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	HFD02-0027	A. BUILDING _____ B. WING _____	09/19/2008

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L 000	Initial Comments An annual licensure survey was conducted from September 15 through 19, 2008. The following deficiencies were based on observations, staff and resident interview and record review. The sample size was 30 residents based on a census of 242 the first day of survey. The sample also included nine (9) supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, staff interview and record review for nine (9) of 30 sampled residents and six (6) supplemental residents, it was determined	L 051		

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L 051	Continued From page 1 that the charge nurse failed to: document allergies on the physician's order sheet and provide adequate supervision for one (1) resident, clarify a diagnosis for one (1) resident, accurately document the resolution of an area of reddened skin for one (1) resident, follow up on one (1) resident ' s loose stool, low blood pressures and consistent documentation of the pain level and the effectiveness of pain medication when administered, reassess pain during a dressing change for two (2) residents, document the administration of a dressing change for one (1) resident, correctly transcribe an order for In/out catheterization for one (1) resident, and administer medication as per physician's orders for one (1) resident. Residents #1, 3, 4, 5, 8, 10, 22, 28 and JH7. The findings include: 1. The charge nurse failed to document allergies on the Physician's Order Sheet (POS) and provide adequate supervision for Resident #1. A. Review of the Medical revealed that Resident #1 had an allergy to Penicillin (PCN) on the front sheet in chart. The facility admission assessment on June 21, 2008 indicated the resident was allergic to PCN and ASA (Aspirin). The history and physical indicated the resident was allergic to PCN. The Physicians Order Sheet (POS) Dated and signed August 5, 2008 indicated that the resident has NKDA [no known drug allergies]. A face-to-face interview was conducted with Employee #5 at approximately 4:00 PM on September 18, 2008. He/she acknowledged that the Physician's Order Sheet indicated NKDA [no known drug allergies] and that the clinical record lacked consistent documentation of allergies for	L 051	**1A.) 3210.4 Nursing Facilities** 1. All allergies were identified on POS for Resident # 1. 2. All resident records will be reviewed to ensure all allergies are identified and care planned. 3. Staff will be in serviced on importance of documenting all allergies on physician order sheet. 4. Care plan audit on allergies will be done by Nurse Manager or designee, submitted to Director of Nursing for presenting at quarterly QI meeting.	9/18/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 2 Resident #1. B. The charge nurse failed to provide adequate supervision to ensure that Resident #1 did not leave the facility with an unauthorized visitor. A face-to-face interview was conducted with Employee #10 on September 19, 2008 at 11:00 AM. He/she stated that the Interdisciplinary Team (IDT) had concerns about Visitor #1 taking Resident #1 off the premise and the possibility of having Resident #1 withdraw funds from a bank account using an ATM (Automatic Teller Machine). The resident's responsible party was his/her nephew/niece who lives out of state. Employee #10 stated, "I spoke with the responsible party on Monday (August 11, 2008) and shared our (IDT) concerns with [him/her]. The responsible party told me that it was okay for [Resident #1] to visit with [Visitor #1]. However, [responsible party] did not want [Visitor #1] to take [Resident #1] out of the facility." A review of Interim physician orders revealed an order obtained from Primary MD [Medical Doctor] on August 11, 2008 "LOA [Leave of absence] with responsible party." The Leave of Absence form for Resident #1 indicated that the resident was signed out by Visitor #1 on the following days: August 14, 2008 from 1:20 PM - 3:20 PM August 14, 2008 from 5:10 PM - 6:30 PM August 15, 2008 from 1:30 PM - 3:10 PM August 18, 2008 from 12:25 PM - 2:00 PM August 21, 2008 from 4:30 PM - 6:10 PM August 22, 2008 from 12:45 PM - 2:15 PM August 23, 2008 from 2:15 PM - 3:30 PM	L 051	**1B.) 3210.4 Nursing Facilities** 1. As directed by the POA, Resident # 1 is not to leave the facility with unauthorized visitors. 2. All residents identified with visitor restrictions will be reviewed with staff. 3. Staff will be in serviced on LOA Policy. 4. Resident LOA plan of care will be reviewed at quarterly IDT conference and care plan audits will be done and submitted to Director of Nursing for presentation at quarterly QI meeting.	10/8/08 9/16/08 11/3/08 11/3/08

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L 051	Continued From page 3 August 25, 2008 from 1:40 PM - 2:30 PM September 10, 2008 from 1:35 PM - 2:50 PM The record lacked evidence that the facility provided supervision to ensure that Resident #1 did not leave the facility with Visitor #1. The facility failed to put a process in place and adequately supervise Resident #1 to prevent the resident from leaving the facility with Visitor #1 and to assure that all applicable staff were knowledgeable about whom the resident could leave facility with. A face-to-face interview was conducted with Employee #10 on September 19, 2008 at approximately 11:00 AM. Employee #10 acknowledged the above findings. 2. The charge nurse failed to clarify a diagnosis of Diabetes Mellitus listed on the"Inter-Agency Referral Transfer Form" for Resident # 3. The "Inter-Agency Referral Transfer Form" dated July 10, 2008 included a diagnosis of Diabetes Mellitus. Further review of the Physician's Order Sheet signed and dated July 24, 2008 and the quarterly Minimum Data Set (MDS) completed July 24, 2008 failed to reveal a diagnosis of Diabetes Mellitus. A face-to-face interview was conducted with Employee #5 at approximately 3:15 PM on September 15, 2008. He/she acknowledged that the resident did not have a diagnosis of Diabetes Mellitus and added " We did not follow this (the referral form) because it was written by the nurse." The record was reviewed on September	L 051	**2.) 3210.4 Nursing Facilities** 1. Physician reviewed resident # 3 record and determined that Resident #3 was not a Diabetic. Finger sticks were being done because of steroids therapy in hospital. 2.. All other residents will be checked to ensure diagnosis is correct. 3. All staff will be in serviced on review of "Inter-Agency Referral Transfer Form" and clarify all discrepancies. 4. Nurse Manager will conduct monthly audits on diagnosis update and submit to Director of Nursing for presentation at quarterly QI meeting.	11/3/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 4 15, 2008. 3. The charge nurse failed to accurately document the resolution of an area of reddened skin for Resident #4. Review of Resident #4's record revealed the following nurses' notes: May 19, 2008 at 9:15 AM: "A darkened area was observed to right buttock and Proshield Plus was applied..." May 27, 2008 at 1100 (11:00 AM): "Reddened area with a dry scab noted over the Right gluteus area ..." There was no further entry regarding the above skin area. A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:45 PM. He/she acknowledged that the above identified skin area was not tracked through healing and resolution of the area. 4. The charge nurse failed to document a follow up assessment when Resident #5 had loose stools, low blood pressures and consistently document the pain level and the effectiveness of pain medication when it was administered. A. The charge nurse failed to document a follow up assessment when Resident #5 had loose stools. An IDT [interdisciplinary team] note dated September 3, 2008 at 2200 ... revealed "Resident was observed with loose stools times three (3). Stomach assessed soft and firm. Stools very offensive in odor ...MD [medical doctor] advised to continue to monitor and	L 051	**3.) 3210.4 Nursing Facilities** 1. Documentation was placed in Resident # 4 chart indicating resolution of reddened area. 2. Follow-up documentation will be done on residents with changes in their status. 3. In-service will be done on staff regarding follow up documentation. 4. Weekly skin sheets will be completed, reviewed by wound nurse and submitted to Director of Nursing for presentation at quarterly QI meeting. **4A.) 3210.4 Nursing Facilities** 1. Resident # 5 was assessed and there was no episode of loose stools. 2. Follow up documentation will be done on residents with change in condition. 3. In-service will be done on staff regarding importance of follow up documentation. 4. Nurse Manager or designee will review 24 hour report daily to ensure that all acute changes are followed up.	9/16/08 11/3/08 11/3/08 11/3/08 9/16/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 5 encourage PO [by mouth] fluids. If stools persist till next day, to call back. Resident condition stable. Drank whole bottle of ensure and orange/pineapple juice 120 cc. No apparent distress noted." A further review of the record lacked evidence that a follow up assessment was conducted until September 10, 2008 at 0500 when the resident had additional loose stools. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that there was no follow up documentation after the resident was observed to have loose stools. The record was reviewed on September 18, 2008. B. The charge nurse failed to document a follow up assessment when Resident #5 had low blood pressures. A review of the July 2008 MAR revealed a physician's order that directed the following: Cozaar 100 mg tablet Losart potassium one (1) tablet by mouth daily for hypertension (hold if SBP [systolic blood pressure] less than 120 DBP [diastolic blood pressure] less than 60). A review of the July 2008 MAR [medication administration record] revealed that on July 19, 21, 23, 26, 27, and 29, 2008 Resident #5 had a low blood pressure and his/her medication was withheld in accordance with the physicians order. The IDT [interdisciplinary team] notes lacked evidence that after the resident's blood pressure reading was documented as low, there were further documented assessments or follow up regarding Resident #5's blood pressure.	L 051	**4B.) 3210.4 Nursing Facilities** 1. Resident # 5 medications were adjusted. 9/18/08 2. Follow up documentation will be done on residents with change in condition. 11/3/08 3. In-service will be done on staff regarding the importance of follow up assessment and documentation. 11/3/08 4. Nurse Manager or designee will review 24 hour report daily to ensure that all acute changes are reassessed and follow up documentation is done. 11/3/08	

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L 051	Continued From page 6 A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that there was no follow up documentation after the resident was observed to have low blood pressures. The record was reviewed on September 18, 2008. C. The charge nurse failed to consistently document the pain level and effectiveness of pain medication when administered for Resident #5. A review of the March 2008 MAR [medication administration record] revealed that Oxycodone w/APAP 5/500 Cap ... for minor pain was administered on March 14, 28, 29, and 31, 2008. Tylox Oxycodone w/APAP was administered for moderate-severe pain on March 12, 13, 14,16, 17, 23, 25, 26, 30, and 31, 2008. A review of the "Vitals Report" revealed that on March 13, 14, 17, 18, 22, 23, 24, 27, 28, 29, 30, and 31, 2008 pain level(s) were assessed for Resident #5. According to the "As needed" Administrations Report, Resident #5's pain effectiveness was assessed on March 13, 14, 16, 17, 23, 25, 26, 28, 29, 30 and 31, 2008. The record lacked evidence that when pain medications were administered, an assessment of the resident's pain level and/or a follow up assessment was not consistently conducted to determine if the pain medication administered was effective. A face-to-face interview was conducted on September 18, 2008 at 11:30 AM with Employee #6. He/she acknowledged that pain assessments	L 051	**4C-) 3210.4 Nursing Facilities** 1. Resident # 5 was assessed for pain and medicated as needed with follow up assessment and documentation. 2. All licensed staff will be observed during med pass to ensure consistent documentation of administered as needed medication. 3. Staff will be in serviced on med pass protocol for as needed medications. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	9/18/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 7 and/or effectiveness of the medication were not consistently documented on Resident #5's record. The record was reviewed on September 18, 2008. 5. The charge nurse failed to reassess Resident #8 for pain during the dressing change and document on the Medication Administration Record [MAR] when a dressing change was conducted. A. Wound treatment observation was conducted on September 16, 2008 at 11:32 AM for Resident #8. During the dressing change to Resident #8's right ankle and right toe, Employee #15 raised the right leg of the resident remove the old visibly soiled dressing. At this time Resident #8 moaned and the employee continued to remove the dressing. After the dressing was removed, Employee #15 raised the right leg again to clean the right ankle, the resident moaned and continued to moan during the cleansing process. When Employee #15 raised the right leg to apply kling to the right ankle the resident moaned and yelled. Employee #5 [who entered the room during the dressing change] stated to the resident, "It's almost done." Employee #15 continued to apply tape to the dressing. During the dressing change Employee #15 failed to reassess Resident #8 for pain when he/she moaned during the dressing change. B. The charge nurse failed to document on the Medication Administration Record [MAR] when a dressing change was conducted for Resident #8. A review of the IDT progress notes revealed,	L 051	**5A-3210.4 Nursing Facilities** 1. Resident # 8 was medicated for pain prior to dressing change, reassessed for pain during dressing change and medicated as needed. 9/16/08 2. Resident with dressing changes will be assessed for pain prior to and reassessed throughout the dressing change. 11/3/08 3. Staff will be inserviced on pain protocol for dressing changes. 11/3/08 4. Monthly treatment competencies will be done by the Wound Nurse and submitted to Director of Nursing for presenting to QI Committee meeting for review. 10/9/08 **5B.) 3210.4 Nursing Facilities** 1. Next treatment done on resident # 8 was signed on MAR. 9/15/08 2. All licensed staff will be observed during treatment competencies to ensure documentation of treatment done. 11/3/08 3. Staff will be in serviced on wound competency protocol. 11/3/08 4. Monthly treatment competencies will be randomly done by wound care nurse and submitted to Director of Nursing for presentation at quarterly QI meeting. 11/3/08	

