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	HFD02-0024	A. BUILDING _____ B. WING _____	08/24/2012

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L 000	Initial Comments A Licensure survey was conducted on August 24, 2012. The deficiencies are based on observation, record review, resident and staff interviews for 27 sampled residents.	L 000		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (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	L 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calanthia Green
TITLE: Nursing Home Administrator
(X6) DATE: 10/11/2012

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L 052	Continued From page 1 (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations during a medication pass administration for one (1) of 50 medication opportunities, and one (1) of 27 sampled residents, it was determined that sufficient nursing time was not given to ensure that facility staff used an appropriate standard of care technique while administering medications via a gastrostomy tubing (G-tube) for Resident #90. The findings include: During an observation of a medication pass administration conducted on August 24, 2012 at 9:40 AM, Employee #10 washed his/her hands and donned a pair of gloves. The employee then crushed and poured medications into six (6) medication cups and poured water into six (6) additional medication cups. The employee removed the Gastrostomy tube [G-tube] connector and inserted a clean 60cc syringe into the G-tube. The employee used the syringe and a stethoscope to check for correct placement of the tube and for residual stomach	L 052	**3211.1 Nursing Facilities** **Resident #90** 1. It is the practice of this facility to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the standards of practice. Employee #10 was re-educated on medication administration, medication administration through a g-tube and infection control protocols related to administering medication. Medication observation of employee #10 was conducted by the Staff Educator on 8-27-2012 to ensure compliance. 2. Medication pass observations were performed to ensure that staff administered medication using accepted standards of practice. No other residents were affected by the deficient practice. 3. All licensed staff were in-serviced on 8-28-2012 thru 8-31-2012 by the Staff Educator, Director of Nursing (DON) and Nursing Supervisor on the clinical guidelines for administering medication, administrating medication through g-tube and infection control in administering medication. In-service will be ongoing. Random medication observations were conducted by the Resident Care Coordinators (RCCs) and Supervisors to ensure proper medication administration and appropriate infection control protocol. RCCs will conduct monthly monitoring to ensure continued compliance. 4. Findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 052	Continued From page 2	L 052		

content. He/she flushed the G-tube and proceeded to pour the six cups of mixed water and medication content into the syringe attached to the G-tube.

However, prior to pouring the medication into the syringe he/she was observed placing his/her right index finger (while still wearing the glove he/she wore to touch other surfaces such as the stethoscope and g-tube connector) inside of the medication cup and used his/her index finger to stir the medication/water combination to dissolve the medication.

This process was repeated three times and after administering the medication via gravity, the tube was flushed with water.

The employee followed the medication administration with the administration of a bolus feeding of one (1) can of Ensure. He/she poured the Ensure into the syringe and held the syringe up to gravity. The Ensure moved slowly through the feeding tube and then stopped flowing. Employee #10 reached for a syringe plunger and completely pushed the ensure feeding through the G-tube instead of using the continuous flow of gravity.

According to the "Lippincott Manual of Nursing Practice Seventh Edition " under General Procedures and Treatment Modalities for Enteral Feeding: In the "performance phase" step two (2): fill catheter tipped syringe with formula (medication) and allow the fluid to flow in by gravity; Rationale: The rate of flow is regulated by raising or lowering the syringe."

