FORM APPROVED

·T OF DEFICIENCIES / OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095(28	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 09/26/2007

·ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE PRESBYTERIAN RETIREM	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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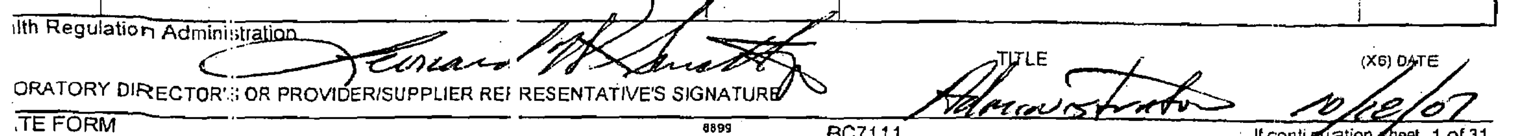
L 000	Initial Comments An annual licensure survey was conducted from September 24 through September 26, 2007. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 15 residents based on a census of 69 residents on the first day of survey and seven (7) supplemental residents.	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on observations during the survey, it was determined that facility staff failed to maintain current licenses and certifications for RNs, LPNs and CNAs. The findings include: A review of the licenses for currently employed RNs revealed that eight (8) of 10 licenses had expired. A review of the licenses for currently employed LPNs revealed that 17 of 17 licenses had expired. A review of the licenses for currently employed CNAs revealed that 12 of 29 licenses had expired. The staff of the Human Resource department immediately obtained a copy of a current licenses and certifications for all the above cited employees from appropriate web sites.	L 012	L012 1. No resident was affected by this deficiency. • All RN's currently employed are required to submit a current copy of the license to the Human Resources department immediately. • All LPN's currently employed are required to submit a current copy of the license to the Human Resources department immediately. • All CNA's currently employed are required to submit a current copy of the license to the Human Resources department immediately 2. All licensed staff and C.N.A. employment records were audited for current licenses. 3. The Human Resource Director or designee will review/ audit the renewal dates of the licensed nursing staff and c.n.a.'s employed by the facility monthly. 4. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec., & Jan. 2008	received 11/7/07 no revision made 11/09/2007



·lth Regulation Administration

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 10/12/07

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L 012	Continued From page 1 A face-to-face interview was conducted on September 25, 2007 at 12:30 PM with Employee #13. He/she stated, "In the past, the staff educator kept the licenses. The staff educator is new and didn't know [he/she] was responsible for keeping a copy of current licenses. We (Human Resources) will own it now. We will maintain the licenses from now on."	L 012		
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 observations, staff interview and record review for six (6) of 15 sampled residents and six (6) supplemental residents, it was determined	L 051		

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L 051	Continued From page 2 that the charge nurse failed to initiate additional goals and approaches for fall prevention for 12 residents with multiple falls. Residents # 2, 4, 5, 9, 13, 14, F1, F2, F3, F4, F5 and F6. The findings include: The facility's falls program is entitled "Leaping Deer Program," policy number C-105, effective date April, 2007. Under "Procedure - 8. Implement interventions as needed to prevent falls. Possible Interventions: Call bell within reach Bed in lowest position Low bed Brakes locked on wheelchair Safe and appropriate footwear Rearranging room furniture Night light for nighttime trips to the bathroom Assistive devices within reach Toileting Schedules. Personalized. Medication assessment Assessment of vision/hearing Monitor during shift change Identify "sundowners" Assess for orthostatic hypotension Restorative Nursing OT/PT consult and intervention Mat beside the bed Assessment of equipment used by the resident that may put resident at risk. 1. The charge nurse failed to implement new interventions for multiple falls. Resident #2 The review of nurses' progress notes dated June 20, 2007 at 6:30 PM indicated, " Resident was sitting in the TV room at 4:30 PM resident was	L 051	1. Residents 2, 4, 5, 9, 13, 14, F1, F2, F3, F4, F5 and F6 care plans were reviewed and new implementations put in place. • Resident # 4 has a bed \chair alarm as of 10/01/2007. • All residents that have orders for bed\chair alarms have them in place as of 10/19/2007. 2. All residents who have fallen in the last 90 days will have their care plans reviewed and updated with individualized new interventions. • All staff will be re-educated on following physician's orders. 10/19/2007 • Licensed nurses will be educated on comprehensive care planning and applying appropriate interventions. • All residents who have fallen the previous day will be discussed at the daily interdisciplinary team meeting for recommendations and review of new interventions. • The Leaping Deer policy and procedure has been revisited.	

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L 051	Continued From page 3 noted on the floor slide out of her wheel chair MD notified no new orders." June 21, 2007 12:15 PM a nurse' s note indicated, " Resident alert and verbally responsive; was found on the floor in a sitting position in front of her bed. She said she just slide out ..." . June 27, 2007 10:55 PM a nurse' s note indicted, " Resident was in bed at about 10:00 PM The writer was called to the resident' s room, and the writer noticed resident sitting on the floor mate near resident' s bed ..." On August 8, 2007 7:40 PM nurses noted indicated, " Resident was noted about 3:15 PM on the floor in the TV room in a supine position. Assessment done no physical injury noted..." The resident had a physician' s order dated January 26, 2007, " Leaping Deer Program, and February 2, 2007, Bed/chair alarm in use at all times." The resident had rehabilitation screens on June 22, 28, and August 10, 2007. The therapist notes indicated, " Not a rehab. candidate at this time. No change in level of functioning. Nursing observing precautions and monitoring oversight to decease risk for falls" There were no added interventions to the resident' s care for fall prevention. The record was reviewed on September 24, 2007 2. The charge nurse failed to implement approaches/interventions listed on the "Falls Prevention Care Plan" for Resident #4 who had multiple falls with one (1) injury..	L 051	3. The falls committee will meet weekly x 90 days to review all falls for compliance. • The supervisor will audit bed\chair alarms q shift and submit findings to DON daily. 10/12/07 4. All deficient practices will be monitored, discussed and reviewed during the monthly QA meetings. The QA committee will recommend the appropriate plans of action to correct this deficient practice.	11/09/2007

