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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	06/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments An annual licensure survey and incident (#06-I-1284) investigation was conducted on June 12 and 13, 2006. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 11 sampled residents based on a census of 44 residents on the first day of survey and six (6) supplemental residents.	L 000		
L 016	3203.6 Nursing Facilities A qualified employee shall be assigned the responsibility for ensuring that records are maintained, completed, and preserved. This Statute is not met as evidenced by: Based on observation, interview and record review for nine (9) of 11 sampled residents and six (6) of six (6) supplemental residents, it was determined that facility staff failed to write a complete description of an elopement incident for one (1) resident and consistently document on percentage of food intake on the " Resident Care Flow Record " for 15 residents. Residents #1, 2, 3, 4, 5, 7, 8, 9, 10, W1, W2, W3, W4, S1, and S2. The findings include: 1. Facility failed to include a complete description of an elopement incident in Resident #9's record. The incident report sent to the State Agency on June 6, 2006, included the following: "Resident observed in sitting position in ambulance entrance driveway. Resident was observed at 2 AM by nursing. Resident sustained an abrasion to Left elbow approximately 3 cm long and an abrasion to Left knee approximately 1 cm long ... "	L 016	(1) A. The Director of Nursing will review the medical record of Resident #9 with the nursing staff and educate them on how to appropriately document and describe an elopement in the medical record. (1) B. Facility staff has begun to consistently document the percentage of food intake on the "Resident Care Flow Record" for Residents #1, 2, 3, 4, 5, 7, 8, 9, 10, W1, W2, W3, W4, S1 and S2. None of the above residents experienced weight loss during this timeframe. (2) A. Nursing staff will be educated on how to complete a more thorough investigation and documentation on elopement in the medical record and on the incident report. 2) B. The Certified Nursing Assistants will be inserviced on the importance of consistent documentation of the food intake of each resident on the flow sheet. (3) The Director of Nursing will randomly audit the records on a monthly basis to assure that all documentation is complete for attempted elopements and the percentage of food intake. (4) The results of the Director of Nursing findings will be incorporated in the Quality Assurance Program.	7/10/06

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Barbara O'Gatonio, LNHA — Administrator — 7/3/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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L 016	Continued From page 1 The nurses' notes read as follows: June 5, 2006 at 7:30 AM, " At 1:30 AM OOB (out of bed) ambulating in hallway... Assisted to bed at 2AM, made comfortable. 2:30 AM resident found on ground in the ambulance driveway. Upon investigation, resident said that he/she was trying to find his/her friend ... Wanderguard not found on either ankle ... " June 5, 2006 at 7:30 AM, " Addendum - Wanderguard reapplied to right ankle. " A telephone interview was conducted on June 5, 2006 at 12:50 PM with the charge nurse on duty the morning of the elopement. He/She stated, " ...One of the engineers past by and said he thought someone was outside; I think he/she heard something. We immediately went out there. [Resident] had fallen in the driveway. " A telephone interview was conducted with the facility engineer on June 5, 2006 at 1:15 PM. He/ She stated, " Someone from upstairs [Independent Living area] called the front desk and they [front desk] called me. The front desk said a resident heard someone outside screaming. I went out there and saw the resident and went back and told the nurse and they went out. It was about 2:30 AM. I helped them put [resident] in the wheelchair. " The nurse's note was not inclusive of the circumstances surrounding the discovery of the resident in the ambulance driveway. The record was reviewed June 12, 2006. 2. Facility staff failed to consistently document the percentage of food intake on the "Resident Care Flow Record" for 15 residents. According to the facility's policy " Resident Flow	L 016		