According to www.medpass.com <http://www.medpass.com> " Administration of

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L 052	Continued From page 3 Medication through a Gastrostomy Tube " " Use aseptic technique ...Make sure the medicine cup, syringe, spoon and gauze are clean. ... Stir well with a spoon... " The employee failed to follow accepted standards of practice for maintaining asepsis as evidenced by the use of his/her gloved finger for stirring medication. Additionally, the staff failed to administer the enteral feeding in accordance with accepted standards of professional practice as evidenced by failing to allow the enteral feeding to flow via gravity. A face-to-face interview was conducted on August 24, 2012 at 10:00 AM with Employees #5 and #10. They both acknowledged the findings. B. Based on observation, staff interview and record review for one (1) of 27 sampled residents, it was determined that sufficient nursing time was not given to ensure that the resident received proper care to minimize pressure ulcers as evidenced by failure to accurately and/or consistently assess the resident's skin integrity on " Weekly Skin Assessment " forms for Resident #116. The findings include: Record Review According to the Admission Minimum Data Set completed April 26, 2012 Resident #116 was coded under Section I [Active Diagnoses] with diagnoses that included: Sacral Decub Hemiplegia, Respiratory Failure and Diabetes Mellitus.	L 052	**3211.1 Nursing Facilities** **Resident #116** 1. Resident #116 was not present long enough in the facility to address the immediate corrective actions found during the survey. 2. From 8-27 thru 8-31, an audit was performed on all residents' Weekly Skin Assessment form to ensure that all residents with impaired skin integrity were correctly noted and recorded accurately. Corrections were made as identified. 3. From 8-27 thru 8-31, all licensed nursing staff were reeducated on the proper techniques to appropriately identify and document the resident's skin integrity on the Weekly Skin Assessment form. A weekly audit of the form will be conducted by the RCCs and Nursing Supervisors for eight (8) weeks. 4. Reports of the weekly audit findings will be reported by the RCCs monthly for two months, then quarterly to the Quality	10/11/2012

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L 052	Continued From page 4 Braden Scale revealed: April 20, 2012 the Resident ' s score was eight (8); on July 20, 2012 the score was 11; and on August 15, 2012 the score was nine (9). According to the Braden Scale form, " Total score of 12 or less represents High Risk " . A review of the " Wound and Skin Care Progress Note" revealed the following wound measurement and dates: Admission April 20, 2012 - community acquired, Stage IV Sacrum Ulcer that measured 6.0x6.0x1cm April 26, 2012 - Stage IV Sacrum Ulcer that measured 6.0x5.0x0.4 cm May 3, 2012 - Stage IV Sacrum Ulcer that measured 5.2x5.0x0.4 cm The May 10, 2012 progress noted revealed that Resident #116 acquired a Stage 2 wound to the right hip on May 5, 2012 that measured 0.8x0.7x0.0 cm May 17, 2012-Right hip resolved; developed incontinence associated dermatitis to the right posterior thigh; Stage IV Sacrum Ulcer that measured 4.8x4.5x0.6 cm May 24, 2012- Incontinence associated dermatitis to the right posterior thigh-improved; Stage IV Sacrum Ulcer that measured 4.7x5.0x0.0 cm May 31, 2012- Incontinence associated dermatitis to the right posterior-improved; Stage IV Sacrum Ulcer that measured 4.5x4.0x0.0 cm June 7, 2012- Incontinence associated dermatitis to the right posterior-resolved; Stage IV Sacrum	L 052		

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L 052	Continued From page 5 Ulcer that measured 3.7x3.3x0.1 cm The June 14, 2012 progress noted revealed that Resident #116 acquired a Skin abrasion to the left knee on June 12, 2012 that measured 1.5x3.3x0.0 cm; and Incontinence associated dermatitis to the right posterior-recurrent; Stage IV Sacrum Ulcer that measured 4.4x3.5x0.2 cm June 21, 2012 -In house acquired Left Ischium -DTI (deep tissue injury) measured 3.0x4.0x0.0 cm, Ordered Santyl with dry dressing qd (every day) and prn (as needed). Incontinence associated dermatitis to the right posterior-improved; Stage IV Sacrum Ulcer that measured 4.5x3.5x0.3 cm; Left Knee, acquired in house-skin abrasion measured 2.0x3.5x0.0 cm (increased in size) June 28, 2012- Left Ischium -now recorded as unstageable measured 3.0x5.5x0.0 cm, the treatment changed to Santyl, polysporin and maxsorb with dry dressing qd (every day) and prn. New areas-Left index finger acquired in-house on June 27, 2012, described as partial thickness due to irritation from pulse O2 device use [Pulse oximetry is a non-invasive medical device that indirectly measures the amount of oxygen in a patient's blood]; Left heel acquired in-house on June 27, 2012, described as DTI and measures 4.0x3.5x0.0 cm; Right heel acquired in-house on June 27, 2012, described as DTI and measures 5.0x4.5x0.0 cm. Incontinence associated dermatitis to the right posterior-improved; Stage IV Sacrum Ulcer that measured 4.5x2.5x0.3 cm; Left knee, acquired in house-skin abrasion measured 1.5x3.5x0.0 cm. A review of the " Weekly Skin Assessment "	L 052		