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L 051	Continued From page 4	L 051		

A review of Resident 4's record revealed the following nurses' notes:

April 12, 2007 at 6:40 AM: " ...Resident was seen lying down to the side of her bed, states she was trying to get to the phone and fell. She denied pain. ....Resident sustained skin tear to right forearm and elbow ... "

June 25, 2007 at 7:00: " AM Late entry ...Resident observed on floor on buttocks at 7:25 AM. "

July 01, 2007 at 6:00 PM: " ...Resident found on kneeling position in her room near her bed. Abrasion noted in both knees. "

July 27, 2007 at 5:30 PM: " Resident observed sitting on the floor in her room near her bed... "

A review of the "Fall Risk Assessment" included the following:

Date	Score.
February 16, 2007	11
March 6, 2007	10
April 12, 2007	9
July 1, 2007	10
August 1, 2007	14

Instruction accompanying the assessment indicated: " If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls."

A review of the Physician ' s Order Form signed and dated July 12, 2007 revealed an order for " chair and bed alarm in use at all times. " The order was first initiated on April 12, 2007.

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L 051	Continued From page 5 The " Falls Prevention Care Plan " was initiated March 5, 2007. In the Approaches/Interventions column on the care plan, item #28 revealed " Bed and Chair Alarm in use at all times. " On September 24, 2007 at about 1:15 PM, the resident was observed seated in his/her wheelchair in the dinning room eating dinner. The chair alarm was not in use. On September 24, 2007 at about 3:00 PM, the resident was observed seated in his / her room. The chair alarm was not in use. On September 25, 2007 at about 8:50 AM, during a wound treatment observation, the resident was in bed. The bed alarm was not in use. A face-to-face interview was conducted with the Resident Care Coordinator on September 25, 2007 at about 2:30 PM. He /she acknowledged that facility staff failed to implement the " Falls Prevention Care Plan: Approaches/Interventions " " #28: Bed and Chair Alarm in use at all times ", for Resident #4 who had multiple falls with one (1) injury. The record was reviewed September 24, 2007. 3. The charge nurse failed to update Resident #5' s care plan with appropriate goals and approaches after multiple falls. The resident was admitted to the facility on November 22, 2006. According to the nurses' notes the resident was found on the floor the following dates: December 5, 11, and 28, 2007; January 22; February 15; March 22; May 20 and 25; July 10 and 29; and August 2, 2007. No injury was sustained from any of the above identified falls.	L 051		

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L 051	Continued From page 6 The " Fall Prevention Care Plan" was initiated November 26, 2006. Under the "Evaluation" column, hand written entries document the resident' s falls. However, there was no evidence that additional goals and approaches were initiated after any of the above cited falls. According to a physician' s order dated April 1, 2007, " Fall Precautions and Bed/Chair Alarm" were initiated. A review of the May, June, July, and August 2007 monthly orders, signed by the physician but undated, did not include an order for the " Bed/chair alarm" . Observations of the resident were conducted on September 24, 2007 at 1:45 PM, September 25, 2007 at 9:30 AM, 11:45 AM, 2:20 PM and 4:45 PM and on September 26, 2007 at 10:10 AM. There was no chair or bed alarm being used for the resident at the above cited times. There was no evidence that the resident was enrolled into the facility's falls program, "Leaping Deer" . A face-to-face interview was conducted with Employee #2 on September 24, 2007 at 4:30 PM. He/she acknowledged that the falls care plan was not updated after the above cited falls. The record was reviewed September 25, 2007. 4. The charge nurse failed to update Resident #9' s care plan with appropriate goals and approaches after multiple falls. A review of the nurses' notes revealed the following: April 25, 2007 at 10:00 PM: "At about 8:30 PM,	L 051		

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L 051	Continued From page 7	L 051		

after care, resident was assisted to bed. Caregiver reported that...observed resident on E-Z mattress at about 9:00 PM in a left side lying position with a small wooden night stand lying on [Resident]...On assessment, noted a bruise on right corner of right eye..."

August 10, 2007 at 7:30 PM: "Resident observed on back lying position...no apparent injury noted."

September 23, 2007 at 3:00 PM: "Resident slid out of wheelchair and sat on wheelchair foot rest with head against wheelchair cushion at 11:45 AM...no injury noted."

The " Fall Prevention Care Plan" was initiated May 5, 2003. Under the "Evaluation" column, hand written entries documented the resident' s falls. However, there was no evidence that additional goals and approaches were initiated after any of the above cited falls.

The resident was placed on the "Leaping Deer Program" on June 24, 2003.

A review of a Rehab. (Rehabilitation) Screen note dated August 20, 2007 stated " No intervention or eval (evaluation) necessary. Rec: (Recommend) Maintain oversight. Assist pt. (patient) with changing positioning to decrease restlessness."