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L 051	Continued From page 8 September 15, 2008 Nursing note at 1455, " ...Right ankle dressing changed yesterday September 14, 2008 due to resident receiving his/her shower dressing change every 3 days. Right toe area dressing changed as ordered ..." On September 16, 2008 a dressing change to the right ankle and the right toe was observed. The old dressing [that was removed] was dated September 14, 2008. Upon completion of the dressing change to the aforementioned areas, Employee #15 failed to sign the MAR [indicating that the dressing change was completed]. A review of the September 2008 MAR revealed that on September 9, 12, and 15, 2008 a dressing change was conducted to the right ankle and the right 5th toe. The record lacked evidence that the MAR was signed on September 14 and 16, 2008 after the dressing change was completed. A face-to-face interview was conducted on September 16, 2008 at 3:55 PM with Employee #6. He/she acknowledged that MAR was not signed indicating that the dressing change was conducted as per the physicians order. The record was reviewed on September 16, 2008. 6. The charge nurse failed to document the correct concentration of a tube feeding product for Resident #10 on the Physician's Order Sheet (POS). A physician's telephone order dated July 17, 2008 and signed by the physician the same day, directed, "Osmolite 1.2 via G-tube every 4 hours ..."	L 051	**6.) 3210.4 Nursing Facilities** 1. Physician order sheet for resident # 10 was reviewed, and reflects current tube feeding orders. 2. All residents with tube feeding will receive the specified formula. 3. Staff will be in serviced on importance of documenting the specified formula of tube feeding ordered by physician. 4. Nurse Manager or designee will review tube feeding orders monthly.	9/16/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 9 A review of Resident #10's record revealed a POS dated August 12, 2008,"Osmolite 1 can every 4 hours from 0600 - 2400." According to the manufacturer, Osmolite is produced as follows per can: Osmolite 1 calorie, Osmolite 1.2 calorie, and Osmolite 1.5 calorie. A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 10:00 AM. He/she acknowledged that the correct strength of Osmolite was not documented on the August 12, 2008 POS. The record was reviewed September 16, 2008. 7. The charge nurse failed to document the current code status on the History and Physical [H&P] form for Resident #22. A review of the Admission and Annual Physical Exam form completed August 12, 2008 revealed, " ... Advance Directives: Full Code ..." A review of the Do Not Attempt Resuscitation/Advance Directive, last updated January 25, 2008 revealed, " ...DNR ..." A review of review of the physician order form for September 1, 2008 through October 31, 2008 and signed by the physician on August 29, 2008 revealed, " ...Advance Directives: DNR ..." The record lacked evidence that the physician documented the current code status when completing Resident #22's H&P. A face-to-face interview was conducted on September 19, 2008 at 9:50 AM with Employee #5. He/she acknowledged that H&P did not document the current code status. The record	L 051	**7.) 3210.4 Nursing Facilities** 1.The physicians who failed to meet this requirement will review the total plan of care for resident #22 and include the current advanced directive on the history. 2.The physicians will review all of their resident's plans of correction to insure compliance with this requirement. 3.The Medical Director will educate all attending physicians on their responsibility to review the total Plan of Care. Monthly audits will be conducted by facility staff to monitor physician visit documentation for compliance. Monthly reports will be prepared for Medical Director. 4.The Medical Director will correct physician compliance as needed and submit a quarterly report to the Administrator summarizing plans reviewed, rates of compliance and corrective actions taken or required.	11/3/08 11/3/08 11/3/08 11/3/08

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L 051	Continued From page 10 was reviewed on September 19, 2008. 8. The charge nurse failed to correctly transcribe an order for In/out catheterization for Resident #28. A review of the medical record reveals an interim physician order dated July 24, 2008 for "intermittent catheterization PRN and daily every hs ..." A review of the Physicians Order Sheet dated and signed August 5, 2008 indicated an "as needed" order dated July 21, 2008 "Intermittent catheterization PRN at Hs daily for sensation of inability to void." A review of the interdisciplinary notes from July 21, 2008 until present lacked documentation that the resident received an In/out cath every HS [hour of sleep]. Facility staff was unable to provide documentation of Input and Output records for this resident at time of survey. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed. The record was reviewed September 17, 2008. 9. The charge nurse failed to document the administration of a controlled substance on the May, June, July and August 2008 Medication Administration Record (MAR) for Resident JH7. The April 1 through May 31, 2008 Physician's Order Sheet signed by the physician on April 4, 2008 directed, "Lorazepam 1mg tablet by mouth every 8 hours as needed for severe agitation".	L 051	**8.) 3210.4 Nursing Facilities** 1. Routine order for intermittent catherization PRN and daily every HS written July 24, 2008 was discontinued for Resident # 28. 2. Residents orders will be transcribed as written by physician. 3. Staff will be in serviced on importance of transcribing physician orders correctly. 4. Nurse Manager or designee will review new orders for correct transcription. **9.) 3210.4 Nursing Facilities** 1.Next dose of Lorazepam administered was signed in MAR for resident # JH7. 2.. All residents identified on controlled substances will be reviewed to ensure the documentation on the MARs were complete. 3. Staff will be in serviced on med pass protocol. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	9/18/08 11/3/08 11/3/08 11/3/08 9/18/08 11/308 11/3/08 11/3/08

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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 051	Continued From page 11 The May 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered three (3) times, May 17, 19 and 22, as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following dates in May 17 (1030 & 1800), 19, 22 and 23 2008. There was no evidence on the May 2008 MAR that the Lorazepam was administered on May 17 (1800) and 23. The June1 through July 31, 2008 Physician's Order Sheet signed by the physician on June 19, 2008 directed, "Lorazepam 1mg tablet by mouth every 8 hours as needed for severe agitation". The June 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered seven (7) times, June 1, 3, 4, 9, 19, 20 and 22 as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record " indicated the Lorazepam was administered on the following dates in June 1, 3, 4, 9, 12, 19, and 22, 2008. There was no evidence on the June 2008 MAR that the Lorazepam was administered on June 12 and 20. The July 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered two (2) times, July 3 and 27, as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following	L 051		

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	HFD02-0027	A. BUILDING _____ B. WING _____	09/19/2008

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L 051	Continued From page 12 dates in July 3,13,14 and 27, 2008. There was no evidence on the July 2008 MAR that the Lorazepam was administered on July 13 and 14. The August 1 through September 30, 2008 Physician's Order Sheet signed by the physician on August 16, 2008 that directed, "Lorazepam 1 mg tablet by mouth every 8 hours as needed for severe agitation." The August 2008 MAR was reviewed and indicated with signatures that Lorazepam was administered seven (7) times in August 5,10,12,18,19, 27 and 28, as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Lorazepam was administered on the following dates in August 3, 5,10,12,18,19, and 27, 2008. There was no evidence on the August 2008 MAR that the Lorazepam was administered on August 3, 2008 and that the Lorazepam was signed as administered on the Controlled Drug Record for August 28, 2008. A face-to-face interview was conducted on September 17, 2008 at approximately 3:55 PM with Employee #3. He/she acknowledged that the MAR and the Controlled Drug Record did not match regarding the administration of Lorazepam. The record was reviewed on September 17, 2008. 10. The charge nurse failed to re-assess Resident S1 for pain during a wound treatment observation. A wound treatment observation was conducted on Resident S1's right ankle on September 16,	L 051	**10.) 3210.4 Nursing Facilities** 1. Order obtained to wrap ankle with kling and secure with tape for resident # S1. 9/17/08 2. Resident with dressing changes will be assessed for pain prior to and reassessed throughout the dressing change. 11/3/08 3. Staff will be in serviced on pain protocol for dressing changes. 11/3/08 4. Monthly treatment competencies will be done by wound nurse and submitted to Director of Nursing for presenting to QI meeting for review. 10/9/08	

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L 051	Continued From page 13 2008 at 10:15 AM. The resident was medicated at 9:30 AM with Tylenol in preparation for the wound treatment. The tape to the right ankle dressing was secured to the resident's skin. While Employee #14 was removing the tape from the old dressing, Resident S1 was grimacing and rapidly tapping the side rail with his/her index finger. Employee #14 told Resident #1, "It's okay. The tape is almost off." Employee #14 failed to re-assess the resident's pain while removing the tape from the old dressing. Additionally, Employee #14 failed to initiate methods that would allow less painful removal of the tape from the resident's skin. A face-to-face interview was conducted with Employee #4 immediately after the dressing change. He/she acknowledged that removing tape from the skin can be painful and would obtain an order from the physician to wrap Resident S1's ankle with kling gauze to secure the dressing and tape the gauze, thus avoiding placing tape directly on the resident's skin.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned	L 052		

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L 052	Continued From page 14 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, staff interview and record review for 10 of 30 sampled residents and six (6) supplemental residents, it was determined that sufficient nursing time was not was not given to each resident as evidence by failure to: supervise one (1) resident with multiple falls, follow up on a psychiatric and speech consult for one (1)	L 052		

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L 052	Continued From page 15 resident, ensure that one (1) resident received two (2) liters of water daily, follow a safe swallowing guide for one (1) resident, one (1) resident received the correct medication, follow up on a psychiatric and pharmacy consult for one (1) resident with weight loss, follow the facility ' s elopement policy for one (1) resident, follow physician's orders for catheterization for one (1) resident, administer a nutritional supplement as per physician ' s orders for three (3) residents, administer medications as per physician's orders for four (4) residents and administer medication as per the manufacturer's recommendations for one (1) resident, , follow clean technique for dressing changes for two (2) residents. Residents #2, 3, 4, 6, 7, 8, 13, 16, 27, 28, JH1, JH2, JH3, JH5, JH6, and S1. The findings include: 1. Sufficient nursing time was not given to supervise Resident #2 who had multiple falls without injury. A review of the IDT progress notes revealed the following: June 22, 2008 at 1920 (5:20 PM), "Resident was observed slipping to the floor ... no pain/injury was noted ... " June 24, 2008 at 0730, " ...observed sitting in the bathroom on the floor ... no complaint of pain or discomfort. " July 23, 2008 at 1930 (5:30 PM), " Charge nurse reported resident slid to floor in bathroom ...no apparent injuries ... " August 6, 2008 at 1500 (3:00 PM), " This writer was called at 1120 that the resident is on the floor ...no physical injury noted ... "	L 052	**1.) 3211.1 Nursing Facilities** 1. Resident # 2 care plan was updated to reflect new intervention. 2. All Resident's Fall Risk Indicator Tool/ Fall Risk Action Plan will be reviewed and updated to reflect changes in the current interventions if necessary. 3. Staff will be in serviced regarding updating Fall Risk Indicator Tool/ Fall Risk Action Plan after each fall to reflect current goals for prevention of further occurrences. 4. Monthly fall audits will be done by QI and submitted to Director of Nursing for reporting to quarterly QI meeting.	9/16/08 11/3/08 11/3/08 10/9/08