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L 052	Continued From page 6 Sheets revealed the following: On admission April 20, 2012 Stage IV- sacral 6x5x.4 depth. The " Weekly Skin Assessment " April 30, 2012- " Skin remains intact " ...Pressure relief mattress on bed=No " The " Weekly Skin Assessment " May 3, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " No " The " Weekly Skin Assessment " May 7, 2012- " Skin remains intact " ...Pressure relief mattress on bed= was left blank The " Weekly Skin Assessment " May 10, 2012- " Skin remains intact " ...Pressure relief mattress on bed=No " The " Weekly Skin Assessment " May 14, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " May 14, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " May 17, 2012- The assessment was left blank ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " May 21, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " May 24, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " May 31, 2012- " Skin remains intact " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 8, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 12, 2012- " no new open areas " ...Pressure relief	L 052		

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L 052	Continued From page 7 mattress on bed= " Yes " The " Weekly Skin Assessment " June 13, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 17, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 22, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 25, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " The " Weekly Skin Assessment " June 27, 2012- " no new open areas " ...Pressure relief mattress on bed= " Yes " According to a telephone interview conducted on September 14, 2012 at approximately 11:00 AM with Employees #2 and #6. He/she stated the " Weekly Skin Assessment " sheets are completed twice a weekly on shower days. The staff are to document everything (all areas of skin impairment) on the skin sheets. After reviewing the " Wound and Skin Care Progress Note " and the " Weekly Skin Assessment " forms, from April 30 to June 27, 2012, there was no evidence that facility staff completing the " Weekly Skin Assessment " sheets documented that the resident had newly identified areas and/or existing wounds or skin impairment on the " Weekly Skin Assessment form. A face-to-face interview was conducted on August 23, 2012 at approximately 3:45 PM with	L 052		

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L 052	Continued From page 8 Employee #6. He/she acknowledged that the weekly skin sheet and the wound care progress notes are not consistent in noting the resident ' s areas of skin impairment. The record was reviewed on August 24, 2012.	L 052	**3217.3 Nursing Facilities** **Infection Control Program** 1. It is the practice of this facility to provide the residents with a safe and sanitary environment and prevent the spread of infections and diseases in accordance with the standards of practice. Developed an analysis tool to track and trend the in-house community and nosocomial acquired infections. The Infection Control Summary report will include analysis, documentation for patterns and trends, action plans and follow-ups 2. On 8-31, an audit was performed on the infection control log book on each unit to ensure accuracy of the information obtained. 3. Licensed staff were in-serviced 8-28 thru 8-31 and ongoing by the DON and ADON, on the implementation of the new analysis tool used for tracking and trending infections and the Infection Control Summary Report. The infection control committee was created to review all infection reports presented, ensuring consistent and systematic collection of data is reviewed and analyzed, identifying any risks, and ensuring treatments and resolution of infections are addressed. 4. Reports of the findings will be reported monthly to the Quality Assurance Committee.	**10/11/2012**
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: A. Based on a review of the facility ' s Infection Control Program and through staff interview, it was determined that facility staff failed to ensure	L 088		

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L 088	Continued From page 9 the implementation of infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility. The findings include: A review of the facility ' s infection control surveillance documentation, " Infection Control Log, " lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The log lacked evidence of the organism type, source of acquisition (whether community or facility acquired), predisposing factors, treatment and/or date of resolution. A review of the facility ' s monthly " Infection Control Log" for the period of December 2011 through July 2012 revealed the following: July 2012 - 14 residents were identified as having infections. The only information revealed on the Log was the type of infection. There were 19 infections during the month of June; 17 infections during the month of May; 24 infections during April; 24 infections during March; 18 infections during February; 14 infections during January 2012 and 25 infections during December 2011. The Infection Control Log included the resident ' s name and type of infection. The infections identified were Upper Respiratory, Lower Respiratory (Pneumonia), Urinary Tract Infections, Gastro Intestinal Infections, Skin Infections, Wound infections - Pressure Ulcers and Surgical sites, Eye Infections, Intravenous	L 088		