A face-to-face interview was conducted with the DON on September 25, 2007 at approximately 1:45 PM and she/he acknowledged that there were no new goals and approaches to the care plan. The record was reviewed on September 25, 2007.

5. The charge nurse failed to initiate additional goals and approaches for Resident #13, who had

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L 051	Continued From page 8 multiple falls with injury. A review of Resident #13' s record revealed that the resident was admitted to the facility on September 12, 2007. An interim plan of care was initiated the same day. The problem area of " Falls" was identified with interventions initiated for " identifying the need for assistance and side rails." Admission orders dated September 12, 2007, included " Initiate Leaping Deer Program. Resident at risk for falls." According to the nurses' notes, the resident was found on the floor on September 12 and 21, 2007 and sustained no injury. On September 23, 2007 the resident was found on the floor and subsequently sustained a fractured left scapula. There was no evidence that additional goals and approaches were initiated after the resident fell on September 12 and 21, 2007. The physical therapist screened Resident #13 on September 15, 2007 and began treatment for gait training and balance. There was no evidence that additional screenings occurred after the fall on September 21 and 23, 2007. A face-to-face interview was conducted with Employee #2. He/she acknowledged that the care plan was not amended after the falls. The record was reviewed September 25, 2007. 6. Facility staff failed to initiate new goals and approaches to the care plan for Resident #14 after a fall. Resident #14 was admitted to the facility on May	L 051		

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L 051	Continued From page 9	L 051		

24, 2007. According to the nurses' notes, the resident was found on the floor on May 25, 2007 with no injuries. On June 16, 2007, the resident sustained a fall, was transferred to the hospital and returned on June 26, 2007.

A " Fall Prevention Care Plan" was initiated on June 11, 2007. No new goals and approaches were added to the care plan after the resident returned to the facility.

The "Leaping Deer Program" was initiated on May 24 and June 26, 2007.

A face-to-face interview with Employee #1 was conducted on September 26, 2007 at 9:30 AM. He/she acknowledged that the care plan was not updated with new goals and approaches after the resident returned from the hospital. The record was reviewed on September 26, 2007.

7. The charge nurse failed to initiate additional goals and approaches for Resident F1, who had multiple falls with injury.

A review of Resident F1' s nurses' notes revealed the following:

July 25, 2007 at 3:45 PM: " Resident observed ...on the floor on back ...no injuries."

July 28, 2007 at 8:10 PM: " Resident observed on the bathroom floor. On assessment observed blood at the back of head. Noted an open area ...with slight swelling ..."

The physical therapist screened the resident on August 18, 2007 noting that the resident was, " Not a rehabilitation candidate at this time"

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L 051	Continued From page 10 According to a physician's order dated September 5, 2006, "Initiate Leaping Deer Program." The " Falls Prevention Care Plan" was initiated on September 9, 2006. The above cited falls were written in the " Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated after the three (3) above cited falls. A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that the care plan was not updated after the above cited falls. The record was reviewed September 25, 2007. 8. The charge nurse failed to initiate additional goals and approaches for Resident F2, who had multiple falls with injury. On June 25, 2003, the resident was placed on the "Leaping Deer Program." A review of Resident F2' s nurses' notes revealed that following: July 15, 2007 at 10:45 PM: " ...Abrasions noted to left shin ..." A note dated July 18, 2007 at 7:00 AM documented that the resident had fallen on the above cited date. July 29, 2007 at 3:50 PM: " ...Resident noted on the floor in sitting position ...no injury noted ..." September 24, 2007 at 1:10 PM: " Resident was observed sliding to the floor by nursing staff while trying to sit on a chair. No apparent injuries ..." The physical therapist screened the resident on July 31 and August 9, 2007. The physical	L 051		

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L 051	Continued From page 11	L 051		

therapist documented that the resident was, " Not a rehabilitation candidate at this time" for both screenings.

The " Falls Prevention Care Plan" was initiated August 5, 2003. The above cited falls were written in the " Evaluation" column on the care plan. However, there was no evidence that facility staff initiated additional goals or approaches after the above cited falls.

A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 4:30 PM. He/she acknowledged that the care plan was not amended after the above cited falls.
The record was reviewed September 25, 2007.

9. The charge nurse failed to initiate additional goals and approaches for Resident F3, who had multiple falls with injury. On December 1, 2005, the resident was placed on the "Leaping Deer Program."

A review of Resident F3 nurses' notes revealed the following:

November 26, 2006 at 7:00 AM: " Observed in a sitting position on the floor mat in room with right elbow stuck in the side rail."

January 14, 2007 at 3:00 PM: " Resident slid out of wheelchair and sat on the floor in the day room at 10:00 AM. No visible injury."

March 23, 2007 at 10:00 PM: " CNA assigned to resident -called writer at 9 PM that resident was on the floor in the room. Noted on assessment with laceration and swelling on the left forehead at upper eye lid and complained of painful right hand /shoulder ..."