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L 052	Continued From page 16 A review of the " Fall risk indicator tool/Fall risk action plan " revealed the following: s/p [status post] fall May 24, 2008 - plan of care updated with new actions/approaches s/p fall May 28, 2008- no new actions/approaches to the current plan of care s/p fall June 24, 2008- plan of care updated with new action/approaches s/p fall July 23, 2008-- plan of care updated with new action/approaches s/p fall August 6, 2008- no new actions/approaches to the current plan of care The record lacked evidence that a "Fall risk indicator tool/fall risk action plan" was completed when the resident had a fall on June 22, 2008. Additionally, the "Fall risk indicator tool/Fall risk action plan" was not consistently updated/amended when Resident #2 was identified as having a fall. There was no evidence that after each fall the facility staff initiated interventions to prevent the resident from falling. A face-to-face interview was conducted on September 16, 2008 at approximately 2:40 PM with Employee #4. He/she acknowledged that the plan of care for Resident #2 was not consistently updated each time the resident had a fall. The record was reviewed on September 16, 2008. 2. Sufficient nursing time was not given to follow a physician's order for a Psychiatric Consult and a Speech Consult for Resident #3 after he/she suffered a significant weight loss and ensure that the resident received medications ordered by the physician.	L 052		

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L 052	Continued From page 17 A . Review of the clinical record revealed a Physician's order dated July 24, 2008, "Dietary Consult, Psych [Psychiatric] Consult and Speech Consult for weight loss." Further review of the clinical record revealed that the Dietary consult was completed on July 25, 2008 but the Psychiatric and Speech Consults were never done. A face-to-face interview was conducted with Employee #5 at approximately 9:35 AM on September 16, 2008. He/she acknowledged that the Psychiatric and Speech consults were not done. He/she added "I am very sorry. I will do them immediately." The record was reviewed on September 15, 2008. B. Sufficient nursing time was not give to ensure that Resident #3 received "Ca. [Calcium] and Vit. [Vitamin] D " recommended by the pharmacist and ordered by the physician. A review of the clinical record for Resident # 3 revealed a Consultant Pharmacist's Communication Report dated August 5, 2008 which stated "Low Calcium level recorded on 7/14/08. Please consider adding Calcium 500 mg with Vitamin D PO [by mouth] Bid [twice daily] routinely to this resident's medication regimen." A review of the Response section of the Consultant Pharmacist's Communication Report revealed that the physician checked the " agree " box indicating that he/she was in agreement with the pharmacist's recommendation and signed the form. However, review of the physician's orders and the Medication Administration Record (MAR)	L 052	**2A. 3211.1 Nursing Facilities** 1. Psych consult and speech consults were completed for Resident # 3. — 9/18/08 2. All residents identified with significant weight loss will be placed on the weight loss protocol which consist of consults by dietary, pharmacy and speech their weights are done weekly. 3. Staff will be reinserviced on the importance of following the weight loss protocol and to ensure the Speech, Pharmacy and Dietary consults are done. 4. Monthly weight loss audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present in quarterly QI meeting. — 11/3/08 **2B. 3211.1 Nursing Facilities** 1. Order written for Calcium and Vitamin D for Resident # 3. — 10/08/08 2. All residents with pharmacy recommendations agreed by physician will be reviewed and carried out. — 11/3/08 3. Staff will be in serviced on protocol for reviewing pharmacy recommendations. — 11/3/08 4. Monthly consult audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting. — 10/9/08	

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L 052	Continued From page 18 revealed that the Calcium and Vitamin D recommended by the pharmacist and agreed upon by the physician was never ordered for the resident. The finding was acknowledged by Employee #2 on September 19, 2008 at approximately 5:40 PM. The record was reviewed on September 16, 2008. 3. Sufficient nursing time was not given to follow physician's orders and ensure that Resident #4 received two (2) liters (L) of fluid daily. A review of Resident #4 record revealed a physician's order dated August 14, 2008, directing, " Increase PO (oral) fluids 2 L/day. D =1000 ml, E=800 ml, N=200 ml. " According to the " Resident I/O (intake/output) " report, the resident consumed the following amount of fluids: September 1, 2008 - 760 ml September 2, 2008 - 1360 September 3, 2008 - 1600 September 4, 2008 - 1120 September 5, 2008 - 1680 September 6, 2008 - 1720 September 7, 2008 - 1240 September 8, 2008 - 1480 September 9, 2008 - 1480 September 10, 2008 - 1480 September 11, 2008 - 1580 September 11, 2008 - 1380 September 14, 2008 - 1320 September 15, 2008 - 1360 A face-to-face interview with Employee #3 was conducted on September 17, 2008 at 8:15 AM. He/she acknowledged that Resident #4 had not	L 052	**3.) 3211.1 Nursing Facilities** 1. Order was reviewed by physician and determined 1500 mL/ day fluid is adequate for resident # 4. 2. All residents with specific fluid intake orders will be reviewed and adhered to. 3. Staff will be in serviced on the importance of documenting PO fluid intake and what constitutes PO fluids. 4. Monthly intake and output audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present in quarterly QI meeting.	10/8/08 11/3/08 11/3/08 10/9/08

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L 052	Continued From page 19 received two (2) liters of water daily. The record was reviewed September 17, 2008. 4. Sufficient nursing time was not given to follow the "Safe Swallow Guide" for Resident #7. A review of Resident #7's record revealed, "Safe Swallow Guide" dated July 21, 2008. The guide included the following: "Regular plate with plate guard; assist resident with cutting food into small manageable pieces; resident should swallow and clear mouth prior to next bite; alternate solids and liquids." The resident was observed at the lunch meal on September 16, 2008 from 12:20 PM through 12:35 PM. The menu consisted of meatballs, spaghetti, asparagus, fruit cocktail and milk. Water was also provided. There was no plate guard. Resident #7 received no assistance with cutting up the meatballs and spaghetti. The resident consumed all of the solid foods first then drank the milk and water. According to the resident's record, weights were recorded as follows for 2008: January 124.8 pounds February 122.7 March 108.4 April 114.0 May 109.0 June 106.4 July 109.0 August 111.6 A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:00 PM. He/she stated, "(Resident #7) no longer requires	L 052	**4.) 3211.1 Nursing Facilities** 1. Resident # 7 was assessed by Speech Therapist and was determined that Safe Swallow Guide and plate guard was no longer needed. 2. All residents identified on a safe Swallow Guide will be reviewed to ensure the guides are adhered to. 3. Staff will be in serviced on the importance of adhering to Safe Swallow Guide instructions. 4. Monthly Safe Swallow Guide audit will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting.	10/8/08 11/03/08 10/09/08

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L 052	Continued From page 20 assistance or a plate guard. I should have discontinued this order long ago." The record was reviewed on September 16, 2008. 5. Sufficient nursing time was not given to follow the clean technique during the dressing change for Resident #8. A wound treatment observation was conducted on September 16, 2008 at 11:32 AM for Resident #8. Employee #15 washed hands and applied gloves that were removed from his/her right uniform pocket. The employee continued with the dressing change by removing the old visibly soiled dressing and discharging it into a clear bag inside the trash receptacle. The wound to the right ankle was cleaned and a new dressing was applied. Employee #15 proceeded to administer a treatment to the right 5th toe and again, placed the soiled dressing in the clear bag. During both treatments Employee #15 failed to place a barrier under the right foot and toe. When the treatment was completed, Employee #15 disposed of the clear plastic bag in the biohazard trash receptacle located in the soiled utility room. Employee #15 then returned back to Resident #8's room to wash his/her hands instead of washing his/her hands at the sink in the soiled utility room. During the dressing change, there was no evidence that Employee #15 followed clean technique by removing and using gloves from his/her uniform pocket and not washing hands at the first available sink after discarding the soiled dressing.	L 052	**5.) 3211.1 Nursing Facilities** 1. Clean techniques were followed for next dressing change for Resident # 8. 9/16/08 2. All residents identified with dressing changes will be observed by the wound care nurse to ensure clean techniques are followed. 11/3/08 3. Staff will be in serviced on clean technique for wound dressing change. 11/3/08 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation to quarterly QI meeting 10/9/08	

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L 052	Continued From page 21 6. Sufficient nursing time was not given to ensure that Resident #13 received the Os-cal D as ordered by the physician. A review of Resident #13's record revealed a "Consultant Pharmacist Communication" form dated August 5, 2008. The recommendation was , "This patient is taking Calcium Carbonate 600 mg po bid (twice daily, orally). Consider adding or switching to a supplement with vitamin D (eg. Os-cal D) to increase absorption of the calcium." The physician indicated under "Your Response - I agree" and wrote "Cal Vit D/Oscal BID[twice daily]." Facility staff failed to clarify the order and ensure that the resident received the Os-cal D twice daily. A face-to-face interview was conducted with Employee #5 on September 17, 2008 at 3:30 PM. He/she acknowledged that the resident had not received the Oscal. The record was reviewed September 17, 2008. 7. Sufficient nursing failed to follow up on a psychiatric and pharmacy consult for weight loss for Resident #16. A review of Resident #16's record revealed a physician's order dated June 16, 2008, "Dietary Consult, Psych Consult, Pharmacy Consult secondary to weight loss." According to the record, the resident's weight for 2008 was as follows: February 123.2 pounds March 120.2 April 117.8	L 052	**6.) 3211.1 Nursing Facilities** 1. Order for OS-Cal D was clarified and administered per physicians orders for Resident # 13. 2. All residents with pharmacy recommendations, agreed by physician will be reviewed and carried out. 3. Staff will be in serviced on protocol for reviewing pharmacy recommendations. 4. Monthly consult audits will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting. **7.) 3211.1 Nursing Facilities** 1. Psych and Pharmacy consults were completed for resident # 16. 2. All residents identified for significant weight loss will be assessed and consults ordered will be done. 3. Staff will be reinserviced on the weight loss protocol and the important of ensuring the Pharmacy, Dietary and Speech consults are done. 4. Monthly weight loss audits will be done by Nurse Manager or designee and submitted to the Director of Nursing to present in quarterly QI meeting.	9/17/08 11/3/08 11/3/08 11/3/08 9/17/08 11/3/08

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L 052	Continued From page 22 May 117.8 June 112.8 The dietary consult was completed June 19, 2008. There was no evidence in the record that the psychiatric or pharmacy consult was completed at the time of this review. A face-to-face interview was conducted with Employee #7 on September 17, 2008 at 11:30 AM. He/she acknowledged that the psychiatric and pharmacy consults were not competed. The record was reviewed September 17, 2008. 8. Sufficient nursing time was not given to follow the facility's policy for elopement for Resident #27. The facility's Policy #1207 titled "Elopement of A Resident" revealed, "...Item #6 ..."Once the resident is found, Communications will take a picture of the resident and place in the lobby." An observation of the receptionist's desk in the lobby at approximately 6:30 PM on September 18, 2008 and on September 19, 2008 at approximately 10:00 AM failed to reveal a picture of Resident #27. A face-to-face interview was conducted with Employee #7 at the time of the observation. He/she acknowledged that there was no picture of the resident at the receptionist's desk. He/she added, "I will place it there immediately." The record and policy was reviewed on September 19, 2008. 9. Sufficient nursing time was not given to correctly follow the physician order for In/out	L 052	**8.) 3211.1 Nursing Facilities** 1. Resident # 27's picture was placed at the receptionist's desk. 2. All resident identified as elopement risks have their pictures placed at the Receptionist desk. 3. Staff will be in serviced on elopement policy. 4. Care plan audits will be done monthly by Nurse Manager or designee and submitted to Director of Nursing to be presented to quarterly QI meeting	9/19/08 11/3/08 11/3/08 11/3/08