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L 016	Continued From page 2 Sheet [Record] " no effective date or policy number indicated, under " Procedure - The following areas are to be checked or documented as stated on the flow sheet ...Food intake - This is to be done in percentages - i.e. 50%... " A face-to-face interview was conducted with the charge nurse on June 13, 2006 at approximately 10:30 AM. He/she acknowledged that documentation for the percentage of food intake for the following residents was inconsistent on the "Resident Care Flow Record." A. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #1 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 7, 8, and 9, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 12, 2006. B. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #2 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch : June 2, 5 through 9, 2006; Dinner: June 1 through 10, 2006 . The resident did not experience weight loss during this timeframe. The record was reviewed June 12, 2006. C. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #3 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 3 through 12, 2006; Dinner: June 2 through 5, and 9, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 12, 2006. D. A review of the " Resident Care Flow Sheet "	L 016		

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L 016	Continued From page 3 for June 2006 for Resident #4 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 2, 4, 8 through 11, 2006; Dinner: June 1 through 4, 8 and 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. E. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #5 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1 through 7, 10 and 11, 2006; Dinner: June 1 through 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 12, 2006. F. A review of the "Resident Care Flow Sheet: for June 2006 for Resident #7 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 2, 4, 8 through 12 , 2006; Dinner June 1 through 4, 8, and 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. G. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #8 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1 and 3 through 13, 2006; Dinner: June 3, 4, 5, 9, 10, 11 and 12, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. H. A review of the " Resident Care Flow Sheet " for June 2006 for Resident #9 revealed that there was no percentage of intake recorded for the following days: Breakfast: June 1 through 3, 5 through 12, 2006; Lunch: June 1 through 12,	L 016		

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L 016	Continued From page 4 2006; Dinner: June 1 through 4, 5 through 12, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. I. A review of the "Resident Care Flow Sheet" for June 2006 for Resident #10 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 2, 4, 8 through 11, 2006; Dinner: June 1 through 4, 8, and 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. J. A review of the " Resident Care Flow Sheet " for June 2006 Resident W1 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 2, 5 through 12, 2006; Dinner: June 1 through 4, 8, and 9, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. K. A review of the " Resident Care Flow Sheet " for June 2006 for Resident W2 revealed that there was no percentage of intake recorded for the following days: Breakfast: June 4 through 9, and 12 2006; Lunch: June 4 through 12, 2006; Dinner: June 1, 3, 4, 8, 9 and 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13 , 2006. L. A review of the " Resident Care Flow Sheet " for June 2006 for Resident W3 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 3, 7 through 12, 2006; Dinner: June 1 through 12, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed	L 016		

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L 016	Continued From page 5 June 13, 2006. M. A review of the " Resident Care Flow Sheet " for June 2006 for W4 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1 through 7, 10 and 11 2006; Dinner: June 1 through 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. N. A review of the " Resident Care Flow Sheet " for June 2006 for Resident S1 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 7 through 12, 2006; Dinner: June 1 through 12, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006. O. A review of the " Resident Care Flow Sheet " for June 2006 for Resident S2 revealed that there was no percentage of intake recorded for the following days: Breakfast and lunch: June 1, 2, 4, 8 through 13, 2006; Dinner: June 1 through 4, 8, and 11, 2006. The resident did not experience weight loss during this timeframe. The record was reviewed June 13, 2006.	L 016		
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	L 052		

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L 052	Continued From page 6 contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 11 sampled residents, it	L 052	(1) It has been witnessed by staff that the wanderguard system was working appropriately on 6/10/06 and had alarmed. This system has a battery back-up in the event of power failures. Therefore, it appears that the alarm failed between the dates of 6/10/06 and 6/12/06. When this was discovered, a staff member was immediately placed at the corridor exit door, which leads to the ambulance entrance. Additionally, a back-up system was installed on this door. Staff monitored the door and kept a log until 6/13/06 when both the wanderguard and the back-up alarm were operational. (2) Nursing staff will monitor and document that the bracelets worn by the residents on the wanderguard system are in place every shift and there will be a documented test of each ankle transmitter each day. The Security Officer or Engineer will monitor and document that the door exits are alarming when a wanderguard device/tester is passed by it on a daily basis. (3) Nursing, Security and Engineer staff will comply with the requirements of this schedule and the Chief Engineer and Administrator will regularly monitor the documentation. (4) Documentation will be incorporated in the Quality Assurance Program.	06/13/06

