

Health Regulation Administration

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2010
NAME OF PROVIDER OR SUPPLIER CARROLL MANOR NURSING & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 725 BUCHANAN ST., NE WASHINGTON, DC 20017		
(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 000	Initial Comments An annual licensure survey was conducted on September 13-17, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The sample size included 30 residents based on a census of 243 the first day of survey, with two (2) supplemental residents.	L 000	Carroll Manor Nursing and Rehabilitation Center makes its best effort to operate in Substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This Plan of Correction (POC) is prepared and/or executed because it is required by the state and federal laws.	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents it was determined that facility staff failed to obtain routine labs as ordered by the physician for one (1) resident for Resident #5. The findings include: A review of the Physician's Order Form for the month of September 2010 revealed "Labs: CBC with diff (complete blood count with differential), CR (creatinine), LIV2 (Liver functions), Fasting Lipid panel every 6 months (February and August) R/T (related to) Lisinipril, ASA (Acetylsalicylic Acid), Simvastatin." A review of the clinical record lacked evidence of the above labs were obtained/drawn for Resident	L 001	3200.1 Nursing Facilities 1. Resident #5 had CBC with diff, CR, LIV2, 0 and Fasting Lipid Panel drawn on 9/14/10. 2. All residents' with routine labs were reviewed to ensure they were completed as ordered when applicable. 3. All licensed staff will be in serviced on lab protocol regarding medication administration. 4. Monthly audits on routine labs will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.	9/14/10 11/26/10 11/26/10 On-going

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Laboratory Director's or Provider/Supplier Representative's Signature
FORM

Tina Sanchez VP/Administrator 11/20/10
08JB11

(X6) DATE
If continuation sheet 1 of 26

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L 001	Continued From page 1 #5 for August 2010. A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:30 AM. After a review of the clinical record he/she acknowledged that the record lacked evidence of labs for August 2010 and immediately placed a request for labs to be drawn. The record was reviewed on September 14, 2010.	L 001		
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:	L 051		

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L 051	<p>Continued From page 2</p> <p>A. Based on record review and staff interview of five (5) of 30 sampled residents it was determined that The charge nurse failed to develop care plans for the potential adverse interaction of the use of nine (9) or more medication for three (3) residents, failed to develop a care plan for pressure ulcer for one (1) resident, failed to develop a care plan for the use of a diuretic for one (1) resident and failed to updated the care plan for skin integrity for one (1) resident . Residents #5, 7, 15, 17, and 28.</p> <p>The findings include:</p> <p>1. The charge nurse failed to develop a care plan for the potential for adverse interaction of nine (9) or more medications for Resident #5.</p> <p>A review of the POS (Physician's Order Sheet) dated and signed by the physician on July 30, 2010 revealed the following medications that were prescribed for Resident #5, Galantamine, Namenda, Simvastatin, Galantamine, Aspirin, Sertraline, Carvedilol, Vitron-C, Vitamin D, Lisinopril, Docusate Sodium, Colace, Calcium, Seroquel, Seroquel, Protein Plus pack, Cyanocobalamin, Zolof, Sorbitol, Fortical Nasal spray.</p> <p>The care plan last reviewed on July 29, 2010 lacked documented evidence of a care plan for the potential adverse interaction of nine (9) or medications.</p> <p>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:30 AM. After review of the clinical record he/she acknowledged that the</p>	L 051	<p>1. 3210.4 Nursing Facilities</p> <p>1. Resident # 5's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications.</p> <p>2. All residents were reviewed for receiving nine (9) or more meds; Care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable.</p> <p>3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medications for residents receiving nine (9) or more meds.</p> <p>4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.</p>	<p>9/14/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On-going</p>

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L 051	Continued From page 3 record lacked evidence of a care plan for the potential adverse interaction of nine (9) or more medications. The record was reviewed on September 14, 2010. 2. The charge nurse failed to develop a care plan for the potential for adverse drug interactions for 9 or more medications for Resident #7. A review of the resident's clinical record revealed a 'Physician's Order Sheet' (POS) dated and signed by the physician on August 7, 2010 for the months of August and September 2010 that directed medications including: "Amlodipine Besylate 10mg tab. 1 tablet by mouth daily for hypertension." "Lasix 80mg daily P.O. [By mouth] for CHF [Congestive Heart Failure]." "Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression." "Multivitamins tablet. 1 tablet by mouth daily for supplement." "Pentoxifylline ER 400mg tab. 1 tablet by mouth three times daily for peripheral vascular diseases." "Gabapentin 300mg capsule. 1 capsule by mouth three times daily for lower extremity pain." "Acetaminophen ER 650mg. 1 tablet by mouth three times daily for pain." "Famotidine 40mg tablet. 1 tablet by mouth twice daily for GERD [Gastro esophageal reflux]." "Bethanechol 10mg. 1 tablet by mouth twice daily for heartburn." "Colchicine 0.6mg tablet. 1 tablet by mouth twice daily for gout." "Docusate sodium 100mg capsule. 1 capsule by mouth twice daily for bowel motility." "Zolpidem tartrate 10mg tablet. 1 tablet by mouth every night at bedtime." "Fleet enema. Give 1 enema per rectum every 3	L 051	2. 3210.4 NURSING FACILITIES 1. Resident # 7's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications. 2. All residents were reviewed for receiving nine (9) or more meds; Care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable. 3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medication for residents receiving nine (9) or more meds. 4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.	9/15/10 11/26/10 11/26/10 On-going