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CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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L 052	Continued From page 23 catheterization for Resident #28. An physician's interim order dated July 24, 2008 directed, "Intermittent catheterization PRN [as needed] and daily every HS [bed time] ..." A review of the Physicians Order Sheet dated and signed August 5, 2008 directed, "Intermittent catheterization PRN at HS daily for sensation of inability to void". A review of the Interdisciplinary Note and the Medication Administration Records from July 21, 2008 to September 18, 2008 lacked evidence that the resident received an In/out cath every HS. The record indicates the resident did receive In/out caths PRN. Additionally, the facility staff was unable to provide documentation of Input and Output records for this resident at time of survey. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on September 17, 2008. He/she acknowledged that the order for intermittent catheterization was not correctly transcribed or implemented by facility staff. The record was reviewed on September 18, 2008. 10. Sufficient nursing time was not given to administer a nutritional supplement as per physician for Residents #6, JH1, JH3, JH5 and JH6. Physician's order signed August 29, 2008 directed, "Beneprotein [3] scoops two times daily po [by mouth] for low albumin." The label on the outside of the Beneprotein	L 052	**9.) 3211.1 Nursing Facilities** 1. Resident #28 catherization order was changed to intermittent catherizations when needed for sensation of inability to void. 9/18/08 2. All residents were reviewed for catherization orders. There is one resident who does self catherizations. 11/308 3. Staff will be in serviced on importance of following physicians order for catherization and assessing need for changes. 11/3/08 4. Monthly audits on MAR will be done on residents with catherization by Manager or designee and submitted to Director of Nursing for presentation at quarterly QI meeting. 10/9/08 **10.) 3211.1 Nursing Facilities** 2. All residents with Beneprotein powder orders will be assessed for correct dosages during Med pass. 11/3/08 3. Staff will be in serviced on correct measurements of Beneprotein powder. 11/3/08 4. Med pass audits will be done on staff every six months. Results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy meeting and QI meeting. 10/9/08	

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L 052	Continued From page 24 container stipulated that [1] scoop is equal to [1 ½] tablespoonful of Beneprotein [powder]. During the morning medication passes, between September 16 and September 17, 2008, Employees #14, 24 and 25 administered the nutritional supplement, Beneprotein, with incorrect measurement to Residents #6, JH1, JH3, JH5 and JH6. A face-to-face interview was conducted on September 18, 2008, at approximately 11:15 AM with Employees #4, 6 and 7. The employees acknowledged that Beneprotein was administered incorrectly. The records were reviewed on September 16, and September 18, 2008. 11. Sufficient nursing time was not given to administer medications as per physician's orders for Residents JH2, JH3 and JH5. A. Physician's order signed August 10, 2008 directed, "Acetaminophen [2] tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325 mg two (2) tablets for his/her pain. A face-to- face interview was conducted at approximately 10:07 AM with Employee #24. He/she stated, "The Acetaminophen was administered to the resident for mild pain." The employee telephoned the physician for Acetaminophen to be given for pain. The records	L 052	**11A.) 3211.1 Nursing Facilities** 1. Order was obtained for pain medication for resident # JH2 and administered. 2. All residents identified with pain records will be reviewed to ensure there are orders for pain medication. 3. Staff will be in serviced on importance of obtaining physicians orders prior to administering medication. 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting.	9/16/08 11/3/08 10/9/08

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L 052	Continued From page 25 were reviewed September 16, 2008. B. Physician's order signed August 19, 2008 directed, "Megace 40 mg / ml administer 400 mg po [orally] daily for appetite stimulant." On September 15, 2008, at approximately 10:15 AM during the morning medication pass for Resident JH3, Employee #25 administered 12.5 ml of Megace, instead of 10 ml to Resident JH3. This observation was reported to Employee #6 on September 17, 2008 at approximately 3:30 PM. The records were reviewed September 17, 2008. C. Physician's order signed August 19, 2008 directed, "Acetaminophen 160 mg/5 ml, 20.3 ml (650 mg) per tube twice daily for comfort." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered 20 ml of Acetaminophen 160 mg/5 ml liquid, instead of 20.3 ml to Resident JH5. A face-to-face interview was conducted on September 19, 2008 at approximately 4:40 PM with Employee #4. He/she acknowledged that Acetaminophen not was administered as per physician orders. The records were reviewed September 17, 2008. 12. Sufficient nursing time was not given to administer medication per manufacturer's specification for Resident JH5. The physician's order signed August 5, 2008 directed, "Nexium 40 mg capsule, [1] capsule per tube daily for GERD[Gastroesophageal Reflux	L 052	**11B.) 3211.1 Nursing Facilities** 1. Resident # JH3 received correct dose of Megace at next med pass. 9/19/08 2. All residents with liquid medication orders will be assessed for correct dosage measurement during med pass. 11/3/08 3. Staff will be inserviced on correct measurement of liquid medication. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08 **11C.) 3211.1 Nursing Facilities** 1. Resident # JH5 received correct dose of Tylenol at next med pass. 9/17/08 2. All residents with liquid medications orders will be assessed for correct dosage measurement during Med pass. 11/3/08 3. Staff will be inserviced on correct measurement of liquid medication. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08	

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L 052	Continued From page 26 Disease]." The manufactures insert under patient information for Nexium, stipulates "...Open capsule and empty the granules into a 60 ml catheter tipped syringe. Mix with 50 ml of water. Replace plunger and shake the syringe well for 15 seconds. Hold the syringe with the tip up and check for granules in the tip. Do not give the granules if they have dissolved or have broken into pieces..." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered Nexium via g-tube [gastric tube]. He/she opened the capsule into a medicine cup, add approximately 5 ml of water then poured it into the g-tube and flushed it with 5 ml of water. A face-to-face interview was conducted on September 19, 2008 at approximately 12:00 PM with Employee #4. He/she acknowledged that the Nexium was administered as per manufacturer's specification. The records were reviewed September 17, 2008. 13. A wound treatment observation was conducted on September 16, 2008 at 10:15 AM for Resident S1. Employee #14 failed to wash off the bed side table before placing 4 x 4 gauze pads, a bottle of normal sterile saline and a tube of Curosol gel in a plastic bag on top of the bed side table. The 4 x 4 gauze pads were in a plastic container. The container was opened and normal sterile saline was poured onto the gauze pads, which were left in the container.	L 052	**12.) 3211.1 Nursing Facilities** 1. Manufacturers specification was followed during next med pass for resident # JH5. 9/18/08 2. All residents with medication orders requiring specific manufacturers instructions will be reviewed and adhered to. 11/3/08 3. Staff will be in serviced on following manufacturers specifications during medications administration. 11/3/08 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing to review at quarterly pharmacy and QI meeting. 10/9/08 **13.) 3211.1 Nursing Facilities** 1. Clean technique was followed for next dressing change for Resident # S1. 9/17/08 2. Clean technique was followed for all residents with dressing changes. 11/3/08 3. Staff will be in serviced on clean technique for wound dressing changes. 11/3/08 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation to quarterly QI meeting. 11/3/08	

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L 052	Continued From page 27 After removing the soiled dressing, Employee #14 cleansed the wound by placing the saturated 4 x 4 gauze pads on top of the wound twice. He/she failed to cleanse the right ankle Stage II pressure sore in a circular motion. Employee #14 opened the 2 x 2 gauze pads, left them in the outer wrapper and placed them into the 4 x 4 gauze pad container on top of the wet 4 x 4 gauze pads. When the treatment was completed, Employee #14 placed the unused 2 x 2 gauze pads and bottle of normal sterile saline back into the treatment cart. The soiled wound dressings were placed in a clear plastic bag and disposed of in non-biohazard trash.	L 052	**1. 3217.6 Nursing Facilities** 1. The employee was immediately corrected. 2. All employees were instructed not to carry food and cleaning utensil simultaneously. 3. In service was given to all staff regarding infection control and proper food handling. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report **2. 3217.6 Nursing Facilities** 1. The mop immediately stored. 2. The entire cook preparation areas were inspected to ensure that cleaning utensils were removed. 3.An in service was given to staff regarding infection control and proper food handling. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **3. 3217.6 Nursing Facilities** 1. Employee was corrected immediately. 2. The entire cook preparation areas were inspected to ensure that cleaning utensils were removed from the area. 3. An in service was given to staff regarding infection control and proper food handling. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly.	9/14/08 9/27/08 9/14/08 9/27/08 10/25/08 9/27/08 10/25/08
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, staff interview and record review, it was determined that facility staff failed to prevent ensure that policies and procedures were implemented to prevent infections as evidenced by: in the main kitchen employee carrying food and floor mop at the same time, floor mop and sanitizer towels near food, transferring food into pan without gloves, hands not washed after returning to preparing food, soiled nebulizer machine, oxygen tubing observed on the floor, soiled lift strap for the mechanical lift, and oxygen concentrator filer soiled; failed to practice aseptic technique while removing the soiled dressings from the resident's	L 091		

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L 091	Continued From page 28 room.; and failed to provide trash receptacles for the hand washing sinks in the kitchen. The findings include: The observations were conducted in the main kitchen on September 15, 2008 from 8:30 AM through 11:30 AM, in the presence of Employee #13, who acknowledged the findings at the time of the observations. 1. At 8:40 AM, Employee #20 was observed in the main kitchen carrying two (2) hotel pans of cooked hamburgers in one hand and a floor mop in other. The employee laid the mop against the counter while placing meat on same counter. 2. At 9:30 AM, the floor mop was observed leaning against sink by the cook's preparation area where food was being prepared. 3. At 9:35 AM Employee #19 was observed carrying the floor mop towards the walk-in refrigerator through the area where food was being prepared. 4. Sanitizer towels were sitting open on counter where macaroni and spaghetti were located and across a food preparation area. 5. Employee #20 was observed transferring rice from a cooking to serving vessel without gloves at approximately 10:50 AM. 6. Employee #21 was observed filling dessert dishes with fruit. The employee was observed removing one (1) glove, retrieved a sanitation card from his/her ID holder, handed it to supervisor, and did not wash hands before replacing glove and returned to filling the dessert	L 091	**4.) 3217.6 Nursing Facilities** 1. Associates instructed to leave sanitized items in appropriate storage area. 9/19/08 2. This is monitored daily by supervisors. 3. In services given to staff . 10/11/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **5.) 3217.6 Nursing Facilities** 1. Associated immediately corrected. 9/19/08 2. All associates were given instructions on wearing gloves when transferring food. 3. Inservices were given to staff. 10/11/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **6.) 3217.6 Nursing Facilities** 1. Employee was immediately corrected. 9/14/08. 2. All associates were given instructions on wearing gloves when transferring food. 3. Infection control /food handling in service given. 9/27/08. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08	