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L 052	Continued From page 7 was determined that facility staff failed to adequately monitor one (1) resident with Dementia who eloped from the facility on June 5, 2006 and was found in the ambulance driveway. Resident #9. The findings include: The incident report dated June 5, 2006, sent to the State Agency included the following: "Resident observed in sitting position in ambulance entrance driveway. Resident was observed at 2 AM by nursing. Resident sustained an abrasion to Left elbow approximately 3 cm long and an abrasion to Left knee approximately 1 cm long ... " The resident was admitted to the facility on January 25, 2006. The admission MDS (Minimum Data Set) dated February 2, 2006 included the following diagnoses in Section I: Other Cardiovascular Disease and Dementia other than Alzheimer ' s Disease. The admission MDS and the quarterly MDS dated April 27, 2006 in Section E4 coded the resident with the behavior of wandering daily. The June 2006 POS (Physician's Order Sheet) included the following order: "Wanderguard to prevent elopement " . The nurses' notes read as follows: June 5, 2006 at 7:30 AM, " At 1:30 AM OOB (out of bed) ambulating in hallway... Assisted to bed at 2AM, made comfortable. 2:30 AM resident found on ground in the ambulance driveway. Upon investigation, resident said that he/she was trying to find his/her friend ... Wanderguard not found on either ankle ... " June 5, 2006 at 7:30 AM, " Addendum -	L 052		

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L 052	Continued From page 8 Wanderguard reapplied to right ankle. " A telephone interview was conducted on June 12, 2006 at 12:50 PM with the charge nurse on duty the morning of the elopement. He/She stated, " He/she got up and was walking as [resident] usually does ... One of the CNAs took [resident] back to his/her room and put him/her back to bed . [Resident] came back and was put back to bed. One of the engineers past by and said he/she thought someone was outside; I think he/she heard something. We immediately went out there. [Resident] had fallen in the driveway. " A follow up telephone interview was conducted with the charge nurse on June 20, 2006 at 10:12 AM. He/she stated, " I had not checked it [wanderguard] that shift. It had been checked the previous shift. There is no set time to check it. Now, I check it the beginning and end of each shift. " A telephone interview was conducted with the facility engineer on June 12, 2006 at 1:15 PM. He/she stated, " Someone from upstairs [Independent Living area] called the front desk and they [front desk] called me. The front desk said a resident heard someone outside screaming. I went out there and saw the resident and went back and told the nurse and they went out. It was about 2:30 AM. I helped them put [resident] in the wheelchair. " The resident had a history of attempting to exit the facility. His/her room was adjacent to the corridor doors that led to the ambulance entrance . The nurses' notes revealed the following: January 27, 2006 at 12 midnight, " ... wandering in hallway. Attempted to leave the unit via the ambulance door. "	L 052		

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L 052	Continued From page 9 January 27, 2006 at 4:15 PM, " Resident attempted elopement from [facility] X3 after lunch today. " January 27, 2006 at 9:30 PM, " ...Continues to wander on unit, attempted to leave via ambulance door X2 ... " January 28, 2006 at 10:30 PM, " ...Wanders about unit, attempted X3 to leave unit, wanderguard effective ... " February 5, 2006 at 6:50 AM, " Resident wandered X2 this shift and tried the exit door ... " February 5, 2006 at 1:25 PM, " Resident remains confused and disoriented. Wandered on unit opened the exit door X3. " February 6, 2006 at 6:50 AM, " ...started wandering on unit trying the exit doors to go home. " February 8, 2006 at 7:00 AM, " ...Several attempts made to go through the ambulance entrance at the hall door ... " February 10, 2006 at 7:00 AM, " ...He/She is always attempting to go through the emergency room door ... " February 11, 2006 at 7:00 AM, " ...Continue to wander in hallway ... Attempt to go out through ambulance door ... " February 12, 2006 at 3:00 PM, " ...Always looking for a door so he/she can go upstairs ... " February 12, 2006 at 10:00 PM, " ...Attempt to leave unit via ambulance entrance ... " February 16, 2006 at 7:00 AM, " ...OOB wandering a hallway. Attempted twice to go through ambulance door ... " February 18, 2006 at 6:45 AM, " ...wandered to the ambulance door ... " February 19, 2006 at 6 " 55 AM, " ...Attempted to leave the unit thru doors and elevators ... " March 1, 2006 at 6:00 AM, " ...OOB ambulating most of the night ... " March 1, 2006 at 1:05 PM, " ...wandered on unit,	L 052		