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L 051	<p>Continued From page 4</p> <p>days PRN/ as needed: DX: Constipation prevention"</p> <p>According to an annual Minimum Data Set (MDS) completed on June 30, 2010, the resident was coded in Section 0 (1) (Number of medications), for "12".</p> <p>A further review of the resident's 'Medication Administration Records' (MAR) for the months of August and September 2010 revealed that the resident was administered the aforementioned medications except for the resident's occasional refusals as evidenced by the initials across the entries for the aforementioned medications on the MAR.</p> <p>A review of the resident's clinical record revealed that the resident's care plans were reviewed and revised after the completion of the resident's annual assessment on June 30 2010.</p> <p>There was no evidence that a care plan with appropriate goals and approaches was initiated for 9 (nine) or more medications for the resident.</p> <p>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 11:00 AM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. He she/she added, I will go and work on it right away. He/she returned moments later with a copy of the newly initiated care plan. The record was reviewed September 15, 2010.</p> <p>3. The charge nurse failed to develop a care plan for the potential adverse interaction of nine (9) or more medications for Resident #15.</p> <p>A review of the POS (Physician 's Order Sheet) dated and signed by the physician on September 3, 2010 revealed the following medications that were prescribed for Resident #15, Glyburide, Atenolol, Folic Acid, Vitamin B-12, Gemfibrozil,</p>	L 051	<p>3. 3210.4 NURSING FACILITIES</p> <p>1. Resident # 15's care plan was updated to include potential adverse interaction of the use of nine (9) or more medications.</p> <p>2. All residents were reviewed for receiving nine (9) or more meds; Care plans were generated for potential adverse interaction of the use of nine (9) or more medications when applicable</p> <p>3. All licensed staff will be in-serviced on initiating care plans for potential adverse interaction of the use of nine (9) or more medication for residents receiving nine (9) or more meds.</p> <p>4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.</p>	<p>9/15/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On-going</p>

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L 051	<p>Continued From page 5</p> <p>senokot, Namenda, Gabapentin, Cetirizine, Acetamenophine.</p> <p>A review of the care plans last updated July 26, 2010 lacked documented evidence of a care plan for the potential adverse interaction of nine (9) or more medications.</p> <p>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 11:15 AM. After a review of the clinical record he/she acknowledged that the record lacked evidence of a care plan for the potential adverse interaction of nine (9) or more medications. The record was reviewed on September 15, 2010.</p> <p>4.The charge nurse failed to initiate a pressure ulcer care plan for Resident #17.</p> <p>A review of Resident # 17's clinical record revealed the followings:</p> <p>A nursing note dated September 5, 2010 at 1130 that noted: "Resident observed with open area on the right posterior thigh measuring 2cm X 1cm. Supervisor, MD [Medical Doctor] and responsible party made aware. New order to cleanse area on [the] Rt. [Right] posterior thigh with soap and H2O [Water], pat dry apply 'Baza' cream and leave open X 15days after each incontinent care and PRN."</p> <p>A nursing note dated September 10, 2010 at 0600 that noted: "Resident was upset staying in the bed without diaper. Resident try to get out of the bed screaming calling from the room and stated 'I want diaper right now, explained the fact why no diaper. Resident disagreed states 'That's</p>	L 051	<p>4. 3210.4 NURSING FACILITIES</p> <p>1. Resident # 17's care plan was updated to include right thigh pressure ulcer.</p> <p>2. All care plans for residents with identified pressure ulcers will be reviewed. A pressure ulcer plan of care will be initiated when applicable.</p> <p>2. All licensed staff will be in-serviced on initiating care plans for residents identified with pressure ulcers.</p> <p>4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.</p>	<p>9/17/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On-going</p>