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L 091	Continued From page 29 dishes. The above cited dietary observations were made in the presence of Employee #13 who acknowledged the findings at the time of the observations. The following observations were made during the environmental tour conducted on September 15 and 16, 2008 in the presence of Employee #23 who acknowledged the findings at the time of the observations. 7. A nebulizer machine was observed with accumulated debris in room 314 in one (1) of one (1) nebulizer machines observed. 8. Oxygen tubing was observed connected to an oxygen concentrator and on the floor in room 316, in one (1) of one (1) observation of oxygen tubing on the floor. 9. The lift strap for the mechanical lift on the 3rd floor was observed soiled in one (1) of one (1) soiled lift straps observed. 10. The filter to an oxygen concentrator in room 546 was soiled with accumulated dust in one (1) of one (1) soiled oxygen concentrator filter observed. 11. Facility staff failed to practice clean technique while removing the soiled dressings from the resident's room. On September 17, 2008 at approximately 10:30 AM Employee #24 performed a dressing change on the right heel and right lateral foot of Resident P1.	L 091	**7. 3217.6 Nursing Facilities** 1. The nebulizer was cleaned. 2..All nebulizers were checked and cleaned as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. **8. 3217.6 Nursing Facilities** 1. The tubing was removed. 2..All residents using oxygen tubing were inspected and tubing was removed as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. **9.) 3217.6 Nursing Facilities** 1. Mechanical lift strap was sent immediately to laundry for cleaning. 2. All mechanical lift straps were assessed and cleaned as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting. **10.) 3217.6 Nursing Facilities** 1. The filter was changed. 2.. All residents on oxygen filters were inspected and changed as needed. 3. Staff will be in serviced on infection control practices. 4. Environmental rounds will be done every shift, submitted to the Director of Nursing quarterly for presentation to quarterly QI meeting.	9/15/08 11/3/08 11/3/08 11/3/08 9/16/08 11/3/08 11/3/08 11/3/08 9/15/08 11/3/08 11/3/08 11/3/08 9/15/08 11/3/08 11/308 11/3/08

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L 091	Continued From page 30 During the dressing change, Employee #24 placed the soiled dressings with drainage into a clear plastic bag in a trash can in the resident ' s room. Upon completion of the dressing change, Employee #24 removed the clear bag (with the soiled dressings) from the trash can and placed it in the biohazardous receptacle in the Soiled Utility Room. A face-to-face interview was conducted with Employee #5 at approximately 11:00 AM on September 17, 2008. He/she stated that the soiled dressings should be placed in a red plastic bag in the resident's room and the red bag should be placed in the biohazardous receptacle in the Soiled Utility Room. A review of the Infection Control (Housekeeping Services) Policy with an effective date of March 11, 1996 and last reviewed on July 31, 2008 revealed the following statements under Procedure: " 2. Disposal of Infectious Material - All infectious or contaminated materials to include, disposable tissue, dressing, paper towels, etc, be bagged before being removed from the resident ' s room for disposal. Such articles should be placed in 'red plastic bag before removing such from the resident's room and disposed of in appropriate receptacles." The policy was reviewed on September 18, 2008. 12. Facility staff failed to provide trash receptacles for the hand washing sinks in the kitchen. Two (2) hand washing sinks were observed in the	L 091	**11.) 3217.6 Nursing Facilities** 1. Disposal of infectious material policy was reviewed with employee # 24. 9/17/08 2. Disposal of Infectious Material Policy will be adhered to during dressing changes. 11/3/08 3. Staff will be in serviced on infection control protocol. 11/3/08 4. Monthly random wound competencies will be done by wound nurse, submitted to Director of Nursing for presentation at quarterly QI meeting. 11/3/08 **12.) 3217.6 Nursing Facilities** 1. The trash cans were replaced. 9/14/08 2. This is monitored daily by supervisors. 3. In-service scheduled. 10/27/08 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of correction will be developed for noncompliant items. This report will be given to the Administrator monthly. 10/25/08	

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L 091	Continued From page 31 main kitchen. The designated trash receptacles for the used paper towels required lifting the lid before disposing of the paper towels, thus re-contaminating washed hands. This observation was made in the presence of Employee #13 who acknowledged the findings at the time of the observation.	L 091	**3218.2 Nursing Facilities** 1. Resident # 7 was assessed by Speech Therapist and was determined that Safe Swallow Guide and plate guard was no longer needed. 2. All residents identified on a safe Swallow Guide will be reviewed to ensure the guides are adhered to. 3. Staff will be in serviced on the importance of adhering to Safe Swallow Guide instructions. 4. Monthly Safe Swallow Guide audit will be done by Nurse Manager or designee and submitted to Director of Nursing to present to quarterly QI meeting.	10/8/08 11/03/08 10/09/08
L 096	3218.2 Nursing Facilities Each resident who needs assistance to eat shall receive it promptly upon the serving of his or her meals. This Statute is not met as evidenced by: Based on observation, staff interview and record review for one (1) of 30 sampled residents, it was determined that facility staff failed to provide an assistive device for Resident #7 for meal time. The findings include: Facility staff failed to follow the "Safe Swallow Guide" for Resident #7. A review of Resident #7's record revealed, "Safe Swallow Guide" dated July 21, 2008. The guide included the following: "Regular plate with plate guard; assist resident with cutting food into small manageable pieces; resident should swallow and clear mouth prior to next bite; alternate solids and liquids." The resident was observed at the lunch meal on September 16, 2008 from 12:20 PM through 12:35 PM. The menu consisted of meatballs, spaghetti, asparagus, fruit cocktail and milk. Water was also provided. There was no plate guard.	L 096	**1. 3219.1 Nursing Facilities** 1. The outside surfaces of the mixer, combi-Stove, outside surfaces of the tilt grill, outside Of the steam kettle, top surfaces of the gas Oven, compressor fan of the ice machine, Outside of the convention oven, outside of Popcorn maker, interior/exterior surfaces of the Deep fryer with grease build-up and the gas Supply lines and electrical wiring underneath Both fryers grease and debris, outside of the Dish machine by the detergent dispenser were All cleaned. 2.. All surfaces were inspected and cleaned 3.. All Food Service equipment will be placed on routine cleaning schedules. The Department Director and the Quality Coordinator will monitor compliance and ensure cleanliness. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A report will be submitted to the Administrator monthly.	9/14/08. 11/3/08 11/30/08 On-going

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L 096	Continued From page 32 Resident #7 received no assistance with cutting up the meatballs and spaghetti. The resident consumed all of the solid foods first then drank the milk and water. According to the resident's record, weights were recorded as follows for 2008: January 124.8 pounds February 122.7 March 108.4 April 114.0 May 109.0 June 106.4 July 109.0 August 111.6 A face-to-face interview was conducted with Employee #4 on September 16, 2008 at 1:00 PM. He/she stated, "(Resident #7) no longer requires assistance or a plate guard. I should have discontinued this order long ago." The record was reviewed on September 16, 2008.	L 096	**2. 3219.1 Nursing Facilities** 1.The floor and grout between the floor tiles throughout the kitchen, cove base and corners, walls by the grease trap, the drain by the three (3) compartment sink, the back splash by the three (3) compartment sink, area underneath three (3) compartment sink, and area under dish disposal were all cleaned. 2.. All other areas were inspected and cleaned as needed. The floor and wall areas will be placed on routine cleaning schedules and checked by the supervisors for cleanliness. 3. The supervisors will check to see if the kitchen areas have been clean and document findings on the evening check list. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A copy of this report will be submitted to the Administrator monthly. **3. 3219.1 Nursing Facilities** 1. The Hood filters were removed and cleaned thoroughly. 2. The supervisors will check the hood for cleanliness weekly. All unsatisfactory hoods will be cleaned. 3. Hood Filters will be placed on a routine cleaning schedule and check by the supervisors. 4.. All cleaning schedules will be reviewed by the Department Director. The Quality Assurance Coordinator will visit the kitchen and inspects the equipment/kitchen areas every 10 days. All cleaning logs will be checked by the Quality Coordinator for compliance. The Quality Coordinator will develop a monthly report. The findings from this report will be reviewed by the department and a plan of action will be developed for noncompliant items. A copy of this report will be submitted to the Administrator monthly. **4. 3219.1 Nursing Facilities** 1. All unlabeled and undated items were Immediately dated and the ones that could not labeled were discarded. 2. All opened food items in the storage areas were inspected and labeled.	9/14/08 On-going 9/14/08. On-going 9/16/08 9/16/08
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, staff interview and record review, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: soiled appliances, floor, grout, cove base, cooking hoods, undated/unlabeled foods in the freezer, walk-in refrigerator, cook' s holding box and undated items in dry storage, thawing chicken improperly, hotel pans stored wet and ready for	L 099		

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	HFD02-0027	A. BUILDING _____ B. WING _____	09/19/2008

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L 099	Continued From page 33 re-use, no monitoring of the three compartment sink, no air gaps for the cook' s prep sink, drain cover unsecured, hand washing sinks with no trash cans, employee carrying food and floor mop at the same time, floor mop and sanitizer towels near food, transferring food into pan without gloves, hands not washed after returning to preparing food, brooms stored on the floor of the janitorial room, expired supplement and milk in the pantries, soiled transport cart and wet plates ready for reuse. These findings were observed in the presence of Employees #13 and 21 on September 15, 2008 from 8:40 AM through 11:30 AM. The findings include: 1. The outside surfaces of the following appliances were soiled with accumulated grease and debris: mixer, Combi-stove, outside surfaces of the tilt grill, outside of the steam kettle, top surfaces of the gas oven, compressor fan of the ice machine, outside of the convection oven, outside of popcorn maker, interior/exterior surfaces of the deep fryer with grease build-up and the gas supply lines and electrical wiring underneath both fryers grease and debris, outside of the dish machine by the detergent dispenser, accumulated dust on top of the dish machine, and the electric boxes above the dish machine with accumulated dust. 2. The floor and grout between the floor tiles throughout the kitchen, cove base and corners were soiled with accumulated debris and grease. Walls by the grease trap, the drain by the three (3) compartment sink, the back splash by the three (3) compartment sink, area underneath three (3) compartment sink, and area under dish disposal were observed soiled with accumulated	L 099	**(con't from page 33)** **4. 3219.1 Nursing Facilities** 3. Supervisors will check storage areas daily to see if foods items are properly labeled. An in-service on properly labeling food items will be given by the Food Service Director. 4.. The Quality Coordinator will visit the kitchen every 10 days to check compliance. All findings will be reviewed by the Department and plan of action will be developed for noncompliant items. This report will be submitted to the administrator monthly. **5. 3219.1 Nursing Facilities** 1.The water was removed from thawed trays. 2.. All trays were inspected to ensure they were dry.. The supervisors will monitor closely the thawing procedures in the kitchen and correct if necessary. 3. An in-service on proper thawing of food items will be given by the Food Service Director. 4.Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly . **6. 3219.1 Nursing Facilities** 1.The celery was immediately discarded . 2.. All produce was inspected for satisfactory appearance.. All unsatisfactory produce was discarded or returned to the seller. 3. All produce will be checked daily by the supervisors for a satisfactory appearance. 4.The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **7. 3219.1 Nursing Facilities** 1.All items in the dry storage containers were labeled and dated immediately. 2. Supervisors will check all dry storage areas and label all unlabelled items.	On-going 9/16/08 9/16/08 10/25/08 9/16/08 ???? 10/25/08 9/16/08