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L 052	Continued From page 10 unable to locate where he/she is ... " The care plan dated February 2, 2006 included the following: " Problem - Resident experiences wandering. Approach - Equip resident with a device that alarms when he/she wanders (Wanderguard). Check for proper functioning of device on a regular basis. 1st quarter review - 4/ 27/06 - The resident likes to walk about, sometimes aimlessly ... Sometimes in search of his/her longtime friend who has remained in Assisted Living. [Resident] does not realize where he/she is actually going because of severe Dementia and wears a wanderguard anklet because he/she may elope ... 6/5/06 - Resident attempted to exit through ambulance entrance. Had cut off or taken off wanderguard. Has since been replaced. " The Treatment Administration Record (TAR) for June 2006 included " Wanderguard To Prevent Elopement " . The TAR was initialed [indicating that the wanderguard was checked] for June 4, 2006 for the evening shift [3PM-11PM]. However, the TAR lacked initials for June 5, 2006 for the night shift [11PM-7AM], the time of the elopement. The record was reviewed June 12, 2006. The resident had a new wanderguard applied after the elopement. Facility staff failed to ensure that the wanderguard device elicited an audible alarm at the corridor door leading to the ambulance entrance. 2. On June 12, 2006, at approximately 9:00 AM, during medication pass, a nurse administered Prevacid 30 mg capsule to S1. The resident proceeded to chew the capsule. The nurse stated that the resident likes to chew his/her medication.	L 052		

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L 052	Continued From page 11 Prevacid is a delayed release medication. The manufacturer's specifications stipulate that this medication should not be crushed or chewed.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served under sanitary conditions as evidenced by : soiled sheet pans and grate surfaces, an oil drip over the mixing bowl on a mechanical mixer, food spillage on the plate warmer on the tray line, water and chemical stains on chinaware and silverware, chinaware soiled with leftover foods, non-dietary staff working in kitchen without hair covering, elevated ambient air temperature in the dining room and cold food foods served above 41 degrees Fahrenheit (F). These findings were observed in the presence of the food service director. The findings include: 1. The inner and outer surfaces of sheet pans were soiled with leftover food and grease after washing in the pot and pan wash area. The pans were stored on a rack and ready for reuse by staff in 10 of 20 observations at approximately 8: 30 AM on June 13, 2006. 2. The grate surfaces of grills located in the cook's preparation area were soiled with residual	L 099	(1) A. The inner and outer surfaces of the sheet pans were rewashed in the pot and pan wash area on 6/13/06. Sheet pans that could not be adequately cleaned were discarded. (1) B. The grate surfaces of grills located in the cook's preparation area were cleaned on 6/13/06 1) C. The leak from a fitting directly located over the mixing bowl area on a mechanical mixer in the cook's preparation area was repaired on 6/15/06. Note: CMS 2567 stated the observation was made 6/24/06, however, the survey team was here 6/12/06 and 6/13/06 so the observation was made on one of these dates. (1) D. The inner and outer surfaces of the plate warmer on the tray line were cleaned on 6/12/06. (1) E. The dishwasher was repaired during the survey and the final rinse solenoid was replaced. The plates, glasses, bowls, cups and silverware were rewashed in the dishwasher. (1) F. The top and bottom surfaces of chinaware plates were rewashed on 6/12/06. (1) G. The non-dietary individuals working in the main kitchen repairing the dishwasher have been instructed to wear proper hair covering.	06/30/06