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L 088	Continued From page 10 Associated Infections, Dental Infections and some infections were classified as " Other. " A face-to-face interview was conducted with Employee #2 on August 24, 2012. He/she acknowledged that the Infection Control Log was incomplete and that there was no evidence, based on the inconsistencies identified in the infection control logs, that the facility consistently implemented an Infection Control Program to help prevent, investigate and control infections in the facility. The employee stated that the facility had been without an Infection Preventionist for the past six months. The records were reviewed August 24, 2012. B. Based on an isolated medication administration observation, it was determined that facility staff failed to maintain appropriate infection control practices as to prevent the spread of infection while administering medication via Gastrostomy tubing (G-tube) for one (1) resident. Resident # 90. The findings include: During an observation of a medication pass administration conducted on August 24, 2012 at 9:40 AM, Employee #10 washed his/her hands and donned a pair of gloves. The employee removed the Gastrostomy tube [G-tube] connector and inserted a clean 60cc syringe into the G-tube. The employee used the syringe and a stethoscope to check for correct placement of the tube and for residual stomach content. He/she flushed the G-tube and proceeded to pour the six cups of mixed water and medication content into the syringe attached to the G-tube.	L 088	**3217.3 Nursing Facilities** **Resident #90** 1. It is the practice of this facility to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the standards of practice. Employee #10 was re-educated on medication administration, medication administration through a g-tube and infection control protocols related to administering medication. Medication observation of employee #10 was conducted by the Staff Educator on 8-27-2012 to ensure compliance. 2. Medication pass observations were performed to ensure that staff administered medication using accepted standards of practice. No other residents were affected by the deficient practice. 3. All licensed staff were in-serviced on 8-28-2012 thru 8-31-2012 by the Staff Educator, Director of Nursing (DON) and Nursing Supervisor on the clinical guidelines for administering medication, administrating medication through g-tube and infection control in administering medication. In-service will be ongoing. Random medication observations were conducted by the Resident Care Coordinators (RCCs) and Supervisors to ensure proper medication administration and appropriate infection control protocol. RCCs will conduct monthly monitoring to ensure continued compliance. 4. Findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 088	Continued From page 11 However, prior to pouring the medication into the syringe he/she was observed placing his/her right index finger (while still wearing the glove he/she wore to touch other surfaces such as the stethoscope and g-tube connector) inside of the medication cup and used his/her index finger to stir the medication/water combination to dissolve the medication. This process was repeated three times and after administering the medication via gravity, the tube was flushed with water. The employee failed to follow accepted standards of practice for maintaining asepsis as evidenced by the use of his/her gloved finger for stirring medication. A face-to-face interview was conducted on August 24, 2012 at 10:00 AM with Employees #5 and #10. They both acknowledged the findings.	L 088		
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 made in dietary services on August 20, 2012 at approximately 9:30 AM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by: 46 of 46 dinner rolls stored uncovered; Five (5) of seven (7) stove top pans soiled and bent; three (3) of three (3) muffin pans soiled; the floor in the main kitchen was soiled. Food items were	L 099	**3219.1 Nursing Facilities #1,2,3,4** 1. It is the practice of this facility to provide clean and sanitary conditions within the dietary area in accordance with dietary standards of practice. On 8-20, the uncooked dinner rolls and five stove top pans observed during the survey were immediately discarded; the three soiled muffin pans were cleaned properly; and the floor in the main kitchen area was immediately cleaned by dietary staff. 2. No residents were impacted by this deficient practice.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 12 stored in walk-in refrigerator #6 beyond their use by date and/or were not dated as follows: nine (9) of nine (9) cups of applesauce and five (5) of five (5) cups of chocolate pudding were stored with a use by date of August 17, 2012; three (3) of three (3) cups of applesauce, one (1) of one (1) large salad plate and two (2) of two (2) small salad plates were stored with a use by date of August 18, 2012; six (6) of six (6) cups of vanilla pudding were stored with a use by date of August 19, 2012 and one (1) of one (1) fruit plate and three (3) of three (3) cups of pureed peaches were stored and not dated. The findings include: 1. 46 of 46 uncooked dinner rolls were stored uncovered on top of the convection oven. 2. Five (5) of seven (7) stove top pans were soiled; dented, bent and/or deformed. 3. Three (3) of three (3) muffin pans were soiled. 4. The floor in the main kitchen was soiled. 5. Food items were stored in walk-in refrigerator #6 beyond their use by date and/or were not dated at all as follows: a) Nine (9) of nine (9) cups of applesauce and five (5) of five (5) cups of chocolate pudding with a use by date of August 17, 2012. b) Three (3) of three (3) cups of applesauce, one (1) of one (1) large salad plate and two (2) of two (2) small salad plates with a use by date of	L 099	**483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY #1, 2,3, 4 (cont'd)** 3. On 9-17, all dietary staff were educated on proper thawing procedures, ensuring uncooked dinner rolls are stored under refrigeration at all times. New stove top pans were reordered to replace discarded pans. Staff were in-serviced on 9-17-2012 on proper washing techniques, ensuring all debris is removed thoroughly before washing and using. Storage of uncooked foods, the conditions of the pots and pans, cleanliness of the muffin tins and floors were added to the daily monitoring assignment schedule to ensure compliance. Monitoring will be done daily by shift supervisors. 4. Daily findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee. **483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY #5a, 5b, 5c, 5d** 1. It is the practice of this facility to provide clean and sanitary conditions within the dietary area in accordance with dietary standards of practice. On 8-20, all items stored in walk-in refrigerator #6 beyond their date of use or not dated at all were immediately discarded. 2. No residents were impacted by this deficient practice.	10/11/2012