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L 051	Continued From page 6 my dignity. I am going to report it "[Resident] offered diaper, resident became calm." A review of the resident's clinical record lacked documented evidence that a care plan was initiated with appropriate goals and approaches for the resident's right thigh pressure ulcer. A face-to-face interview was conducted with Employee #5 on September 17, 2010 at approximately 2:30 PM. After a review of the resident's clinical record, he/she acknowledged the aforementioned findings. The record was reviewed September 17, 2010. 5. The charge nurse failed to develop a care plan for the use of a diuretic for Resident #28. The Admission Orders dated July 14, 2010 revealed, " Lasix 20 mg po (by mouth) one (1) tab daily for edema." A review of the July 2010 Medication Administration Record revealed that the Lasix 20 mg was administered from July 14 - 31, 2010; and the August 2010 Medication Administration Record revealed that the Lasix 20 mg was administered from August 1- 18, 2010. A nutrition note dated August 5, 2010 at 3:30 PM documented the following: "...Weekly weights done on 8/4/10. Wt recorded @ 156.8. Last week weight @ 166.2 lbs (pounds). Wt loss of 9.4 lbs. x 1 week and about 30 lbs wt loss since admission. Resident on Lasix 20 mg daily for edema. Wt loss expected. Will continue with plan of care." A review of the care plans located in the clinical record lacked evidence that a care plan was initiated for the use of Lasix A face-to-face interview was conducted on September 17, 2010 at approximately 3:47 PM with Employee #4. He/she acknowledged that the	L 051	5. 3210.4 NURSING FACILITIES 1. Resident # 28 was discharged on 8/18/10. 2. All residents were assessed for diuretic use and a care plan was initiated for residents on diuretics when applicable. 3. All licensed staff will be in-serviced on initiating care plans for residents receiving diuretics. 4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.	8/18/10 11/26/10 11/26/10 On-going

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L 051	<p>Continued From page 7</p> <p>there was no care plan initiated for the use of Lasix. The record was reviewed on September 17, 2010.</p> <p>6. The charge nurse failed to revise and/or update the care plan for skin integrity for Resident #28. Resident #28's "Care Plan and Family Meeting Sign In Sheet" revealed that care plans initiated on July 14, 2010 were reviewed by the facility on July 21 and 27 and August 3, 4, 11 and 18, 2010. Problem #3 [initiated July 14, 2010], revealed "Altered Skin Integrity, pressure related; potential for skin breakdown" was included in the care plan. The goal was "Resident will experience no compromise of skin integrity related to pressure over the next 30 days."</p> <p>There was no evidence that a plan of care was updated to reflect the development of the unstageable (Stage IV) right heel pressure wound on July 20, 2010 and the Stage II coccyx on July 29, 2010 wound.</p> <p>B. Based on observation, record review and staff interview for three (3) of 30 sampled residents, it was determined that the charge nurse failed to provide documented evidence of gradual dose reductions for one (1) resident and adequately monitor for the use of psychotropic medications for two residents. Residents #5, 7, and 26.</p> <p>The findings include:</p> <p>1. The charge nurse failed to adequately monitor the use of Seroquel for Resident #5.</p> <p>A review of Resident #5's clinical record revealed routine medication orders signed and dated by the physician on July 30, 2010 directed,</p>	L 051	<p>6. 3210.4 NURSING FACILITIES</p> <p>1. Resident # 28 was discharged on 8/18/10. 8/18/10</p> <p>2. All care plans for residents with identified pressure ulcers will be reviewed. A pressure ulcer plan of care will be initiated when applicable. 11/26/10</p> <p>3. All licensed staff will be in-serviced on generating and/or updating care plans for residents identified with pressure ulcers to include preventive measures. 11/26/10</p> <p>4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. On-going</p> <p>B1. 3210.4 NURSING FACILITIES</p> <p>1. Resident #5's behavior/intervention monthly flow record was reviewed and updated to include monitoring and targeted behaviors. 9/14/10</p> <p>2. All residents with behavior/intervention monthly flow records were reviewed to ensure all monitoring and targeted behaviors are identified when applicable. 11/26/10</p> <p>3. All staff will be in-serviced on monitoring and identifying targeted behaviors on behavior/intervention monthly flow record. 11/26/10</p> <p>4. Monthly audits on the behavior/intervention record will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. On-going</p>	