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	095026	A. BUILDING _____ B. WING _____	06/13/2006

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L 099	Continued From page 12 food and carbon buildup in two (2) of two (2) observations at 8:15 AM on June 13, 2006. 3. Oil was observed leaking from a fitting directly located over the mixing bowl area on a mechanical mixer in the cook's preparation area in one (1) of one (1) observation at 9:24 AM on June 24, 2006. 4. The inner and outer surfaces of a plate warmer on the tray line were soiled with accumulated food spillage in one (1) of one (1) observation at approximately 9:50 AM on June 12, 2006. 5. Hard water and chemical stains were visibly present on chinaware such as plates, glasses, bowls, cups and silverware after washing in the dishwasher in five (5) of five (5) observations between 1:45 PM and 2:30 PM on June 12, 2006. 6. The top and bottom surfaces of chinaware plates were soiled with leftover food and dark particles in 17 of 33 observations at 12:50 PM on June 12, 2006. 7. Non-dietary staff were observed working in the main kitchen without proper hair covering in three (3) of three (3) observations between 1:00 PM and 3:00 PM on June 12, 2006 and in four (4) of four (4) observations between 11:00 AM and 2:00 PM on June 13, 2006.	L 099	(2) A, B, D, E and F. Food Service staff has been re-educated on the proper washing techniques and proper use of dishwashing chemicals. Management will continue to monitor and spot check dishes on a daily basis as they come out of the dishwasher and pot and pan area. (2) C. The Food Service Manager will conduct a review of all equipment to assure it is in proper working order. If any equipment is found to be in need of repair, this information will be relayed to the Chief Engineer for immediate repair. (2) G. The Food Service Manager will inform all contractors who enter the kitchen that they must wear proper hair covering. (3) A. B. C. D. F. G. Food Service Management will monitor the above on a daily basis. The Director of Dining Services and Administrator will monitor this during grand rounds. (3) E. Engineering will monitor the salt solution of the water softener to reduce spotting. (4) The results of management's findings will be incorporated into the Quality Assurance Program.	
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.	L 108	(1) A. The ambient air temperature in the health care kitchen has been adjusted to a range of 71-81 degrees Fahrenheit (F). (1) B. The temperatures of cold foods served from the health care kitchen to residents in the dining room were affected by the ambient air temperature. The air temperature has been adjusted and decreased to help preserve the temperature of cold foods.	6/30/06

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L 108	Continued From page 13 This Statute is not met as evidenced by: Based on observations during the inspection of the kitchen, it was determined that cold foods were served above 45 degrees Fahrenheit (F). The findings include: The temperatures of cold foods served from the health care kitchen to residents in the dining room were above 45 degrees F: chicken salad 60 degrees F, tuna salad 60 degrees F, cottage cheese 52 degrees F and pudding 50 degrees F in four (4) of four (4) observations at 12:40 PM on June 12, 2006.	L 108	(2) A. and B. The ambient air temperature in the health care kitchen will be recorded by engineering staff on a daily basis to assure proper temperature. In addition, the cold food temperatures will be taken during every meal by food service staff and recorded for proper temperature. (3) A. Food Service Management will monitor the above on a daily basis. The Director of Dining Services and Administrator will monitor this quarterly during grand rounds. (3) B. Engineering will monitor the salt solution of the water softener to reduce spotting. (4) The results of management's findings will be incorporated into the Quality Assurance Program.	
L 157	3227.8 Nursing Facilities Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility failed to store all drugs and biologicals under proper temperature controls. The findings include: 22 DCMR, Chapter 19, § 1907.4 (g) stipulates," Have refrigeration facilities exclusively for the storage of drugs requiring cold storage with a temperature controlling the interior temperature to keep it maintained between thirty-six (36) and	L 157	(1) The thermostat on the refrigerator containing drugs and biologicals has been increased to reflect temperatures in the range between thirty-six (36) and forty-six (46) degrees Fahrenheit (F). (2) A new refrigerator has been ordered to store all drugs and biologicals under proper temperature controls. (3) The "Medication Refrigerator Temperature Log" will be monitored on a daily basis by nursing staff, a weekly basis by the Office Manager, and a monthly basis by the Consultant Pharmacist to assure proper temperature controls are in place. The staff has been inserviced on the appropriate temperature range for the medication refrigerator and adjusting the temperature as indicated. (4) The results of the "Medication Refrigerator Temperature Log" will be incorporated into the Quality Assurance Program.	07/10/06