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	HFD02-0024	A. BUILDING _____ B. WING _____	08/24/2012

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L 099	Continued From page 13 August 18, 2012. c) Six (6) of six (6) cups of vanilla pudding with a use by date of August 19, 2012. d) One (1) of one (1) fruit plate and three (3) of three (3) cups of puree peaches were not dated. These observations were made in the presence of Employee #11 who acknowledged the findings.	L 099	**483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY #5a, 5b, 5c, 5d (cont'd)** 3. On 9-17, all dietary staff were educated on proper labeling and dating of items stored in all refrigerators. Items stored in all refrigerators were added to the daily monitoring assignment schedule to ensure compliance. Monitoring will be done daily by shift supervisors. 4. Findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: A. Based on observation and staff and resident interviews for one (1) of 27 sampled residents, it was determined that facility staff failed to ensure that the mattress was appropriate for Resident #57's bed. The findings include: On August 22, 2012 at approximately 9:17 AM a face-to-face interview was conducted with Resident #57, he/she stated, "My mattress has an indentation in it and is now causing my back to hurt. It has been this way since March [2012]. They [the staff] told me I was going to get a new one. I flipped the mattress. This mattress has a one inch gap. My feet get caught in the bottom quarter rail(s)."	L 214	**3234.1 Nursing Facilities** **Resident #57** 1. It is the practice of the facility to provide for each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing in accordance with professional standards. Resident #57 received a new bed and mattress on 10-9-12. 2. All other residents with the potential to be affected by the same deficient practice beds were inspected to ensure appropriate fitted mattress. No other resident was affected by the deficient practice. 3. All CNA's were in-serviced on 8-27 thru 8-30 by the RCCs, ADON and Staff Educator on reporting mattresses unable to fit properly on the bed and defective mattresses to the RCC for corrective actions. CNAs will monitor mattresses during the change of linen to ensure compliance. 4. Reports of the findings will be reported by the RCCs quarterly to the Quality Assurance Committee.	10/11/2012