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L 051	Continued From page 12 May 3, 2007 at 5:55 PM: " ...Observed on the [bedside] mattress on the floor ...no observed injuries at this time ..." August 8, 2007 at 8:00 PM: " At 3:15 PM resident was noted on the floor in a sitting position, slid out of the chair ...no physical injury ..." September 24, 2007 at 7:30 PM: " Resident slid out of the couch while trying to sleep on it and knelt down ...No injury noted." The physical therapist screened Resident F3 on January 24, March 6, March 26, June 26 and August 9, 2007. All screenings documented that the resident was not a candidate for physical or occupational therapy. The " Falls Prevention Care Plan" was initiated on November 29, 2007. The falls were documented under the " Evaluation" column of the care plan. There was no evidence that additional goals and approaches were initiated after the above cited falls. A face-to-face interview was conducted with Employee #2 on September 25, 2007 at 3:05 PM. He/she acknowledged that the care plan was not amended after the above cited falls. The record was reviewed September 25, 2007. 10. The charge nurse failed to update Resident F4' s care plan with appropriate goals and approaches after multiple falls. There was no evidence that the resident was placed on the "Leaping Deer Program." A review of Resident F4's record revealed that he/she was admitted to the facility on July 23,	L 051		

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L 051	Continued From page 13 2007. A review of the nurses' notes revealed the following: August 15, 2007 at 4:00 PM: " Resident alert and verbally responsive was seen in a sitting position in her room ...sustained a skin tear on left hand ..." August 29, 2007 at 12:10 PM: Resident was observed sitting in an upright position on the floor in the TV area near wheelchair. Sustained a skin tear on right arm near elbow ..." September 3, 2007 at 7:00 PM: " Resident found sitting on the floor near the bed in room ...No injury ..." The " Fall Prevention Care Plan" was initiated August 6, 2007. The falls were documented under the " Evaluation" column on the care plan. There was no evidence that additional goals and approaches were initiated by facility staff after the above cited falls. The physical therapist screened Resident F4 on August 15, August 29, August 31 and September 3, 2007. All screenings documented that the resident was not a candidate for physical therapy. A review of the July (admission), August and September 2007 physician' s orders revealed that the resident was not placed on the facility' s fall prevention program, " Leaping Deer." A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 11:30 AM. He/she acknowledged that there were no additional goals and approaches initiated after the above cited falls. The record was reviewed September 26, 2007.	L 051		

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L 051	Continued From page 14 11. The charge nurse failed to update Resident F5' s care plan with appropriate goals and approaches after multiple falls. According to physician's orders dated August 17 and August 30, 2007, the resident was not placed on the "Leaping Deer Program." A review of Resident F5' s record revealed the following nurses' notes: March 30, 2007 at 7:00 AM: " Resident was observed on the floor in a sitting position ...no injuries ..." July 9, 2007 at 2:30 PM: " Resident observed on the floor in the room ...no injuries ..." July 16, 2007 at 7:00 PM: " At about 3:30 PM resident was observed on the bathroom floor in a sitting position ...complained of left wrist pain ...x-ray scheduled for 7/17/07 ..." The x-ray was negative for fracture of the left wrist. August 28, 2007 at 6:00 PM: " Resident was observed on [floor] at about 5 pm in a sitting position ...no complaints voiced ..." The " Falls Prevention Care Plan" was initiated on October 30, 2006. The above cited falls were listed under the " Evaluation" column. There was no evidence that additional goals and approaches were initiated after the above cited falls. The occupational therapist screened the resident on August 3 and September 10, 2007 and began treatment for balance and transfers. The physical therapist screened the resident and began treatment for gait training and balance on September 7, 2007.	L 051		

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L 051	Continued From page 15 A face-to-face interview was conducted with Employee #2 on September 26, 2007 at 3:00 PM. He/she acknowledged that there were no additional goals and approaches initiated after the July 9 and July 16, 2007 falls. The record was reviewed September 26, 2007. 12. The charge nurse failed to update Resident F6's care plan with appropriate goals and approaches after multiple falls. According to a physician's order dated February 13, 2007, the resident was placed on the "Leaping Deer Program." A review of the nurse's notes revealed the following: March 2, 2007 at 9:00 PM: "Resident was found sitting on the floor near wheelchair in room." May 27, 2007 at 3:30 PM: "...Observed on floor in front of wheelchair in room." The " Falls Prevention Care Plan" was initiated on December 5, 2005 and reviewed May 29, 2007. There was no evidence that additional goals and approaches were initiated after the above cited falls. A face-to-face interview was conducted with Employee #2 on September 25, 2007 at 2:50 PM. He/she acknowledged that the care plan was not amended after the above cited falls. The record was reviewed September 25, 2007.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident	L 052		

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L 052	Continued From page 16 receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she 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	L 052	1. Resident # 4, 2,and 3 have a bed \chair alarm as of 10/01/2007. • Facial hair was removed from resident #2 chin 10/01/07 • Soiled clothes were changed, untrimmed toe nails were cut and resident # 3 was also encouraged to use the dining room and eat with other resident. 2. All residents that have orders for bed\chair alarms have them in place as of 10/19/2007. • Residents on all units were assessed for soiled clothes. All residents that needed to shaved or other grooming issues were services. 10/01/07 3. All staff will be re-educated on following physician's orders. 10/19/2007 • The supervisor will audit bed\chair alarms q shift and submit findings to DON daily. 10/12/07 • The Falls Committee will review all audits for compliance. 10/19/07 • Charge Nurses will check residents daily for adequate hygiene and the condition of their clothing. 10/01/07 • The nursing staff will encourage all residents to use the dining room and eat with others. 10/01/07 4. QA committee will review all deficient practices monthly and give recommend.	11/09/2007