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L 051	<p>Continued From page 8</p> <p>"Seroquel 12.5 mg every AM (morning) for Psychosis...".</p> <p>According to the " Behavioral Health Service Consultation Notes " completed and signed by the Psychiatrist on April 8, 2010 directed " ...continue low dose Seroquel "</p> <p>A review of the " Behavior/Intervention Monthly Flow Record " revealed that the targeted behaviors were not identified, for the months of July, August and September 2010.</p> <p>The July 2010 "Behavior/Intervention Monthly Flow Record" tool revealed that on July 22, and 29th there was no documented monitoring for the 7:00 AM -3:00 PM shift. On the September 2010 monitoring tool for September 2nd, and 9th there was no documented monitoring for the 7:00 AM - 3:00PM shift.</p> <p>A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:15 AM. After a review of the "Behavior/Intervention Monthly Flow Record " , he/she acknowledged that the tool was not completed, documented or monitored. The record was reviewed on September 14, 2010.</p> <p>2. The charge nurse failed to attempt a gradual dose reduction for Resident #7 who was receiving Sertraline100 mg by mouth daily for depression.</p> <p>The resident was observed on September 15, 2010 at approximately 10:30 AM sitting calmly in a wheelchair in his/her room. He/she said, "I like it best here in my room." He/she was alert and responsive to name when addressed.</p>	L 051	<p>B2. 3210.4 NURSING FACILITIES</p> <p>1. Resident #7's psychotropic drug use and depressive disorder care plan was reviewed and updated to include physician's and or the psychiatrist's directed attempted GDR as appropriate goals and approaches.</p> <p>2. All residents' care plans for psychotropic drug use and depressive disorder were reviewed and updated to include physicians and psychiatrists directed attempted GDR as appropriate goals and approaches.</p> <p>3. All licensed staff will be in serviced on including physicians and psychiatrists directed attempted GDR as appropriate goals and approaches on psychotropic drug use and depressive disorder care plan.</p> <p>4. Monthly care plan audits will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.</p>	<p>9/17/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On-going</p>

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L 051	<p>Continued From page 9</p> <p>The "Physician's order sheets" for January through September 2010 that directed, "Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression".</p> <p>According to Resident #7's Medication Administration Record [MAR] he/she was administered "Sertraline HCL 100mg tablet 1 tablet by mouth daily for depression" January through September 14, 2010.</p> <p>The resident was seen by the psychiatrist on January 21, 2010 as evidenced by the psychiatrist signed and dated consultation record. The resident was seen by the attending physician on January 28, May 13, and July 12, 2010 as evidenced by the attending physician's signed and dated documentation on the resident's "Interdisciplinary Progress Notes."</p> <p>There was no evidence in the psychiatrist and/or physician's documentations that gradual dose reduction [GDR] was attempted or documentation present to indicate that a dose reduction was clinically contraindicated for the use of " Sertraline HCL 100mg tablet. 1 tablet by mouth daily for depression."</p> <p>According to the annual Minimum Data Set assessment completed June 30, 2010, the resident was not coded for displaying moods and/or behaviors in Section E (Mood and Behavior Patterns).</p> <p>The resident's "Psychotropic Drug Use and Depressive Disorder" care plans completed on June 30, 2010 failed to include the physician's and or the psychiatrist's directed attempted GDR as appropriate goals and approaches.</p>	L 051		

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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 10 A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 10:45 AM and with Employee #16 on September 17, 2010 at approximately 12: 15 AM. After a review of the resident's clinical record, they both acknowledged the above findings. The record was reviewed September 17, 2010. 3. The charge nurse failed to identify targeted behaviors and consistently monitor the targeted behaviors for the use of Clonazepam for Resident #26. A review of Resident #26's clinical record revealed routine medication orders signed and dated by the physician on August 11, 2010 directed, "Clonazepam 0.5 mg tablet, 1/2 (half) tablet by mouth at bedtime for anxiety (1/2 tablet = 0.25 mg)". A review of the August 2010 "Behavior/Intervention Monthly Flow Record" tool revealed that once a week monitoring was conducted for the use of Clonazepam but targeted behaviors were not identified. A face-to-face interview was conducted with Employee #6 on September 14, 2010 at approximately 11:15 AM. After a review of the "Behavior/Intervention Monthly Flow Record". He/she acknowledged that the tool lacked identification of targeted behaviors and consistent monitoring of the behaviors. The record was reviewed on September 14, 2010.	L 051	B3. 3210.4 NURSING FACILITIES 1. Resident #26's behavior/intervention monthly flow record was reviewed and updated to include monitoring and targeted behaviors. 2. All residents with behavior/intervention monthly flow record were reviewed to ensure all monitoring and targeted behaviors were identified when applicable. 3. All staff will be in-serviced on monitoring and identifying targeted behaviors on behavior/intervention monthly flow record. 4. Monthly audits on behavior/intervention flow record will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.	9/14/10 11/26/10 11/26/10 On-going
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each	L 052		

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L 052	Continued From page 11 resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (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,	L 052		