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L 099	Continued From page 34 grease and debris. 3. Seven (7) of seven (7) cooking hood filters were soiled with accumulated dust, grease and debris. 4. The following unlabeled/undated food items were observed in the freezer, walk-in refrigerator and cook's holding box: Freezer: 4 packages of chicken livers, 2 packages of scones, and 4 packages of chicken with 2 whole chickens in each package. Walk in refrigerator: 8 packages of beef stew, 2 packages of chopped ham, 2 cases of chicken, container of sliced oranges, 1 cooked omelet in a plastic container, 1 box glorious morning muffin batter, 1 box blueberry muffin batter, 2 packages of shredded lettuce, open package of green peppers, and 135 Strawberry Shakes with no thaw date and marked on the sided of each container "After thawing, keep refrigerated. Use within 14 days of thawing." Cook's holding box: package of French toast (12 pieces), 1 package of open bacon, and 1 container of beef flavoring. 5. Approximately 1-2 inches of water accumulated on two (2) trays where cartons of scrambled egg mix were stored, with 13 cartons on one tray and 10 cartons one tray in the walk-in refrigerator. 6. A bin of several bunches of celery with brown spots on stalks and wilted leaves in the walk-in refrigerator. 7. Items in the dry storage area were undated.	L 099	**(con't from page 34)** **7. 3219.1 Nursing Facilities** 3. A daily walk through of the dry storage areas by the supervisors will be done to monitor compliance. 4.The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly . **8. 3219.1 Nursing Facilities** 1. The cook was immediately instructed regarding proper thawing techniques and the chicken parts were immediately discarded. 2.. The area was inspected to ensure that no other chicken parts were thawing , covered in ice. All cooks were instructed on proper handling of thawing techniques. 3. In-services were given to staff by the Food Services Director. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **9. 3219.1 Nursing Facilities** 1. The entire rack of pans were immediately cleaned by the dish machine. 2.. All pots and pans were inspected and Cleaned on the hotel pan rack, as needed. 3. An in service will be given by the Food Service Director to staff on proper cleaning of pans. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly.	On-going 9/15/08. 9/27/08 10/25/08 9/15/08. 9/27/08 10/25/08

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L 099	Continued From page 35 8. The two (2) cook's preparation sinks were filled with chicken parts that were thawing and covered with ice. 9. The following hotel pans were stored wet with a greasy residue and ready for reuse: Nine (9) 1/3 hotel pans, seven (7) 2 inch hotel pans, 18 ¼ hotel pans, 17 ½ hotel pans, and 22 full size hotel pans. 10. There was no evidence that the pH for the sanitizer and water temperature for washing and sanitizing were monitored at the three (3) compartment sink. 11. There were no air gaps or back flow prevention valves for the two (2) sinks by cook's prep area. 12. The drain cover by three (3) compartment sink was not secured and the interior was soiled. 13. The designated trash cans for the two (2) hand washing sinks required lifting lid to place paper towels in it. 14. Employee #20 was observed carrying two (2) hotel pans of cooked hamburgers in one hand and a floor mop in other. The employee laid the mop against the counter while placing meat on same counter. 15. The floor mop was observed leaning against sink by the cook's preparation area where food was being prepared. 16. Employee #19 was observed carrying the floor mop towards the walk-in refrigerator through the area where food was being prepared.	L 099	**10. 3219.1 Nursing Facilities** 1. The water was tested using test strips for proper pH and documented. 2. All testing documentation will be placed on the pH testing log and monitored by supervisor. 3. An in-service is scheduled by ECOLAB. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **11. 3219.1 Nursing Facilities** 1. Maintenance was contacted and a back Flow valve was installed immediately. 2.. All other sink areas were inspected and corrected as needed. This will be monitored by supervisors. 3.Results will be submitted to the Director. 4. A report will be presented quarterly to the QI committee. **12.) 3219.1 Nursing Facilities** 1. The drain cover was cleaned. 2.. All other drains were inspected and cleaned as needed. This is monitored by supervisors. 3. An in-service will be given by Director. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **13.) 3219.1 Nursing Facilities** 1. The lidless trash cans were placed by sink and the employee rewashed their hands. 2.. All employees instructed to use lidless trash cans after washing their hands. This is monitored daily by supervisors. 3. In-service scheduled by Director. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly.	9/15/08. 10/27/08. 10/25/08 9/22/08 9/22/08 On-going 9/15/08. 10/27/08. On-going 9/15/08 10/27/08. 10/25/08

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L 099	Continued From page 36 17. Sanitizer towels were sitting open on counter where macaroni and spaghetti were located and across a food preparation area. 18. Employee #20 was observed transferring rice from a cooking to serving vessel without gloves at approximately 10:50 AM. 19. Employee #21 was observed filling dessert dishes with fruit. The employee was observed removing one (1) glove, retrieved a sanitation card from his/her ID holder, handed it to supervisor, and did not wash hands before replacing glove and returned to filling the dessert dishes. 20. Four (4) brooms and two (2) push brooms were observed on floor of janitorial closet in the main kitchen. These observations were acknowledged by Employee #13 at the time of the observations. 21. Nine (9) of nine (9) cans of Nepro supplement had an expiration date of April 1, 2008 in the 3rd floor pantry. 22. Four (4) of four (4) cartons of skim milk and one (1) of five (5) cartons of whole milk with expiration date of September 12, 2008 in the 3rd floor pantry and seven (7) of 11 cartons of skim milk with an expiration date of September 12, 2008 in the 5th floor pantry. 23. Food transport cart observed soiled and with a cracked top shelf in the 1st floor pantry. 24. 19 of 42 dinner plates observed wet and ready for reuse in the 1st floor pantry.	L 099	**14.) 3219.1 Nursing Facilities** 1. The cooked hamburgers were thrown away. The employee was immediately corrected. 9/15/08 2.. All employees were instructed by the Food service Director about preventing cross contamination. 3. An in service will be given by Food Service Director on preventing cross contamination. 9/27/08 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **15.) 3219.1 Nursing Facilities** 1. The mop was removed and area sanitized. 9/14/08 2. The cooks were instructed by the Food Svc. Director of the importance of preventing cross contamination. 3.An in service will be given by Food Service Director on prevention of cross contamination. 9/27/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **16.) 3219.1 Nursing Facilities** 1. Employee was instructed to take another path 9/16/08 2. All staff were instructed to take another path outside of the prep areas to prevent cross contamination. 9/16/08 3.. An in service will be given on prevention of cross contamination by Food Service Director. 9/27/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **17.) 3219.1 Nursing Facilities** 1. Sanitizer towels were removed from food preparation area and the food preparation area was cleaned with a sanitizer. 9/19/08	

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L 126	3224.1 Nursing Facilities Each facility shall establish methods and written procedures for dispensing and administering drugs and biologicals. This Statute is not met as evidenced by: Based on observation, staff interview and record review, it was determined that facility staff failed to maintain a safe environment and supervise residents as evidenced by: attempt to light the gas burner with paper, multiple outlet strips on the floor, glass vases stored unsafely, unsecured lamp covers in residents' rooms, unsecured HVAC (Heating, Ventilation and Cooling) unit covers, and worn walking surface between the parallel bars. Residents #1, 2 and 27. The findings include: 1. Facility staff attempted to light a gas burner with a piece of paper. During the tour of the main kitchen on September 15, 2008 at approximately 10:15 AM, the one (1) of the six (6) burner oven failed to light. Employee #13 was asked what method was used to light the burner. Employee #13 tore a piece of paper off paper located on the cook's preparation table and attempted to light the burner. Employee #13 acknowledged that there was no procedure in place for lighting the gas burner when the burner did not automatically light. 2. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, mulit-plug outlet strips were observed on the floor in rooms 405, 555, and 5 East clean utility room and the 1st floor pantry floor outlet lacked a cover in four (4) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at	L 126	**17.) 3219.1 Nursing Facilities** 2. Food Service Director instructed staff on the Prevention of food contamination on prep areas. 3. An in- service will given by Food Service Director. 10/11/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **18.) 3219.1 Nursing Facilities** 1. The associate was instructed to weat gloves when handling ready to serve foods. 9/19/08 2. All employees were instructed by Food Service Director to wear gloves when handling ready to serve foods. This is monitored daily by supervisors. 3. An in service will be given to staff by Director. 10/11/08 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **19.) 3219.1 Nursing Facilities** 1. Employee was instructed by Director to wash hands immediately and change gloves. 9/15/08. 2..All employees were instructed on proper usage of gloves when preparing foods. 3. An in service will be given by Food Svc. Director on proper usage of gloves when handling foods. 9/27/08. 4 The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **20.) 3219.1 Nursing Facilities** 1. All brooms were immediately hung in the janitorial closet. 9/15/08 2..Supervisors will monitor daily to see if the brooms are hung properly in the janitorial closet. 3. An in-service will be given on the importance of hanging broom properly in the closet by the Director. 10/11/08. 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08	

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L 126	Continued From page 38 the time of the observations. 3. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, four (4) glass vases were observed stored on the floor in 314 near the bathroom door, in the walking path and one (1) glass vase was stored on the top shelf above the bed in room 510 in two (2) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 4. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, the ceiling lamp covers were not secured to the fixture in rooms 347, 502 and 523 in three (3) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 5. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, HVAC covers were not secured in rooms 502 and 523 in two (2) of 64 rooms observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations. 6. During the environmental tour conducted on September 15, 2008 from 8:45 AM through 8:20 PM, the walking surface between the parallel bars in the Rehabilitation area on the 3rd floor was worn and skid strips were not secured to the walking surface in one (1) of one (1) set of parallel bars observed. These observations were made in the presence of Employee #23 who acknowledged the findings at the time of the observations.	L 126	**21.) 3219.1 Nursing Facilities** 1. All expired Nepro cans were discarded. 9/16/08 2.. The pantries were inspected and all expired cans were discarded. This is monitored daily by Supervisors. 3. Food Service Director instructed staff on the Importance of discarding expired supplements. 9/27/08 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **22.) 3219.1 Nursing Facilities** 1. All expired milk was discarded immediately. 9/16/08 2.. All pantries were inspected and all expired milk was discarded. This is monitored daily. 3. An in-service was given to staff by Director. 9/27/08 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **23.) 3219.1 Nursing Facilities** 1. The food transport cart and tray were discarded. 9/15/08 2.. All food trays and carts were inspected and cleaned as needed. This is monitored daily. 3. Staff instructed by Director to use clean carts with prepared food. 9/27/08 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. 10/25/08 **24.) 3219.1 Nursing Facilities** 1. The employee was instructed to stop using the wet plates and to use dry plates only. 9/19/08 2.. All dinner plates were inspected and dried as needed. This is monitored daily 3.. All employees were instructed to use dry plates during meal service. 9/27/08	

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L 142	3226.2 Nursing Facilities Each dose of medication shall be properly and promptly recorded and initiated in the resident's medical record by the person who administers it. This Statute is not met as evidenced by: Based on observations during the medication pass for one (1) of 30 sampled residents and three (3) supplemental residents, it was determined that facility staff failed to ensure that medication was properly and promptly administered as evidenced by: leaving medication unattended after being poured for one (1) resident, failing to administer medication as per physician's orders for three (3) residents and failing to administer medication as per the manufacturer's recommendations. Residents #6, JH2, JH3 and JH5. The findings include: 1. On September 16, 2008 at approximately 9:10 AM during the medication pass for Resident #6, from approximately 9:15 AM until 9:18 AM, Employee #24 left all of the residents' medications on the medication cart unattended to retrieve Beneprotein from the medication room. At approximately 9:20 AM he/she left all the medication on the cart to sanitize her hands in the resident's room. The following medications were left on the medication cart: Buderprion SR 100mg [1] tablet, Colace 100 mg [1] capsule, Zinc 50 mg [1] capsule, Vitamin C 500 mg [1] tablet, Cyclobenzaprine 10 mg [1] tablet, Oystershell Ca plus Vitamin D 500mg/200mg [1] tablet , Ferrous Sulfate 325 mg tablet [1] tablet, Amlodipine 10 mg [1] tablet, Multivitamin [1] tablet, Meclizine 12.5mg [1] tablet, Spiriva 18 mcg Handihaler [1] capsule, Cospt eye drops, and Advair 500/50	L 142	**(con't from page 39)** **24.) 3219.1 Nursing Facilities** 4. The Quality Assurance Coordinator will inspect the kitchen every 10 days for compliance. All findings will be reviewed with the Department and a plan of corrections will be develop for noncompliant items. This report will be given to the Administrator monthly. **1. 3224.1 Nursing Facilities** 1. The Maintenance department was notified to immediately lite the burner. 2. All burners were inspected. 3. Employees attended a meeting on the importance of notifying the Maintenance dept. to lite burners if they fail to lite An inservice will be held on the proper procedures. The manager will monitor compliance. 4.. Report monitoring results and corrective actions to the QI committee quarterly. **2. 3224.1 Nursing Facilities** 1. All multi-plug outlets were secured to the Walls and the covers were replaced. 2. All other multi-plug outlets and covers were inspected, secured and covers replaced where needed. 3.. Monitor the multi-plug outlets and covers covers and take corrective action as needed. 4.. Report monitoring results and corrective actions to the QI committee quarterly. **3.) 3224.1 Nursing Facilities** 1. Glass vases were immediately removed from room 314 and 510. 2. All residents rooms were checked for Hazardous items. 3. Staff will be inserviced on the guidelines of F-tag 323 Accidents and Supervision and will conduct environmental rounds every shift to ensure a resident safe environment. 4. Environmental rounds will be done every shift, and submitted to Director of Nursing quarterly for review in the quarterly QI meeting.	10/25/08 9/15/08 9/15/08 11/3/08 On-going 9/16/08 9/24/08 11/3/08 On-going. 9/15/08 11/3/08 11/3/08 11/3/08