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/26/2007

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L 052	Continued From page 17 j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, staff interview and record review for two (2) of 15 sampled residents, it was determined that sufficient nursing time was not given to residents as evidence by failure to: follow the physician's orders for the use of a bed/chair alarm for residents with multiple falls for two (2) residents and failure to assist in grooming for two (2) residents.. Residents #2, 3 and 4. The findings include: 1. Facility staff failed to utilize the bed/chair alarm as per physician's orders for Resident #2. A physician ' s order dated February 2, 2007, and renewed on June 14, 2007 directed "Bed/chair alarm in use at all times." The resident was observed on September 24, 2007 sitting in the wheelchair at 10:00 AM in the TV room with no chair alarm present. On September 25, 2007 at 7:30 AM the resident was observed in bed with no bed alarm present. According to the September 2007 Treatment Administration Record, the nurse signed on the day shift (7:00 AM through 3:30 PM) for September 24, 2007 that the alarm was in place. A face-to-face interview was conducted with Employee #2 on September 25, 2007 at approximately 9:30 AM. He/she acknowledged that a bed/chair alarm should have been in place for Resident #2. the record was reviewed	L 052		

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L 052	Continued From page 18	L 052		

September 24, 2007.

2. Facility staff failed to implement the physician's order for "Chair and bed alarm in use at all times" for a resident with multiple falls. Resident #4.

A review of Resident #4's record revealed the following nurses' notes:

April 12, 2007 at 6:40 AM: "Resident was seen lying down to the side of the bed, states was trying to get to the phone and fell. [He/She] denied pain. ... Resident sustained skin tear to ...right forearm and elbow ..."

June 25, 2007 at 7:00 AM: " Late entry ...Resident observed on floor on buttocks at 7:25 AM. "

July 1, 2007 at 6:00 PM: "...Resident found on kneeling position in [his/her] room near bed. Abrasion noted in both knees."

July 27, 2007 at 5:30 PM: "Resident observed sitting on the floor in [his/her] room near bed ... "

A review of the resident's record revealed a physician's order signed and dated July 12, 2007 that included an order for "Chair and bed alarm in use at all times." The order was first initiated on April 12, 2007.

On September 24, 2007 at approximately 1:15 PM, the resident was observed seated in his/her wheelchair in the dining room eating dinner. The chair alarm was not in use.

On September 24, 2007 at approximately 3:00 PM, the resident was observed seated in his/her room. The chair alarm was not in use.

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L 052	Continued From page 19 On September 25, 2007 at approximately 8:50 AM, during a wound treatment observation, the resident was in bed and no bed alarm was observed. A face-to-face interview was conducted with the Employee # 2 on September 25, 2007 approximately 2:30 PM. He/she acknowledged that a chair and/or bed alarm was not being used. The record was reviewed September 24, 2007. 3.Sufficient nursing time was not given to Resident #2 who was observed with facial hair on her chin. On September 24, 2007 at approximately 10:00 AM and September 25, 2007 at approximately 11:00 AM, Resident #2 was observed in the day room with facial gray hairs on her chin. A face-to-face interview was conducted with Employee #2 on September 25, 2007 at approximately 11:10 Am. He/she stated, "We shave [Resident #2] when we can. Sometimes he/she is not cooperative." After asking the staff if an attempt was made to shave Resident #2 the past two (2) mornings, Employee #2 stated, "The staff didn't try yesterday or today (September 24 and 25, 2007)." 4. Sufficient nursing time was not given to Resident #3 who was observed with soiled clothes and untrimmed toe nails and not encouraged to use the dining room and eat with other residents. A. On September 25, 2007 at approximately 12:00 PM Resident #3 was observed in the dining area with soiled clothes and untrimmed toe nails.	L 052		

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L 052	Continued From page 20 B. On September 24 and 25, 2007 at approximately 9:30 AM, Resident #3 was observed in the dining room eating breakfast alone. The resident expressed to the surveyor the desire to eat breakfast with other residents. Resident #3 was asked if he/she expressed this request to the staff. Resident #3 stated, "Yes, but they get me up too late to eat with the others."	L 052		
L 053	3211.2 Nursing Facilities Each facility shall have at least the following employees: (a)At least one (1) registered nurse on a twenty-four (24) hour basis, seven (7) days a week; (b)Twenty-four (24) hour licensed nursing staff sufficient to meet nursing needs of all residents; (c)At least one practical or registered nurse, serving as charge nurse, on each unit at all times; (d)A minimum of two (2) nursing employees per nursing unit, per shift. This Statute is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees. The findings include: According to the 22DCMR 3211.2 (d), "The facility shall have at least the following employees: A minimum of two (2) nursing employees per nursing unit, per shift."	L 053	**L 053** 1. No residents were affected by this deficiency. • The facility will ensure that a minimum of two nursing employees be on a nursing unit, per shift. 2. The staffing patterns were observed on each unit for each shift to ensure that a minimum of two nursing employees was met. 3. The staffing coordinator will monitor the staffing patterns on the units daily. 4. Results of this audit will be presented to the QA committee by the Administrator or designee monthly times three. Nov., Dec., & Jan. 2008.	11/09/2007