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L 052	<p>Continued From page 12 including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by:</p> <p>A. Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff provided sufficient nursing time to assess and provide appropriate interventions to prevent complications of constipation for Resident # 7.</p> <p>The findings include:</p> <p>According to the facility's policy: Bowel Management/Constipation Number: 1242.2 effective December 1999, revised August 2004 and last reviewed August 1, 2009:</p> <p>I. Policy It is the policy of this facility to prevent fecal impaction secondary to inadequate elimination of feces."</p> <p>II. Purpose "To provide guidelines that ensure proper monitoring of residents regarding adequate elimination of feces. To prevent complications of constipation, fecal impaction, and bowel obstruction which have the potential for occasional hospital admission.</p> <p>III. Supportive Data: "Constipation is a decrease in the number of bowel movements along with prolonged or difficult passage of stools. Constipation ...May progress to fecal impaction, which predisposes individuals to urinary tract infection and urinary incontinence.</p> <p>VII. Intervention: If the resident complains of being constipated and / or has not had a bowel movement within 72 hours after admission...Obtain a physician's order for bulk laxative...If Milk of Magnesia (MOM) is unsuccessful after 6 hours, obtain a physician's</p>	L 052		

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L 052	<p>Continued From page 13</p> <p>order for a fleets enema.</p> <p>V. Assessment: ...Validate complaints with further history ...stool frequency is less often than every three days unless the resident has been NPO [No oral intake] or if there is an acute change in the resident ' s bowel pattern.</p> <p>V111. Documentation: ...Document the presence / absence of constipation, stool consistency, and frequency in the 'Nurses Progress Notes' section of the resident's clinical record.</p> <p>Facility staff failed to provide appropriate interventions to prevent complications of constipation for Resident #7 and accurately document the resident's elimination pattern in the monthly summaries.</p> <p>The resident was observed on September 15, 2010 at approximately 10:30 AM seated in a wheelchair in his/her room. He/she said, "I use the bathroom by myself. I like it here in my room."</p> <p>A review of the resident's clinical record revealed the followings: An electronic "Resident Bowel and Bladder by shift Chart" that documented that the resident did not have bowel movement from April 8 to12, 2010, May 3 to 7, 2010 and June 21 to 24, 2010..</p> <p>A nursing note of May 8, 2010 at 1420 that noted "Resident C/O [Complained of] feeling constipated, stated [he/she] has not had a bowel movement in a week. Resident abd. [Abdomen] is distended soft and obese...Resident assisted to bed, checked for impaction. Large amount of stool palpated. Resident unable to pass stool. Call placed to the PMD [Primary Care Provider] Order obtained for enema. Enema administered, moderate amt. [Amount] of soft, formed...brown</p>	L 052	<p>3211.1 NURSING FACILITIES</p> <ol style="list-style-type: none"> 1. Resident # 7 was assessed for regular bowel elimination pattern. He/She is having regular bowel movements. Physician notified, Resident # 7 is currently getting colace BID and fleet enema every 3 days as needed for constipation. 2. All residents will be assessed for regular bowel elimination pattern and physician will be notified when applicable. 3. All staff will be in-serviced on facility bowel elimination protocol. 4. Monthly audits will be conducted on bowel elimination pattern by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting. 	<p>9/15/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On- going</p>

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L 052	Continued From page 14 stool passed. However, moderate amt. of stool palpated in rectum. Resident states [he/she feels better after administration of enema and [he/she] will stay in bed because [he/she] continues to feel some stool coming out. Order also obtained for Lactulose 30ml po [By mouth]. QHS [At hour of sleep]. Will continue to monitor resident for safety/comfort." A nursing note of May 8, 2010 at 1500 that noted: "Resident c/o not having BM [Bowel movement] x 1wk [1 (one) week], found to be impacted. MD [Medical doctor] notified. order for enema given and carried out. Had med. [Medium] BM. Continue to monitor." A nursing note of May 8, 2010 at 2240 that noted: "...Multiple bms after receiving enema for C/O constipation. Encouraged PO H2O [Water] intake BS (+) [Positive bowel sound] in quadrants x4. Abd. soft, non-tender/non-distended. Resident reports 'It's a whole lot better ' initiated Lactulose for bowel regularity at HS [At time of sleep]." A nursing note of May 16, 2010 at 0800 that noted: Lactulose discontinued. "Resident to continue Colace cap. [Capsule] one twice daily. " A nursing note of May 9, 2010 at 8:00AM that noted: "Resident alert and verbally responsive. Soft loose stool x2 during this shift, no C/O stomach discomfort." A nursing note of May 12, 2010 at 2230 that noted: "Resident seen by Dr. [Name of doctor] for F/U [Follow-up]. Next visit in one year. Colace 100mg p.o. twice daily for bowel motility ordered per Dr. [Name of doctor]." A nursing note of May 8, 2010 at 1420 that noted:	L 052	3211.1 NURSING FACILITIES 1. Resident # 7's monthly summaries were reviewed and accurately documented to reflect resident's actual elimination pattern. 2. Monthly summaries will be reviewed on all residents to ensure accurate documentation elimination pattern when applicable. 3. All licensed staff will be in-serviced on accurately documenting resident's elimination pattern on monthly summary. 4. Monthly summary audits will be conducted monthly by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.	9/15/10 11/26/10 11/26/10 On-going

