, toilet room, supply room and dining room in eight (8) of 17 observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 203, 205, 211, 215, 225, 233, 237 , dining room, pantry, Rehabilitation Department and soiled utility room in 11 of 13 observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 210, 212, 238, and janitor's closet in four (4) of 10 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305 and 349 in two (2) of seven (7) observations on May 18, 2006 from 8:30 AM to 11:45 PM. 3 South room 312 in one (1) of six (6) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 11. Baseboards were soiled and damaged in the following areas: 1 North rooms: 123, 125, 145, dining room and lounge in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 110, 122, 142, and toilet room in four (4) of nine (9) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 233, 237, 245 and soiled utility room in four (4) of 11 observations on May 17,	L 410	4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Privacy curtains 1. The privacy curtains cited at the time of the survey have been thoroughly cleaned and repaired when necessary. 2. All privacy curtains have been evaluated and clean/repaired when necessary. 3. The Housekeeping Supervisors evaluate the condition of the privacy curtains on a monthly basis, scheduling their cleaning and repair as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Ceiling Tiles 1. The ceiling tiles cited at the time of the survey have been replaced. 2. All ceiling tiles have been evaluated and replaced when necessary. 3. The Maintenance Supervisor evaluates	6/30/06 5/19/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 43 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 220, 238 and dining room in three (3) of six (6) observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 321 and dining room in two (2) of seven (7) observations on May 18, 2006 from 8: 30 AM to 11:45 PM. 3 South room 302 in one (1) of nine (9) observations on May 18, 2006 from 1:48 PM to 4: 54 PM. 12. Sprinkler heads were soiled with dust and debris in rooms 110 and 151 in two (2) of 22 observations during the survey period. 13. HVAC units were damaged in the following areas: 1 North rooms: 111, 113, 145, 151 and the dining room in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms 142 and 146 in two (2) of six (6) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 South rooms 210, 236 and the dining room in three (3) of nine (9) observations on May 17, 2006 at 3:30 PM. 3 North rooms 309 and the dining room in two (2) of eight (8) observations on May 18, 2006 from 8: 30 AM to 11:45 AM. 14. The interior surfaces of exhaust vents were soiled in the following areas:	L 410	the ceiling tiles on a daily basis, scheduling their replacement as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Baseboards 1. The baseboards cited at the time of the survey have been cleaned and/or replaced. 2. All baseboards have been evaluated and cleaned or replaced when necessary. 3. The Maintenance and Housekeeping Supervisors evaluate the baseboards on a daily basis, scheduling their cleaning or replacement as needed. They will report their findings to their respective department heads. 4. The Directors of Housekeeping and Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Sprinkler Heads 1. The sprinkler heads cited at the time of the survey have been dusted. 2. All sprinkler heads have been evaluated	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 44 1 North rooms: 105, 123, 125, 139, and 153 in five (5) of 11 observations on May 15, 2006 from 11:20 AM to 1:30 PM. 1 South rooms: 110, 114, 142, 160 and toilet room in five (5) of nine (9) observations on May 17, 2006 from 8:40 AM to 11:30 AM. 2 North rooms: 209, 233, and staff bathroom in three (3) of five (5) observations on May 17, 2006 from 11:33 AM to 2:30 PM. 2 South rooms: 212, 232 and 238 in three (3) of 12 observations on May 17, 2006 from 2:33 PM to 4:54 PM. 3 North rooms: 305, 309, 335 and 353 in four (4) of eight (8) observations May 18, 2006 from 8:30 AM to 11: 45 AM. 3 South rooms: 312, 326 and 334 in three (3) of seven (7) observations on May 18, 2006 1:48 PM to 4:54 PM. 15. The flat surfaces of parallel bars in the Rehabilitation Department were soiled and stained in one (1) of one (1) observation on May 17, 2006 at 12:30 PM. 16. Mops and buckets were soiled and stored on the floor in the janitor's closet on 1 North, 2 North, 2 South, 3 North and 3 South in five (5) of six (6) observations during the survey period. 17. Wheelchairs were soiled on the spoke and frame surfaces and arms were worn in the following areas: 1 South rooms: 106, 110 and 146 in three (3) of 13 observations on May 17, 2006 at 8:40 AM to	L 410	and dusted when necessary. 3. The Maintenance Supervisor evaluates the sprinkler heads on a monthly basis, scheduling their dusting as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Damaged HVAC units 1. The HVAC units cited at the time of the survey have been repaired or replaced. 2. All HVAC units have been evaluated and repaired or replaced as deemed necessary. 3. The Maintenance Supervisor evaluates the interior of the HVAC units on a monthly basis, scheduling their repair or replacement as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Interior surfaces of the exhaust vents 1. The interior surfaces of the exhaust	6/30/06 6/30/06 6/30/06 6/30/06 6/30/06 6/30/06

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L 410	Continued From page 45 11:30 AM. 2 North rooms: 209 and 215 in two (2) of 11 observations on May 18, 2006 at 11:33 AM to 2: 30 PM. 2 South room 338 in one (1) of five (5) observations on May 17, 2006 from 2:33 PM to 4: 54 PM. 3 North rooms: 305, 321, 349, and 357 in four (4) of eight (8) observations on May 18, 2006 from 8: 30 AM to 11:45 AM. 3 South rooms 326 and 334 in two (2) of seven (7) observations on May 18, 2006 at 1:48 to 4:54 PM. 18. Residents' straight back chairs were soiled on seat surfaces in three (3) of 11 observations on 3 North on May 18, 2006 from 8:30 AM to 11:45 AM and three (3) of 14 observations in 1 North lounge on May 15, 2006 from 11:20 AM to 1:30 PM. 19. Dining room table legs were soiled with dust and food in the 3 North dining room in 18 of 20 observations on May 18, 2006 from 8:30 AM to 11:45 PM. 21. Arm surfaces of geri chairs were torn and worn in rooms 220 and 253 during the survey period.	L 410	vents cited at the time of the survey have been cleaned. 2. All interior surfaces of exhaust vents have been evaluated and cleaned when necessary. 3. The Maintenance Supervisor evaluates the interior surfaces of the exhaust vents on a quarterly basis, scheduling their routine cleaning as needed. He will report his findings to the Director of Maintenance. 4. The Director of Maintenance will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality Improvement Committee, which is chaired by the Administrator. Flat surfaces of the parallel bars 1. The flat surfaces of the parallel bars cited at the time of the survey have been cleaned. 2. All therapy equipment was evaluated for cleanliness and cleaned as necessary. 3. The Housekeeping Supervisor evaluates the rehabilitation equipment on a monthly basis, scheduling their cleaning as needed. He will report his findings to the Director of Environmental Services. 4. The Director of Environmental Services will oversee the monitoring. The results of his monitoring, along with any action plans for improvement, will be presented at the quarterly Quality	6/30/06 6/30/06 6/30/06 6/1/06 6/1/06 6/30/06 6/30/06