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L 052	Continued From page 20 B. On September 24 and 25, 2007 at approximately 9:30 AM, Resident #3 was observed in the dining room eating breakfast alone. The resident expressed to the surveyor the desire to eat breakfast with other residents. Resident #3 was asked if he/she expressed this request to the staff. Resident #3 stated, "Yes, but they get me up too late to eat with the others."	L 052		
L 053	3211.2 Nursing Facilities Each facility shall have at least the following employees: (a)At least one (1) registered nurse on a twenty-four (24) hour basis, seven (7) days a week; (b)Twenty-four (24) hour licensed nursing staff sufficient to meet nursing needs of all residents; (c)At least one practical or registered nurse, serving as charge nurse, on each unit at all times; (d)A minimum of two (2) nursing employees per nursing unit, per shift. This Statute is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to ensure that the Rehabilitation unit was staffed with two (2) nursing employees. The findings include: According to the 22DCMR 3211.2 (d), "The facility shall have at least the following employees: A minimum of two (2) nursing employees per nursing unit, per shift."	L 053	**L 053** 1. No residents were affected by this deficiency. • The facility will ensure that a minimum of two nursing employees be on a nursing unit, per shift. 2. The staffing patterns were observed on each unit for each shift to ensure that a minimum of two nursing employees was met. 3. The staffing coordinator will monitor the staffing patterns on the units daily. 4. Results of this audit will be presented to the QA committee monthly times three. Nov., Dec., & Jan. 2008.	received 11/7/07 no revis[illegible] 11/09/2007

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L 053	Continued From page 21 On September 24, 2007 at approximately 9:00 AM during the tour of the rehabilitation unit, it was observed that one (1) licensed practical nurse (LPN) was caring for five (5) residents. There were no other nursing employees on the Rehabilitation unit at the time of the observation. A face-to-face interview was conducted at 9:05 AM with Employee #4. He/she stated, "The CNA (certified nurse aide) called in sick at one o'clock this morning and wasn't replaced."	L 053		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to provide a safe and sanitary environment as evidenced by residents ' bathing basins stored on closet floors and failure to post signs indicating which residents required special isolation precautions. These observations were made in the presence of Employees #10 and #11 . The findings include: 1. Facility staff stored residents' bathing basins containing personal grooming items on closet floors. During the initial environmental tour, bathing basins containing personal care items, such as dentures cups, deodorant, and a kidney basin, were observed stored on the floor in rooms 166	L 091	1. Residents found to have been affected by the deficient practice. • Items stored on the floor were removed immediately 9/26/2007 • Isolation signs were posted immediately 10/24/2007 2. Other resident identified having the potential to be affected by the same practice. • All residents in isolation has signage posted .10/26/2007 • All residents with items on the floor we are working with the residents and families to resolve these issues 10/26/2007	

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L 091	Continued From page 22 and 178 on September 24, 2007 at approximately 9:30 AM for two (2) of 12 rooms observed. 2. Facility staff failed to post signs to notify visitors and staff which residents required special isolation precautions. During the initial tour, it was observed that isolation signs were not posted on rooms 79, 97 and 181, to notify visitors and staff that those residents required special isolation precautions and should not be entered prior to speaking to nursing staff on September 24, 2007 between 8:30 AM and 10: 00 AM for three (3) of three (3) residents in isolation. Employees #10 and #11 acknowledged these findings at the time of the observations.	L 091	3. Measure put into place. • All nursing staff will be educated on isolation control procedures • All residents requiring isolation will be put on the 24 hour report • The Infection Control Nurse will do random weekly audits for compliance of isolation precautions. • QA committee will discuss, review and monitor Infection Control data during monthly QA / QA Committee will recommend appropriate plans of action to correct deficient practice. 4. QA • Isolation audits will be discussed, reviewed and monitored during the monthly QA meeting. QA committee will recommend appropriate	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during a tour of the main kitchen on September 24, 2007 between 8:50 AM and 12:30 PM, it was determined that facility staff failed to prepare, store and serve food in a safe and sanitary manner as evidenced by the following: soiled floors, wall, hand sinks, appliances, baking pans, storage bins; perishable food delivery stored on the floor and out of required temperature range, food stored in the salad cold box at 52 degrees F. These observations were made in the presence of Employees #8 and 9.	L 099		11/09/2007

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L 099	Continued From page 23 The findings include: 1. The floor throughout the main kitchen was observed with accumulated grease, food spillages and debris in one (1) of one (1) floor observed in the main kitchen. 2. The walls throughout the main kitchen were observed soiled with accumulated food spillages, grease and debris in one (1) of one (1) wall observed in the main kitchen. 3. Hand washing sinks were observed soiled with accumulated grease and debris in three (3) of three (3) hand washing sinks in the main kitchen. 4. In the main kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease, food and debris: top surfaces of the gas oven, grill surface and drip pans, fry master including the gas lines, upper and lower convection ovens, hot box, steamer kettle, steamer, freezer, salad cold box, and the exterior of the dish machine in 10 of 12 appliances observed. In the Suites kitchen, the following appliances were observed soiled on the interior and/or exterior surfaces with grease, food and debris: steam kettles, convection oven, and gas oven in three (3) of five (5) appliances observed. 5. Muffin tins were observed stored and ready for reuse soiled and with a greasy residue in 10 of 10 muffin tins observed in both kitchens. 6. 24 inch hotel pans were stored with accumulated debris and a greasy residue in three (3) of three (3) 24 inch hotel pans observed in the main kitchen.	L 099	L099 1. No resident was affected by this deficiency. 1) Floors cleaned completed as of 10-20-07 2) Walls cleaned completed as of 10-24-07 3) Hand washing sink cleaned completed as of 10-15-07 4) Equipment cleaned completed as of 10-30-07 5) Muffin Tins replaced as of 10-20-07 6) Hotel Pans cleaned completed as of 10-16-07 7) Sheet Pans cleaned as of 10-16-07 8) Plastic Bin Covers cleaned as of 10-18-07 9) Loaf Pans cleaned as of 10-18-07 10) Bulk Storage Bins cleaned as of 10-24-07 11) Utensil Bins cleaned as of 10-19-07 12) The 27 cartons of perishable food that were observed stored on the floor near the back entrance to the kitchen were discarded as of 09/24/2007	