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L 214	Continued From page 14 An observation of the resident ' s bed revealed that the mattress failed to fit the bed properly. A follow up observation was conducted on August 22, 2012 at approximately 4:20 PM. The bed frame exceeded the width of the mattress by approximately 2 inches. A face-to-face interview was conducted with Employee # 6 at approximately 4:25 PM on August 23, 2012. During the interview the manager stated, " I have documentation about his/her concerns. This is a new mattress. It came in March 2012. " Facility staff failed to ensure that that the mattress was an appropriate fit for the resident's bed. B. Based on observations made during a tour of the facility on August 21, 2012 at approximately 10:00 AM, it was determined that the facility failed to ensure that three (3) surge protectors were mounted/secured to the wall. The findings include: Two (2) of two (2) surge protectors were observed on the floor in room #6-138 and one (1) of one (1) was also on the floor of room #4-105 in two (2) of 45 resident rooms observed. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 214	**3234.1 Nursing Facilities** **#B, Rm 6 138, Rm4 105** 1. The three surge protectors observed unsecure during the survey period were immediately attached and secured onto the wall. 2. All other residents' rooms and areas throughout the facility with surge protectors were inspected and no other deficient practices observed. 3. On 10-8-12, an inservice was given to all maintenance staff by the Life Safety Director on the proper technique of securing surge protectors. The Maintenance Supervisor or designee will conduct monthly rounds to ensure that all areas with surge protectors are properly secured. 4. Reports of the monthly findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee	10/11/2012

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L 293	Continued From page 15	L 293		
L 293	3243.4 Nursing Facilities Each handrail or banister end shall return to the wall. This Statute is not met as evidenced by: Based on observations made during the environmental tour on August 21, 2012 between 9:35 AM and 3:30 PM, it was determined that facility staff failed to maintain handrails in good working condition as evidenced by handrails with missing end pieces on three (3) of three (3) residents care units. The findings include: Handrails were observed with missing end pieces on three (3) of three (3) residents care units as follows: on the fourth floor outside of room #4-133; on the fifth floor outside of rooms #5-118, #5-125 and #5-154 and on the sixth floor outside of room #6-111 These observations were made in the presence of Employee #8 who acknowledged the findings.	L 293	**3243.4 Nursing Facilities** 1. Handrails observed with missing end pieces on the 4th floor outside of room 4133, on the 5th floor outside of room 5118, 5125 and 5154 and on the 6th floor outside of room 6111 have been repaired by reattaching the missing part. 2. All other areas on all units having the potential to be affected by the same deficient practice rails were inspected to ensure they were in working condition. There were no other areas identified. 3. The Maintenance Supervisor or designee will monitor handrails monthly to ensure compliance. 4. Findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 21, 2012 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and	L 410		