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L 142	Continued From page 40 MDI. A face-to-face interview was conducted at that time of the observation with Employee #24. He/she acknowledged that the medications were left on the medication cart unattended. 2. The facility staff failed to administer Acetaminophen as per physician's orders for Resident JH2. Physician's orders signed August 10, 2008 directed, "Acetaminophen (2) tablets (650 mg) by mouth every 6 hours as needed for elevated temperature." On September 16, 2008, at approximately 10:00 AM during the morning medication pass, Resident JH2 was complaining of pain in the cheek area. Employee #24 administered Acetaminophen 325 mg two (2) tablets for his/her pain. A face-to-face interview was conducted at approximately 10:07 AM with Employee #24. He/she stated, "The Acetaminophen was administered to the resident for mild pain." The physician was telephoned for a verbal order of Acetaminophen to be given for pain. The records were reviewed September 16, 2008. 3. The facility staff failed to administer Megace as per physician's orders for Resident JH3. Physician's order signed August 19, 2008 directed, "Megace 40 mg/ml suspension, administer 400 mg po daily for appetite stimulant." On September 15, 2008, at approximately 10:15	L 142	**4.) 3224.1 Nursing Facilities** 1. The ceiling lamp covers were secured to the Fixtures. 9/19/08 2. All other ceiling lamp covers were inspected and secured to the fixtures as required. 9/22/08 3.. Monitor the condition of the ceiling lamp covers and take corrective action as needed. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-goi **5.) 3224.1 Nursing Facilities** 1. The HVAC covers were secured immediately. 9/15/08 2. All other HVAC covers were inspected and secured as required. 9/22/08 3. Inservice staff on guidelines of F-tag 323 Accidents and Supervision. The HVAC covers will be monitored and corrective action will be taken as needed. 11/3/08 4.. Report monitoring results and corrective actions to the QI committee quarterly. On-going **6.) 3224.1 Nursing Facilities** 1. The platform was cleaned and all worn tape was removed. The platform will be sanded in order to restore the surface. New skid tape will be applied to the walking surface of the parallel bars in a perpendicular fashion. 10/24/08 2. An inspection of all training stairs, parallel Bars, standing tables and any areas requiring antiskid support was performed from 9/16/08 thru 9/19/08. All areas showing evidence of worn tape were replaced with new antiskid tape 3. All physical therapy and occupational Therapy associates were counseled on the Safety risks that exist by not having these Surfaces secured. This topic will also be an Agenda item at the 10/31/08 Rehabilitation Services Staff Meeting, i.e., F-tag 323 Accidental and Supervision. 4. The Director will report monitoring results And corrective actions to the QI quarterly Meeting. On-going	

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L 142	Continued From page 41 AM during the morning medication pass for Resident JH3. Employee #25 administered 12.5 ml of Megace, instead of 10 ml to Resident JH3. The findings were reported in a face-to-face interview which was conducted on September 17, 2008 at approximately 3:30 PM with Employee #6. The records were reviewed September 17, 2008. 4. The facility staff failed to administer Acetaminophen as per physician's orders and Nexium as per the manufactures recommendations for Resident JH5. A. Physician's order signed August 19, 2008 directed, "Acetaminophen 160 mg/5 ml, 20.3 ml (650 mg) per tube twice daily for comfort." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5. Employee #14 administered 20 ml of Acetaminophen 160 mg/5 ml liquid, instead of 20.3 ml to Resident JH5. A face-to-face interview was conducted on September 19, 2008 at approximately 4:40 PM with Employee #4. He/she acknowledged that Acetaminophen not was administered as per physician orders. The records were reviewed September 17, 2008. B. Facility staff failed to administer medication per manufacturer's specification for Resident JH5. The physician's order signed August 5, 2008 directed, "Nexium 40 mg capsule, [1] capsule per tube daily for GERD[Gastroesophageal Reflux Disease]."	L 142	**1.) 3226.2 Nursing Facilities** 1. Employee # 24 was observed on next Med pass to ensure that medications were not left on cart unattended. 9/16/08 2. All licensed staff will be observed during Med pass to ensure that medications are not left on cart unattended. 11/3/08 3. Staff will be in serviced on med pass safety. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meeting. 11/3/08 **2.) 3226.2 Nursing Facilities** 1. Order was obtained for pain medication for Resident # JH2 and administered. 9/16/08 2. Staff will obtain orders for resident prior to administering medication. 11/3/08 3. Staff will be in serviced on importance of obtaining physician orders prior to administering medication. 11/3/08 4. Med pass audits will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08 **3.) 3226.2 Nursing Facilities** 1. Resident # JH3 received correct dose of Megace at next med pass. 9/19/08 2. All residents with liquid medication orders will be assessed for correct dosage measurement during med pass. 11/3/08 3. Staff will be in serviced on correct measurement of liquid medication. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. 10/9/08	

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L 142	Continued From page 42 The manufactures insert under patient information for Nexium, stipulates "...Open capsule and empty the granules into a 60 ml catheter tipped syringe. Mix with 50 ml of water. Replace plunger and shake the syringe well for 15 seconds. Hold the syringe with the tip up and check for granules in the tip. Do not give the granules if they have dissolved or have broken into pieces..." On September 17, 2008, at approximately 8:30 AM during the morning medication pass for Resident JH5, Employee #14 administered Nexium via g-tube [gastric tube]. He/she opened the capsule into a medicine cup, add approximately 5 ml of water then poured it into the g-tube and flushed it with 5 ml of water. A face-to-face interview was conducted on September 19, 2008 at approximately 12:00 PM with Employee #4. He/she acknowledged that the Nexium was administered as per manufacturer's specification. The records were reviewed September 17, 2008.	L 142	**4A.) 3226.2 Nursing Facilities** 1. Resident JH5 received correct dose of Tylenol at next medication pass. 2. All residents with liquid medication orders will be assessed for correct dosage measurement during medication pass. 3. Staff will be in serviced on correct measurement of liquid medication. 4. Med. pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly pharmacy and QI meeting. **4B.) 3226.2 Nursing Facilities** 1. Manufacturer's specification was followed during next med pass for resident #JH5. 2. All residents with medication orders requiring specific manufacturers instructions will be reviewed and adhered to. 3. Staff will be in serviced on following manufacturers specification during medication administration. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meeting.	9/19/08 11/3/08 11/3/08 11/3/08 9/18/08 11/3/08 11/3/08 10/9/08
L 152	3227.3 Nursing Facilities Proper storage temperature shall be maintained for each medication according to the manufacturer's direction. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to properly store the medications in accordance to the manufacturer's specifications in two (2) of six (6) units and medications improperly stored in Resident JH2's room.	L 152		

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L 152	Continued From page 43 The findings include: 1. Facility staff failed to store medications in accordance with the manufacturer's specifications. According to the facility's "Specialized Long Term Care Nursing Drug Handbook 2008", pages 145 - 146 Calcitonin nasal spray, stipulates, " Fortical: Store unopened bottle under refrigeration 36 degrees Fahrenheit (F) to 46 degrees F. After opening, store for up to 30 days at 68 degrees F to 77 degrees F, ... Store in upright position."; and pages 561-562 Xalantan ophthalmic drops, stipulates, "Store intact bottles under refrigeration 36 degrees F to 46 degrees F." On September 19, 2008 between 11:20 AM and 3:40 PM during the inspection of the medication storage areas, containers of unopened Fortical nasal spray and Xalantan eye drops were observed in the medication carts. 1st Floor (1) Unopened Fortical nasal spray200 units container (1) Intact Xalantan eye drops 3rd Floor (1) Unopened Fortical nasal spray 200 units container (1) Intact Xalantan eye drops A face-to-face interview conducted at the time of the observations with Employees #3 and #28. They acknowledged that the Fortical nasal spray and Xalantan eye drops were stored improperly. 2. Facility staff left medications at resident's	L 152	**1.) 3227.3 Nursing Facilities** 1. Fortical Nasal Spray 200 units and Xalantan eye drops were immediately stored per manufacturers specification. 9/19/08 2. Storage specifications on all medications will be adhered to. 11/3/08 3. All licensed staff will be in serviced on proper storage of medication. 11/3/08 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meetings. 10/9/08	

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L 152	Continued From page 44 bedside unattended. On September 16, 2008 at approximately 10:00 AM during the medication pass for Resident JH2, Employee #24 left medication at the resident's bedside and went out of the room from 10:05 AM returning at 10:08 AM to the medication cart to search for pain medication to administer to the resident. The following medications were left at the bedside: Buderprion SR 100mg [1] tablet, Colace 100 mg [1] capsule, Zinc 50 mg [1] capsule, Vitamin C 500 mg [1] tablet, Cyclobenzaprine 10 mg [1] tablet, Oystershell Ca plus Vitamin D 500mg/200mg [1] tablet , Ferrous Sulfate 325 mg tablet [1] tablet, Amlodipine 10 mg [1] tablet, Multivitamin [1] tablet, Meclizine 12.5mg [1] tablet, Spiriva 18 mcg Handihaler [1] capsule, Cospt eye drops, and Advair 500/50 MDI. A face-to-face interview was conducted at the time of the observation with Employee #24. He/she acknowledged that the medications were improperly stored left unattended.	L 152	**2.) 3227.3 Nursing Facilities** 1. Employee # 24 was observed on next Med pass to ensure that medications were not left in residents room unattended. 2. All licensed staff will be observed during Med pass to ensure that medications are not left in room unattended. 3. Staff will be in serviced on the med. pass protocol. 4. Med pass audit will be done on staff every six months, results submitted to Nurse Manager and Director of Nursing for review at quarterly Pharmacy and QI meetings. meetings.	9/19/08 11/3/08 11/3/08 10/9/08
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 and staff interview during the environmental tour conducted on September 15, 2008 from 8:45 AM through 9:00 PM and September 16, 2008 conducted from 8:45 AM through 1:30 PM, it was determined that the	L 410		