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L 099	Continued From page 24 7. Metal sheet pans were observed stored wet and ready for reuse in nine (9) of nine (9) metal sheet pans observed in both kitchens. 8. Plastic bin covers were observed stored wet and ready for reuse in 26 of 27 plastic bin covers observed in the main kitchen. 9. Loaf pans were observed stored and ready for reuse with a greasy residue on the exterior surface in five (5) of five (5) loaf pans in the suites kitchen. 10. Four (4) storage bins used for flour, sugar, pasta and rice were observed soiled on the exterior with accumulated debris in four (4) of four (4) bins observed. 11. Storage bins used for clean utensils and dessert dishes were observed soiled with an accumulated white substance on the bottom of the bin in two (2) of two (8) eight bins observed. 12. 27 cartons of perishable food were observed stored on the floor near the back entrance to the main kitchen. The food was delivered between 6:00 AM and 7:00 AM on September 24, 2007. Temperatures of the food were as follows: Wild berry pie was 22 degrees Fahrenheit (F), with the manufacturer ' s directions printed on the top of the box to " Keep Frozen " in eight (8) of eight (8) cartons of pies observed. Blueberry yogurt was 45.5 degrees F in two (2) of two (2) cartons of yogurt observed. Liquid eggs were 41 degrees F and 46 degrees F with the manufacturer ' s directions printed on the	L 099	13) All items on the salad cold box observed at 52 degrees F were discarded as of 09/24/2007. 2. The Dining Service Director or designee in each of the Ingleside kitchens will conduct a sanitation audit monthly. The Service Manager or designee will conduct weekly audits. 3 .The Dining Service Director will monitor daily and corrective action will be taken to maintain compliance with standards as needed based on the results of the audits. 4. Sanitation audits and need action plans will be reported at the QA committee meeting monthly. 11/07	11/09/2007

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 099	Continued From page 25	L 099		

box " Store at 33-40 F " in two (2) of four (4) cartons observed.

Cartons of cranberry and orange juice manufacturer ' s directions printed on the box " Keep Frozen " . When examined, the juices were in liquid form in four (4) of four (4) cartons of juice observed.

Muffins were 20 degrees F with manufacturer ' s directions printed on the box to " Keep Frozen " in four (4) of four (4) cases.

The temperature of the other seven (7) cartons was within the safe temperature range.

13. The temperature of the salad cold box was observed at 52 degrees F. The following items were stored in the salad cold box:

Sliced Mushrooms- 9/23 (date opened)
Tomato Puree - 9/23
Tartar Sauce - 6/28
Honey Dijon Dressing - 7/16
Sesame Dressing - 7/23
Raspberry Vinaigrette - 7/26
Pickle Relish - 8/9
Duck Sauce - 8/1
Salsa - 8/12
Fahini dip - 8/14
Olives - 8/14
Mayonnaise - 8/19
French Dressing - 8/20
Thousand Island Dressing - 8/20
BBQ Sauce - 8/27
Caesar Dressing - 8/30
Vinaigrette Dressing - 9/1
Blue Cheese Dressing - 9/6
Ranch Dressing - 9/10
Raspberry Vinaigrette Dressing -9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING ______ B. WING ______	09/26/2007

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L 099	Continued From page 26 Mayonnaise - 9/13 Cottage Cheese - 9/17 Cocktail Sauce - no open date Peach Yogurt - no open date Grey Pupon Mustard - no open date Village Garden Cole Slaw Dressing - no open date Employees #8 and 9 acknowledged the above findings at the time of the observations.	L 099		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations during the survey, it was determined that the facility staff failed to remove expired medication from the currently dated medication. The findings include: The facility ' s policy #5.3, " Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles " stipulates, (3) " Drugs and biological that have an expired date on the label or are after manufacturer/supplies guidelines/recommendations, or if contaminated ... are stored separately, away from use, until destroyed or returned to the provider. " A. On September, 24 2007, at 2:30 PM, during the inspection of the Lower Level ' s medication storage area, nine (9) containers were observed stored in the medication refrigerator. Two (2) of nine (9) opened insulin containers were stored beyond the 30 day expiration date.	L 161		

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L 161	Continued From page 27	L 161		

The following Insulins were observed:

Lantus insulin - Expiration date - 8/22/2007
Novolin N Insulin - Expiration date - 8/16/2007

During a face-to face interview, on September 24, 2007, at approximately 2:40 PM with Employee #20, he/she acknowledged that the insulin was given to the resident that morning and the bottles of insulin had expired. No untoward effects were noted per nursing documentation.

B. On September 25, 2007, at during the inspection of the medication carts, blister package of Hydrocodone/APAP 5mg/500 mg, was observed with an expiration date of July 30, 2007.

During a face-to-face interview, on September 25, 2007, at approximately 2:30 PM, Employee #15 acknowledged that the medication was expired.

According to The Drug Information Handbook for Nursing, stipulates, under Storage, " Intact vial should be refrigerated, protected from light; do not use discolored ... May be stored at room temperature for up to 60 days. "

On September 25, 2007, at 2:30 PM, the medication carts were inspected, four (4) of four (4) Lorazepam Injection 2mg/ml vial were found undated in the controlled substance drawer. This medication requires an expiration date on the container when stored at room temperature.