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L 157	Continued From page 14 forty-six (46) degrees Fahrenheit (F). " On June 12, 2006, during the review of the unit inspection reports from the consultant pharmacist, it was noted that the refrigerator temperature fluctuated out of range in four (4) of the 12 months of unit inspections from June 2005 through June 2006. The unit inspection reports showed the following: April 21, 2006 - 33° F, May 19, 2006 - 30° F, December 22, 2005 - 32° F, September 22, 2005 - 32° F. A review of the facility's "Medication Refrigerator Temperature Log" form showed entries that were below 36° F. The form indicated to " Please maintain temperature between 36-40 degrees Fahrenheit " . Temperatures were recorded as 30 degrees Fahrenheit (F) on April 1, 2006. Temperatures were recorded as 32 degrees F on January 30 and 31, 2006; February 3, 7 and 10, 2006; March 25, 2006; April 12 and 22, 2006. Temperatures were recorded as 34 degrees F on February 2, 4, 5, 6, 8 and 23, 2006; March 1, 3, 8 and 21, 2006; April 3, 18 and 32, 2006. A face-to-face interview was conducted on June 13, 2006 at 10:30 AM with the Director of Nursing . He/she stated that he/she was not aware that the medication refrigerator temperatures were out of range.	L 157		
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.	L 214		

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L 214	Continued From page 15 This Statute is not met as evidenced by: Based on observations during the survey, it was determined that the facility failed to ensure that five (5) of five (5) exit doors located in resident hallways had a system to notify staff when residents exited the doors. This was observed in the presence of the Director of Nursing and the Administrator. The findings include: It was observed on June 12, 2006 at 5:10 PM that the nursing unit had five (5) ingress/egress doors. None of the doors had a system to notify staff when residents exited the unit. Two (2) doors opened onto stairwells. One (1) door opened to an enclosed patio that was surrounded by a waist high wall. Beyond the wall, was an area of trees and shrubs abutting the facility's driveway. One (1) door opened onto a long corridor, termed by facility staff as the "black and white" hallway. The hallway terminated with a door opening to the outside. One (1) door exited to the ambulance entrance; the ambulance entrance door automatically opens to the facility driveway. A resident with Dementia eloped through the ambulance entrance and fell on the driveway. Facility staff was unaware that the resident had exited through the corridor door which led to the ambulance entrance.	L 214	(1) The five (5) ingress/egress doors on the nursing unit have had a system added to notify staff when residents exit the unit. The resident with Dementia that eloped through the ambulance entrance and fell on the driveway was brought back through the ambulance entrance by nursing staff and the minor scratches due to the fall were immediately treated. (2) The five (5) ingress/egress doors on the nursing unit now have a system to notify staff when any resident may exit from the unit. (3) The five (5) ingress/egress doors will be tested on a daily basis by the Security Officer or Engineer to assure the alarms are operating properly. A daily log will be maintained at the nurse's station and will be monitored by the Administrator. (4) Results of these findings will be incorporated into the Quality Assurance Program.	06/20/06
L 245	3238.1 Nursing Facilities Each piece of heating and air conditioning equipment and its installation shall comply with the 1996 BOCA International Mechanical Code (Heating, Air Conditioning and Refrigeration), and all applicable District laws and regulations. This Statute is not met as evidenced by:	L 245	(1) The ambient air temperature in the health care kitchen as been adjusted and decreased to an appropriate temperature. (2) The ambient air temperature in the health care kitchen will be recorded by engineering staff on a daily basis to assure proper temperature. 3) Food Service Management will monitor the above on a daily basis. The Director of Dining Services and Administrator will monitor this during grand rounds. (4) The results of management's findings will be incorporated into the Quality Assurance Program.	6/30/06