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L 410	Continued From page 45 facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, and homelike environment for residents as evidenced by: soiled/damaged floors, wall paper borders, doors, walls, baseboards, exhaust vents, accordion bathroom doors, furniture, HVAC (Heating, Ventilation and Air Conditioning) units, ceiling tiles, blinds, window screens, thresholds to bathroom doors, call bells, counter tops, sprinkler heads and linen carts; caulking damaged on backsplash in bathrooms; dusty bed frames, top of closet surfaces, bathroom lamps, shelf over the bed, window sills, and damaged/soiled toilet seats. These observations were made in the presence of Employees # 3, 4, 5, 6, 7, 8, 23, 26 and 27. The findings include: 1.13 of 64 floors were observed damaged/soiled as follows: 1st floor rooms: 125, 131, 136 and 156. 2nd floor rooms: 207, Activity room. 3rd floor rooms: 342, staff bathroom and Rehabilitation toilet room. 4th floor rooms: 405, 424 and 426. 5 East room: 562. 2.12 of 64 wall paper borders were observed damaged/marred as follows: 1st floor rooms: 103, 107, 136, 153 and 156. 2nd floor room: 231. 3rd floor rooms: 347 and 354. 4th floor rooms: 405 and 454. 5th floor rooms: 502 and 530. 3. 32 of 64 doors were observed marred/worn/soiled as follows: 1st floor rooms: 103, 107, 115, 124, 130, 131, 141, 153 and 156.	L 410	**1.) 3256.1 Nursing Facilities** 1. An outside contractor was notified to repair and/or replace floors. 10/16/08 2. All other floors were inspected and identified. repairs and replacement will be done by an outside contractor. 10/17/08 3. Monitor the floors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **2.) 3256.1 Nursing Facilities** 1. The wallpaper borders have been ordered and will be replaced upon receipt of the new borders. 11/3/08 2. All other wall paper borders were Inspected and will be replaced as needed. 11/3/08 3. Monitor the wallpaper borders and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **3.) 3256.1 Nursing Facilities** 1. The doors were cleaned and restained. 10/6/08 2. All doors were inspected and will be restained as needed. 10/6/08 3. Monitor the doors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **4.) 3256.1 Nursing Facilities** 1. The walls are scheduled to be repaired. 11/3/08 2. All walls were inspected on 10/17/08 and Will be repaired as needed. 11/3/08 3. Monitor the walls and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going	

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L 410	Continued From page 46 2nd floor rooms: 207, 228, 231, 245, 253, 254 and storage and soiled utility rooms. 3rd floor rooms: 301, 326, 347 and pantry. 4th floor rooms: 405, 424, 426, 454, storage and soiled utility rooms. 5th floor rooms: 502, 510, 515, 546 and Dining room. 5 East room: 560. 4. 28 of 64 rooms were observed with marred/scarred/damaged walls as follows: 1st floor rooms: 107, 115, 124, 126, 136, clean utility room, bathing room and rest room. 2nd floor rooms: 202, 207, 213, 228, 231, 253, storage room, and activity room. 3rd floor rooms: 314, 354, and pantry. 4th floor rooms: 405, 410, 416, 426, clean utility room and day room. 5th floor rooms: 505, 546 and 530. 5 East room: Clean utility room. 5. 20 of 64 rooms were observed with soiled/damaged cove base as follows: 1st floor rooms: 107, 126, 131, 141, 153, 156, soiled utility room and pantry. 2nd floor room: 207. 3rd floor rooms: 324, 326, 342, 354 and Rehabilitation room. 4th floor rooms: 405, 454 and bathing room. 5th floor rooms: 523, 530, and staff bathroom. 6. 12 of 64 exhaust vents were observed soiled as follows: 1st floor rooms: 112, 131, 153, laundry, bathing room, and soiled utility. 2nd floor rooms: 202 and 241. 3rd floor room: 301. 4th floor rooms 405 and 454. 5th floor: staff bathroom.	L 410	**5.) 3256.1 Nursing Facilities** 1. The soil and damaged cove bases will be cleaned and repaired. 2.. All other cove bases were inspected on 10/5/08, cleaned and will be repaired as needed. 3. Monitor the cove bases and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **6.) 3256.1 Nursing Facilities** 1. Vents in rooms identified on #6 have been cleaned and power washed. 2. Inspect remaining rooms and repair and clean as needed. 3.. Monitor the vents in the rooms and take corrective action as needed. 4.. Report monitoring results and corrective actions to the QI committee quarterly. **7.) 3256.1 Nursing Facilities** 1. Rooms identified in #7 have been repaired and cleaned. 2..Inspect remaining rooms and repair and clean as needed. 3. Monitor the accordion bathroom doors and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **8.) 3256.1 Nursing Facilities** 1. The furniture will be repaired in its entirety. 2. All other furniture were inspected and will be repaired as needed. 3. Monitor the furniture and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly.	11/3/08 11/3/08 On-going 11/03/08 On-going 11/03/08 On-going 11/3/08 11/3/08 On-going

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L 410	Continued From page 47 7. 14 of 64 accordion bathroom doors were observed damaged/soiled as follows: 1st floor rooms: 112, 136, 153 and 156. 2nd floor rooms: 245 and 253. 3rd floor rooms: 301, 316, 326 and 354. 4th floor rooms: 416 and 454 5th floor rooms: 523 and 530. 8. 14 of 64 rooms were observed with worn/marred furniture as follows: 1st floor rooms: 107, 112, 130, and day room. 2nd floor rooms: 228, 241, and day room. 4th floor rooms: 405, 410, 416, and 445. 5th floor room: 546. 5 East room: 560 and a geri chair stored in tub room. 9. 22 of 64 HVAC units were observed soiled/damaged as follows: 1st floor rooms: 130, 131 and 156. 2nd floor rooms: 202, 207, 213, 231, 245, 253 and 254. 3rd floor rooms: 301,316, 326, 335 and 342. 4th floor rooms: 405, 410, 424, 443 and day room. 5th floor rooms: 510 and 530. 10. 14 of 64 rooms observed with soiled/damaged ceiling tiles as follows: 1st floor rooms: Rest room and soiled utility room. 2nd floor rooms: Soiled linen, soiled utility, and hallway by 245. 3rd floor rooms: 335 and Rehabilitation room. 4th floor rooms: 426, clean utility room, bathing room and activity room. 5th floor rooms: Soiled utility room and activity room. 5 East room: 560.	L 410	**9.) 3256.1 Nursing Facilities** .1. The HVAC units were cleaned and repaired. 2. All other HVAC units were inspected, cleaned and repaired as needed. 3. Monitor the HVAC units and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **10.) 3256.1 Nursing Facilities** 1. The soiled/damaged ceiling tiles replaced. 2. All other ceiling tiles were inspected and replaced, as needed. 3. Monitor the ceiling tiles and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **11.) 3256.1 Nursing Facilities** 1. Removed blinds in windows identified in #11. 2. Inspect remaining window blinds and clean as needed. 3. Monitor condition of blinds and take correction actions when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **12.) 3256.1 Nursing Facilities** 1 The window screens were replaced. 2. All window screens were inspected and Replaced as needed.. 3. Monitor the window screens and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. **13.) 3256.1 Nursing Facilities** 1. An outside contractor was notified to replace all thresholds.. 2. All other thresholds were inspected and will be replaced as needed. 3. Monitor the condition of the threshold and take correction actions when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly.	9/17/08 9/22/08 11/3/08 On-going 10/10/08 10/13/08 11/3/08 On-going 9/23/08 9/23/08 On-going 11/3/08 11/3/083. On-going

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L 410	Continued From page 48 11. 11 of 64 rooms observed with soiled/damaged window blinds as follows: 1st floor room: 136. 2nd floor rooms: 228, 245, activity room, end of hall by 254 and beauty shop. 3rd floor rooms: 301, 314, 347 and 354. 4th floor room: 405. 5th floor room: 510. 12. Two (2) of 64 rooms were observed with damaged window screens as follows: rooms 314 and 502. 13. Four (4) of 64 thresholds were observed damaged as follows: 1st floor rooms: 112 and 131. 2nd floor room: 253. 5th floor room: 532 14. Three (3) of 64 rooms were observed with functional but damaged call bells as follows: 124, 130 and 153. 15. One (1) of one (1) worktable in hallway on 1st floor damaged laminate by room 112. Counter top in 4th floor activity room. 16. Nine (9) of 14 sprinkler heads observed 1st floor rooms: one (1) of two (2) in pantry and three (3) of three (3) in dining room, 3rd floor room: Two (2) of four (4) in the Rehabilitation room. 5th floor room: Two (2) of four (4) in the activity room. 5 East room: One (1) of one (1) in 562. 17. Five (5) of 10 yellow linen transport carts were observed soiled on the interior and exterior surfaces in the 2nd floor, 3rd floor and 4th floor laundry rooms.	L 410	**14.) 3256.1 Nursing Facilities** 1. The call bells were repaired. 9/17/08 2. All other call bells were inspected on 9/16 and repaired. 9/17/08 3. Monitor the condition of the call bells and take correction actions needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **15.) 3256.1 Nursing Facilities** 1. The laminate material was ordered to replace the worktable. 10/13/08 2. All other worktables were inspected and will be repaired as needed. 11/3/08 3. Monitor the worktables and take corrective action when needed. 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **16.) 3256.1 Nursing Facilities** 1. The sprinkler heads were cleaned of debris. 10/13/08 2. All sprinkler heads were inspected and cleaned as needed. 10/13/08 3. Monitor the sprinkler heads and take corrective action when needed. 11/3/08 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **17.) 3256.1 Nursing Facilities** 1. The carts were cleaned and sanitized. 9/19/08 2. The Personal Laundry Aide was inserviced on proper cleaning & sanitizing. 9/19/08 3. Monitor the carts and take corrective action when needed. 11/308 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going **18.) 3256.1 Nursing Facilities** 1. Back splash was ordered and will be repaired/replaced upon arrival of materials. 11/3/08 2. All back splash was inspected On 10/16 and will be repaired/replaced accordingly. 11/3/08 3. Monitor the back splash and take corrective action when needed. 11/308 4. Report monitoring results and corrective actions to the QA committee quarterly. On-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING _____ B. WING _____	09/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 49 18. 13 of 64 rooms observed with back splash area above sink with damaged caulking in the following areas: 1st floor rooms: 131 and rest room. 2nd floor rooms: 228, 245, 253, bathing room and employee rest room. 3rd floor room: Employee rest room. 4th floor room: 445. 5th floor rooms: 510, 530, soiled utility room and toilet in activity room. 19. 14 of 64 rooms were observed with dusty bed frames as follows: 1st floor rooms: 107, 124, 126, 136 and 156. 2nd floor rooms: 228 and 245. 3rd floor room: 342. 4th floor rooms: 405, 424 and 426. 5th floor room: 510. 5 East rooms: 560 and 564. 20. Seven (7) of 64 rooms were observed with the top surface of the closet dusty as follows: 1st floor rooms: 107, 130 and 153. 2nd floor rooms: 213, 228 and 254. 4th floor room: 405. 21. Seven (7) of 64 rooms were observed with dusty lights in the bathroom as follows: 1st floor rooms: 126 and bathing room. 2nd floor rooms: 202, 228 and 254. 3rd floor room: Bathing room. 4th floor room: 454. 22. Seven (7) of 64 rooms were observed with dusty over the bed shelves as follows: 2nd floor rooms: 231 and 254. These findings were acknowledged by the above cited employees at the time of the observations.	L 410	**19.) 3256.1 Nursing Facilities** 1. Dusty bed frames identified in #19 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of bed frames and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly. **20.) 3256.1 Nursing Facilities** 1. Rooms identified with dusty closets (top) in #20 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of closets and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly. **21.) 3256.1 Nursing Facilities** 1. Rooms identified with dusty lights in #20 have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of lights and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly. **22.) 3256.1 Nursing Facilities** 1. Rooms identified with dust over the bed shelves have been cleaned. 2. Inspect remaining rooms and clean as needed. 3. Monitor condition of lights and take corrective action as needed. 4. Report monitoring results and corrective actions to the QI committee quarterly.	11/03/08 11/03/08 11/03/08 11/03/08

Health Regulation Administration

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