Employee #15 acknowledged that the Lorazepam 2mg/ml injection vials were stored undated in the

Provider's Plan of Correction:

1. Residents found to have been affected by the deficient practice.
   - All carts involved during survey were inspected and all expired medications were removed and unlabeled medications dated and labeled correctly. 9/26/2007
   - Pharmacy faxed over the in-service information to comply with the 2 in-services a year requirement
2. <u>Other potential involvement</u>
   - All medication carts have been audited for expired medications and unlabeled medications. 10/1/2007
3. <u>Measure put in place</u>
   - All licensed nurses will be educated on storage f medication, dating, and handling of expired medications protocol 10/26/2007
   - Random medication cart audits will be conducted weekly by the 11-7 shift to insure compliance 10/12/2007
   - Staff Development Coordinator will be educated on the requirement to have the handout for proof of in-service
4. <u>QA</u>
   - Audits will be discussed and reviewed during QA meeting. Deficient practice will be discussed, reviewed and recommendations given during monthly QA meeting.

11/09/2007

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 161	Continued From page 28 medication cart at the time of the inspection.	L 161		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the environmental tour of the facility, it was determined that housekeeping and maintenance services were not provided to maintain a sanitary, orderly and comfortable interior as evidenced by: soiled baseboards, floors and carpeting, furniture and ceiling tiles; marred and/or damaged walls, baseboards, doors, ceiling, floor tiles, furniture and cabinets; broken furniture; odors; and clutter. These observations were made in the presence of the Housekeeping Director, Maintenance Manager and/or nursing staff on September 25, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. Soiled baseboards were observed in the following areas: First level-dayroom and dining room; Lower level-dayroom and activity/dining room and room 178. 2. Soiled floors and carpeting were observed in the following areas: Soiled carpet throughout the first and lower level nursing units in 10 of 10 observed areas and the clean linen room on the first floor in one (1) of two (2) clean linen rooms observed. 3. Soiled furniture was observed in the following areas: First floor dayroom and wheel chair pad	L 410	L410 1. No residents were affected. • Soiled baseboards observed on the first level dayroom and dining room ; lower level dayroom and activity/ dining room and room 178 were cleaned as of 10/01/2007. • Soiled floors and carpeting throughout the first and lower levels nursing units and the clean linen room on the first floor in the clean linen rooms were cleaned as of 10/01/2007. • Soiled furniture in the first floor dining room and wheel chair pads soiled on the first floor and dining room were cleaned as 10/01/2007. • Soiled ceiling tiles observed in the first floor dayroom and first floor pantry were replaced as of 10/01/2007. • Walls with marred and / or damaged surfaces observed on the first floor dining room and lower level dayroom repaired as of 10/30/2007. • Baseboards with marred and/or damaged surfaces observed in the first floor pantry cabinet first floor dining room and lower level dayroom were repaired or replaced as of 10/30/2007. • Doors with marred and /or damaged surfaces observed in the first floor dining room and the lower level dining room and the first floor storage room were repaired or replaced as of 10/30/2007.	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095028	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 09/26/2007

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L 410	Continued From page 29 soiled in first floor and dining room. 4. Soiled ceiling tiles were observed in the first floor dayroom and first floor pantry. 5. Walls with marred and/or damaged surfaces were observed in the first floor dining room and lower level dayroom. 6. Baseboards with marred and/or damaged surfaces were observed in the following areas: First floor pantry cabinet, first floor dining room and lower level dayroom. 7. Doors with marred and/or damaged surfaces were observed in the first floor dining room and the lower level dining room and the first floor storage room. 8. Damaged areas to the ceiling was observed in room 092 in one (1) of 12 areas observed. 9. Cracked floor tile in the first floor dining room measuring approximately 17 ft long. 10. Furniture marred worn and/or damaged observed in the following areas: 10 of 10 arm chairs observed in the first floor dayroom and first floor across from the nursing station area and four (4) of four (4) arm chairs in the lower level dayroom. 11. The cabinet in the first floor pantry failed to close and rubber bands were looped around the cabinet handles to prevent the doors from opening 12. Missing knobs -first floor dining room beverage station cabinet.	L 410	• Damaged ceiling tile observed in room 092 will be repaired or replaced as of 10/30/2007. • The cracked tile in the in the first floor dining room is due to the expansion and contraction of the concrete floor. If the floor is replaced, the movement of the building would cause the new tile to crack. • Furniture marred worn and /or damaged observed in the first floor dayroom and on the first floor, across from the nursing station and in the lower level dayroom (arm chairs) will be cleaned or replaced as of 11/1/2007. • The cabinet in the first floor pantry will be repaired or replaced as of 11/01/2007. • Missing knobs on the first floor dining room beverage station cabinet will be replaced as of 10/30/2007. • Broken over the bed table and a broken drawer on a side table in the first floor dayroom were removed as of 10/30/2007. • The odor in room 188 was sanitized and cleaned as of 10/30/2007. • Clutter in the lower level dayroom and in room 188 was cleaned up as of 10/30/2007. 2. Environmental Rounds were conducted 10/12/2007 and no other deficiencies were noted. 3. The Maintenance Supervisor or designee will conduct monthly preventive maintenance rounds. All work generated will be completed within 48 - 72 hours with written affirmation.	

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L 410	Continued From page 30 13. A broken over the bed table and a broken drawer on a side table was observed in the First Floor dayroom. 14. Odors were present in room 188 in one (1) of 12 rooms observed. 15. Clutter observed in the lower level dayroom and room 188.	L 410	4. The Facility Management Director will conduct random audits and will be presented monthly to the QA committee.	11/09/2007