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L 410	Continued From page 16 comfortable interior as evidenced by: dusty ventilator screens and filters in ten (10) of 12 resident rooms; one (1) soiled wheelchair and one (1) dresser in disrepair one (1) of 45 resident rooms; one (1) broken hot water faucet handle and one (1) broken trash can foot lever in one (1) of 45 resident rooms; marred entrance doors in ten (10) of 45 resident rooms; cracked, torn and/or perforated walls in three (3) of 45 resident rooms and five (5) window blinds missing slates. The findings include: 1. The screens and the filters from 10 of 12 ventilators in resident ' s rooms were dusty. 2. The wheelchair was soiled and the door to the bedside dresser was partially detached in room #6-154 in one (1) of 45 resident rooms observed. 3. The hot water faucet handle and the foot lever from the trash can were both broken in room 6-142 in one (1) of 45 resident rooms observed. 4. Entrance doors were marred in 31 of 45 residents rooms, walls were marred in 10 of 45 residents rooms and walls were perforated, torn or cracked in three (3) of 45 residents rooms. 5.Three (3) of four (4) window blinds from the day room on the sixth floor and one (1) of one (1) from room #6-119 were missing slats. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities** **#1, Screens & Filters** 1. Screens and filters identified on ventilators in resident's rooms as being dusty were immediately cleaned. 2. All other residents identified as potentially affected by the same deficient practice were checked and cleaning was done as needed. 3. On 8-21-2012, the Director of Respiratory Therapy in-serviced the respiratory technicians regarding cleaning screens and filters of the ventilator machines. Cleaning of the ventilator screens and filters have been put on a weekly cleaning schedule and will be monitored by the Respiratory Director or designee. 4. Reports of the monitoring will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 410	Continued From page 16 comfortable interior as evidenced by: dusty ventilator screens and filters in ten (10) of 12 resident rooms; one (1) soiled wheelchair and one (1) dresser in disrepair one (1) of 45 resident rooms; one (1) broken hot water faucet handle and one (1) broken trash can foot lever in one (1) of 45 resident rooms; marred entrance doors in ten (10) of 45 resident rooms; cracked, torn and/or perforated walls in three (3) of 45 resident rooms and five (5) window blinds missing slates. The findings include: 1. The screens and the filters from 10 of 12 ventilators in resident ' s rooms were dusty. 2. The wheelchair was soiled and the door to the bedside dresser was partially detached in room #6-154 in one (1) of 45 resident rooms observed. 3. The hot water faucet handle and the foot lever from the trash can were both broken in room 6-142 in one (1) of 45 resident rooms observed. 4. Entrance doors were marred in 31 of 45 residents rooms, walls were marred in 10 of 45 residents rooms and walls were perforated, torn or cracked in three (3) of 45 residents rooms. 5.Three (3) of four (4) window blinds from the day room on the sixth floor and one (1) of one (1) from room #6-119 were missing slats. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities** **#2, Room 6-154** 1. The wheelchair observed in room 6154 as being soiled was immediately cleaned and the dresser with the partially detached door was repaired during the survey period. 2. All other resident with the potential to be affected by the same deficient practice wheelchairs and dresser doors were inspected for cleanliness and proper attachment and cleaning and repairs were made as needed. 3. Wheelchairs have been included on a monthly cleaning schedule to ensure compliance. Random rounds will be conducted by the Director of Environmental Services or designee and Maintenance Technician to ensure compliance of furniture and wheelchairs. 4. Reports of the rounding results will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 410	Continued From page 16 comfortable interior as evidenced by: dusty ventilator screens and filters in ten (10) of 12 resident rooms; one (1) soiled wheelchair and one (1) dresser in disrepair one (1) of 45 resident rooms; one (1) broken hot water faucet handle and one (1) broken trash can foot lever in one (1) of 45 resident rooms; marred entrance doors in ten (10) of 45 resident rooms; cracked, torn and/or perforated walls in three (3) of 45 resident rooms and five (5) window blinds missing slates. The findings include: 1. The screens and the filters from 10 of 12 ventilators in resident ' s rooms were dusty. 2. The wheelchair was soiled and the door to the bedside dresser was partially detached in room #6-154 in one (1) of 45 resident rooms observed. 3. The hot water faucet handle and the foot lever from the trash can were both broken in room 6-142 in one (1) of 45 resident rooms observed. 4. Entrance doors were marred in 31 of 45 residents rooms, walls were marred in 10 of 45 residents rooms and walls were perforated, torn or cracked in three (3) of 45 residents rooms. 5.Three (3) of four (4) window blinds from the day room on the sixth floor and one (1) of one (1) from room #6-119 were missing slats. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities #3, Room 6-142** 1. The hot water faucet handle in room 6142 that was identified as being broken was immediately repaired. A new trash can was purchased to replace the one with the broken foot lever. 2. Rounds were conducted by the maintenance staff on all three units to identify other areas that may have been affected by the same deficient practice; repairs were made and new trash cans were purchased to replace defective ones as needed. 3. Maintenance technicians assigned to each unit will weekly monitor residents' rooms and other areas potentially affected by the same deficient practice to ensure compliance. 4. Reports of weekly findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 410	Continued From page 16 comfortable interior as evidenced by: dusty ventilator screens and filters in ten (10) of 12 resident rooms; one (1) soiled wheelchair and one (1) dresser in disrepair one (1) of 45 resident rooms; one (1) broken hot water faucet handle and one (1) broken trash can foot lever in one (1) of 45 resident rooms; marred entrance doors in ten (10) of 45 resident rooms; cracked, torn and/or perforated walls in three (3) of 45 resident rooms and five (5) window blinds missing slates. The findings include: 1. The screens and the filters from 10 of 12 ventilators in resident ' s rooms were dusty. 2. The wheelchair was soiled and the door to the bedside dresser was partially detached in room #6-154 in one (1) of 45 resident rooms observed. 3. The hot water faucet handle and the foot lever from the trash can were both broken in room 6-142 in one (1) of 45 resident rooms observed. 4. Entrance doors were marred in 31 of 45 residents rooms, walls were marred in 10 of 45 residents rooms and walls were perforated, torn or cracked in three (3) of 45 residents rooms. 5.Three (3) of four (4) window blinds from the day room on the sixth floor and one (1) of one (1) from room #6-119 were missing slats. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities** **#4, Entrance doors and walls** 1. Entrance doors cited as being marred in residents room, have been repainted. Walls cited in 10 of 45 residents' rooms during the survey period have been repaired. The perforated, torn and cracked walls cited in three of 45 residents' rooms were repaired and repainted. 2. Maintenance technicians conducted room inspections on units 4, 5 and 6, in all other residents rooms with the potential to be affected by the same deficient practice and any room found out of compliance were addressed immediately. 3. Monthly room rounding will be performed by maintenance technicians in residents' rooms to ensure compliance. Noncompliant rooms will be reported to Life Safety Director to address 4. Reports of the monthly findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	**10/11/2012**