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L 245	Continued From page 16 Based on observations during the inspection of the kitchen, it was determined that air tempertures in the health care kitchen were elevated. The findings include: Ambient air temperatures in the health care kitchen were elevated and reached 90 degrees Fahrenheit (F) in one (1) of one (1) observation at 12:40 PM on June 12, 2006.	L 245		
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 evidenced by scarred and marred furnishings in residents' rooms and foot boards with holes and splintered edges. These findings were observed in the presence of the Administrator, Housekeeping and Maintenance Directors. The findings include. 1. The frontal surfaces of television stands, night stands and chair legs were marred and scarred in residents' rooms 8, 14a, 12, 19 and 27 in five (5) of 13 observations between 11:20 AM and 12:20 PM on June 12, 2006. This is a repeat deficiency from the annual re-certification survey completed May 19, 2005.	L 410	(1) A. The frontal surfaces of television stands, nightstands, and chair legs will be repaired in residents' rooms 8, 14A, 12, 19 and 27. (1) B. Foot boards on residents' beds in Rooms 19, 23, 26, 27 and 28 with drilled holes with splinters around the edges have been repaired. (2) The Environmental Services Supervisor for the HSC will conduct an audit of all residents' rooms to determine if any television stands, night stands, chair legs and foot boards are in need of repair. If any are found, a contractor will be contacted to make the needed repairs. (3) The above will be monitored on a quarterly basis by the Administrator and the Director of Environmental Services during grand rounds. (4) The result of these inspections will be incorporated in the Quality Assurance Program.	07/20/06

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L 410	Continued From page 17 2. Foot boards on residents' beds were observed to have drilled holes with splintered areas around the edges in rooms 19, 23, 26, 27 and 28 in five (5) of 13 observations between 11:20 AM and 12: 20 PM on June 12, 2006.	L 410		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations during the survey, it was determined that the facility failed to ensure that the wanderguard system on the corridor exit door which leads to the ambulance entrance was operational. This was observed in the presence of the Director of Nursing. The findings include: On June 12, 2006 at 5:05 PM it was observed that the wanderguard system located on the corridor exit door which leads to the ambulance entrance failed to elicit an alarm when a wanderguard device passed by it. The ambulance entrance door automatically opens to the facility driveway. Facility staff passed two (2) wanderguard devices across the alarm box located at the base of the corridor exit door. Neither device caused the system to elicit an audible alarm. The Director of Nursing accompanied a resident wearing a wanderguard device through the corridor exit door. The system failed to elicit an audible alarm.	L 442	(1) It has been witnessed by staff that the wanderguard system was working appropriately on 6/10/06 and had alarmed. This system has a battery back-up in the event of power failures. Therefore, it appears that the alarm failed between the dates of 6/10/06 and 6/12/06. When this was discovered, a staff member was immediately placed at the corridor exit door, which leads to the ambulance entrance. Additionally, a back-up system was installed on this door. Staff monitored the door and kept a log until 6/13/06 when both the wanderguard and the back-up alarm were operational. (2) Nursing staff will monitor and document that the bracelets worn by the residents on the wanderguard system are in place every shift and there will be a documented test of each ankle transmitter each day. The Security Officer or Engineer will monitor and document that the door exits are alarming when a wanderguard device/tester is passed by it on a daily basis. (3) Nursing, Security and Engineer staff will comply with the requirements of this schedule and the Chief Engineer and Administrator will regularly monitor the documentation. (4) Documentation will be incorporated in the Quality Assurance Program.	06/13/06