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L 052	<p>Continued From page 15</p> <p>"Medicated for right leg pain. Scale 6/10 given Tylenol #3 two tabs. [Tablets] p.o. at 1900. Relief reported after 30 minutes. [Decreased] scale 2/10. Pain at present 0/10."</p> <p>An attending note of May 13, 2010 at 1930 that noted: "Pt. [Patient] had problem with constipation now is better...seen by ophthalmology for diabetes retinopathy. Continue to refuse med. [Medication] from time to time...continue current med."</p> <p>A May 2010 "Medication Administration Record" [MAR] that revealed that the resident was administered Fleet enema per rectum on May 8, 2010 as evidence by the initials across from the entry for "Fleet Enema: Give 1 enema per rectum x1 now."</p> <p>A May monthly summary dated June 1, 2010 that inaccurately documented regular bowel for the resident and failed to check constipation, incontinent, laxatives and enemas.</p> <p>A June monthly summary dated July 5, 2010 that inaccurately documented regular bowel for the resident and failed to check constipation, incontinent and laxatives.</p> <p>A further review of the resident's clinical record lacked documented evidence that facility staff provided appropriate interventions to prevent complications of constipation when Resident #7 and failed to accurately document the resident's elimination pattern in the monthly summaries.</p> <p>A face-to-face interview was conducted with Employee #5 on September 15, 2010 at approximately 10:45 AM. After a review of the resident's clinical record, he/she acknowledged</p>	L 052		

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L 052	<p>Continued From page 16</p> <p>the aforementioned findings. The record was reviewed September 15, 2010.</p> <p>B. Based on staff interviews and record reviewed for one (1) of 30 sample residents, it was determined that facility staff failed provided sufficient nursing time to assess to implement measures to prevent the development of a Stage IV right heel pressure sore and a Stage II coccyx pressure sore and provide necessary treatment and services to promote healing for Resident #28. The findings include:</p> <p>A review of Resident #28 ' s record revealed that he/she was born on October 15, 1953 and was admitted to the facility on July 14, 2010. According to the admission Minimum Data Set assessment completed July 27, 2010, the resident was coded for long and short term memory problems with moderately impaired cognitive skills for daily decision making in Section B (Cognitive Patterns). Resident #28 was coded as requiring extensive assistance for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing in Section G (Physical Functioning and Structural Problems). Disease diagnoses listed in Section I included: Hypertension, Arthritis, Status Post Hip Fracture, and Anemia.</p> <p>A review of the Braden Pressure Ulcer Risk Assessment dated July 21, 2010 revealed a total score of 13.</p> <p>A face-to-face interview was conducted with Employee #2 at approximately 3:47 PM. He/she stated, "A score less than 18 means that [facility staff] will implement pressure prevention protocol. We [facility staff] would obtain an order to float</p>	L 052	<p>B. 3211.1 NURSING FACILITIES</p> <p>1. Resident #28 was discharged on 8/18/10 Skin protection detail report contained in CareTracker documentation system reflects evidence of measures initiated to prevent development of pressure ulcers from admission through her entire stay in the facility. Measures put in place included turning and repositioning every 2 hours, floating heels, application of protective barrier to skin and use of chair cushion.</p> <p>2. All residents will be re-assessed for pressure ulcers and the risk of developing pressure ulcers and facility staff will document preventive measures for developing pressure ulcers as well as treatment when applicable.</p> <p>3. All staff will be in-serviced on facility pressure ulcer prevention/treatment protocol.</p> <p>4. Monthly audits for documentation of preventive measures for developing pressure ulcers/treatment will be conducted by Nurse Managers or designee to ensure compliance and the results will be submitted to the DON for presentation at the QA/QI meeting.</p>	<p>8/18/10</p> <p>11/26/10</p> <p>11/26/10</p> <p>On-going</p>