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L 410	Continued From page 16 comfortable interior as evidenced by: dusty ventilator screens and filters in ten (10) of 12 resident rooms; one (1) soiled wheelchair and one (1) dresser in disrepair one (1) of 45 resident rooms; one (1) broken hot water faucet handle and one (1) broken trash can foot lever in one (1) of 45 resident rooms; marred entrance doors in ten (10) of 45 resident rooms; cracked, torn and/or perforated walls in three (3) of 45 resident rooms and five (5) window blinds missing slates. The findings include: 1. The screens and the filters from 10 of 12 ventilators in resident ' s rooms were dusty. 2. The wheelchair was soiled and the door to the bedside dresser was partially detached in room #6-154 in one (1) of 45 resident rooms observed. 3. The hot water faucet handle and the foot lever from the trash can were both broken in room 6-142 in one (1) of 45 resident rooms observed. 4. Entrance doors were marred in 31 of 45 residents rooms, walls were marred in 10 of 45 residents rooms and walls were perforated, torn or cracked in three (3) of 45 residents rooms. 5.Three (3) of four (4) window blinds from the day room on the sixth floor and one (1) of one (1) from room #6-119 were missing slats. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**3256.1 Nursing Facilities** **#5, Room 6-119** 1. Blinds cited as missing on the sixth floor day room and room #6119 was immediately replaced during survey period. 2. All other residents' rooms and day rooms were inspected by maintenance and housekeeping staff to ensure blinds were not missing. Replacement blinds were inserted as needed. 3. During weekly environmental rounds all rooms will be inspected by housekeeping and maintenance staff. All areas found to be non-compliant will be reported to departmental directors for repair. 4. Reports of the weekly findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012

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L 426	Continued From page 17	L 426		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during the survey, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects observed throughout the survey period. The findings include: Flying pests were observed in resident room #5133, and during the tour of the main kitchen. These observations were made in the presence of Employee # 11 who acknowledged the findings.	L 426	**3257.3 Nursing Facilities** 1. Regional Pest Control, facility exterminator contractor, was called during the survey period to address the flying insects observed in room 5133 and the main kitchen area. 2. All other areas in the facility that could be affected by the same practice have been inspected to ensure compliance and corrective action was initiated as needed. Pest control inspections and service will continue to inspect and install fly traps for the removal of flying insects. 3. Staff were reeducated on the pest control log book to log any citing of flying insects and contacting the exterminator to address any concerns The Director of Environmental Services will conduct weekly rounds throughout the facility to ensure compliance. 4. Findings will be reported monthly for three (3) months, then quarterly to the Quality Assurance Committee.	10/11/2012