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L 052	<p>Continued From page 17</p> <p>heels."</p> <p>A review of the nurse's admission assessment completed July 14, 2010, revealed the following: "Resident admitted from [hospital] with multiple old black skin discolorations on body. Has surgical incision with thirteen staples on right hip, smaller incision on right mid-thigh and knee with three staples ...redness on right toe 1 x 0.8 cm ..." There was no documentation in the clinical record that the resident was admitted with a right heel pressure sore and a Stage II coccyx ulcer.</p> <p>According to a nurse's note dated July 20, 2010 at 11:00 AM (six days after admission): "During morning rounds noted resident's right heel with dark red deep tissue injury measuring approximately 6 cm x 7 cm. Resident denies any pain; able to move his/her foot without any problems. His/her right leg is edematous to +2. Notified [physician] and family member ...Received order for Ehob boots to bilateral foot [feet] while in bed. Will continue to monitor resident as needed "</p> <p>A nurse's note dated July 21, 2010 at 8:30 AM documented, "Resident admitted on 7/14. Alert and verbalizes well. Noted on the right heel suspected deep tissue injury with dry scaly skin around the edges measures 6 x 6 cm; dark area appearance of the wound does not suggest any [unable to read]. Ehob boots and keep heels floated."</p> <p>According to a nurse's note dated August 4, 2010 at 9:00 AM: "Follow up coccyx Stage II ulcer healing well with pale, pink epithelial tissue. Currently on Vasolex. Right heel SDTI (Suspected Deep Tissue Injury) now appears unstageable measuring approximately 4.5 x 4.5</p>	L 052		

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L 052	<p>Continued From page 18</p> <p>cm. Soft necrotic area; peri-wound clean; currently with Ehob boots. Continue to keep the heels floated."</p> <p>A review of the " Pressure Ulcer Report ", undated, documented, "Right heel, unstageable, dark deep red discoloration, acquired, 6 cm x 7 cm treatment EHOB boots." The second entry was, "Coccyx Stage II resolving area from wound report August 20, 2010, acquired, 6 cm x 0.5 cm treatment Vasolex."</p> <p>Resident #28's weekly "Skin Sheets" were unable to be located at the time of this investigation.</p> <p>A review of the Problem #3, care plan initiated and last updated July 14, 2010 revealed, "Altered skin integrity, pressure related; potential for skin breakdown " was included in the care plan. The goal was "Resident will experience no compromise of skin integrity related to pressure over the next 30 days." There was no evidence that a plan of care was updated to reflect the development of the unstageable (Stage IV) right heel pressure wound and the Stage II coccyx wound.</p> <p>The admission "Nutritional Assessment" was completed July 15, 2010. The area labeled "Lab Results" was blank for FBS (Fasting Blood Sugar), HGB (Hemoglobin), HCT (Hematocrit), AIB (Albumin), T.Pro (Total Protein) and K (Potassium). BUN was listed as "32" and CREA was listed as "1.0 "</p> <p>Under "Physical Indicators of Nutritional Status" edema was not checked. However, this was addressed in the accompanying note on the back of the form: "Some edema noted with Lasix given. Weight expected to fluctuate secondary to</p>	L 052		

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L 052	<p>Continued From page 19</p> <p>the use of diuretics." The dietician recommended a regular, 2 gram sodium diet, with no additional supplements.</p> <p>The admission laboratory tests drawn on July 14, 2010, revealed the following: HGB 11.4 (normal 11.5-16.0 g/dl) HCT 33.8 (normal 37.0-47.0%) Glucose 106 (normal 74-105 mg/dl) Laboratory values that accompanied the resident from the hospital and dated July 12, 2010, documented the following: T Protein 5.2 (normal 6.0-8.5 mg/dl) Albumin 1.6 (normal 3.2 - 5.5 mg/dl) Potassium 5.2 (normal 3.5-5.3 meq/L)</p> <p>According to the Merck manual at merck.com, " Treatment-Treating a pressure sore is much more difficult than preventing one. The main goals of treatment are to relieve pressure on the sores, keep them clean and free of infection, and provide adequate nutrition. Adequate nutrition is important in helping pressure sores heal and in preventing new sores from forming. A well-balanced, high-protein diet is recommended as well as a daily high-potency vitamin and mineral supplement. Supplemental vitamin C and zinc may help with healing as well ... "</p> <p>There was no evidence that the dietician reviewed the above cited laboratory values and recommended interventions to improve the total protein, albumin, Hemoglobin and glucose. Additionally, the dietician failed to update the care plan to reflect the resident ' s abnormal laboratory values.</p> <p>A nutrition note dated August 5, 2010 at 3:30 PM documented the following: " Appetite good = 80-90% P.O oral) intake. Weekly weights done</p>	L 052		

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L 052	<p>Continued From page 20</p> <p>on 8/4/10...Will continue with plan of care. " There was no evidence that the dietician included the right heel pressure ulcer in his/her aforementioned assessment of the resident.</p> <p>A face-to-face interview was conducted with Employee #12 on September 17, 2010 at 3:56 PM. After reviewing the resident ' s record, he/she acknowledged that the resident ' s admission labs were not included in the initial assessment; the resident ' s wounds were not re-assessed from a nutritional perspective and that the resident ' s care plan was not updated as needed to reflect the resident ' s status.</p> <p>Additionally, the physician documented the resident's status in the "Interdisciplinary Progress Notes" on July 15 and 27, August 5 and August 10, 2010. There was no evidence that the physician reviewed Resident #28's total plan of care and addressed the status of the resident's right heel wound and subsequent coccyx wound. A physician's note dated August 3, 2010 documented, "Right heel eschar noted ...elevate right foot/heel and continue Ehob boots."</p> <p>A face-to-face interview was conducted on September 17, 2010 at 3:47 PM with Employees #3 and #4. After reviewing the resident's record, both employees acknowledged that the resident's right heel wound was not identified prior to July 20, 2010 when it was noted as unstageable; the skin care plan was not developed and/or updated to reflect the resident's right heel and coccyx wounds. The record was reviewed September 17, 2010.</p> <p>There was no documented evidence that facility staff implemented measures to prevent Resident #28's right heel pressure ulcer from developing.</p>	L 052		

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L 099	<p>3219.1 Nursing Facilities</p> <p>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:</p> <p>Based on observations that were made during a tour of the dietary services on September 13, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by a low wash water temperature in the three compartment sink, a slippery kitchen floor, three (3) of three (3) soiled ice machines, three (3) of three (3) outdated health drinks, two (2) of five (5) damaged well covers; handles, two (2) of nine (9) floor drains extended too far into the drains, a high temperature of one(1) of one (1) refrigerator on the fourth floor pantry and a carton of milk that was measured at 47.7 degrees Fahrenheit (F) on the second floor pantry.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The wash water temperature in the three compartment sink was 98.6 degrees F, the required temperature by company 's policy is 110 degrees F. 2. The kitchen floor was slippery and presented a safety hazard. 3. Ice machines on the first, second, third and fourth floor pantries were soiled. 4. Three (3) of three (3) strawberry flavored health shake drinks stored in the refrigerator on the second floor were expired as of August 10, 2010. 5. The handles from two (2) of five (5) well covers on the second floor steam table were damaged. 6. Floor drains from the kettle in the main kitchen and the three compartment sink on the third floor provided insufficient air gap or 	L 099	<p>3219.1 NURSING FACILITIES</p> <p>1.</p> <ol style="list-style-type: none"> 1. A corrective order was generated for the three compartment sink and was corrected. 2. Floor mats and wet floor signs were placed at indicated areas. Flooring company was contacted and asked to come back to resurface kitchen floor. This will be completed by the plan of correction date. 3. The ice machines were cleaned immediately. 4. The strawberry flavored health shakes were discarded. 5. A corrective order was generated for the Steam table handles and was corrected. 6. A corrective order was generated for flow drains at indicated areas and was corrected 7. A sign was placed on the identified refrigerator "NOT TO BE USED". All contents were removed and disposed of. The items located in this refrigerator were not for residents 8. The carton of milk was discarded. <p>2. A comprehensive inspection was conducted in the main kitchen and floor pantries. This included all food items in the refrigerators and freezers were inspected thoroughly for expiration dates. All food items that were past the expiration date or above appropriate temperatures were discarded. All refrigerators and freezers were checked for appropriate temperatures. All remaining ice machines were inspected. An environmental check was done on all pantries for damaged steam table handles and floor drain air gaps.</p> <ol style="list-style-type: none"> 3. The food Service staff will be re-educated on the storage, preparation and distribution of food as well as cleanliness of equipment. The Sanitation Check List will be revised to include items identified in survey. The supervisors will be re-educated on the sanitation of the kitchen. 	<p>9/13/10</p> <p>12/3/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/13/10</p> <p>9/30/10</p> <p>12/3/10</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2010
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L 099	Continued From page 22 separation from the drain. 7. The temperature of the refrigerator on the fourth floor was 80 degrees F. 8. A carton of milk was measured at 47.7 degrees F on the second floor pantry. These observations were made in the presence of Employees #13 and #15 who acknowledged the findings.	L 099	3219.1 NURSING FACILITIES (CONTINUED) 4. Sanitation audits will be done by the dietary Manager/designee monthly to insure compliance. Results will be submitted quarterly to the QA/QI committee.	On-going
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made during the environmental tour of the facility on September 15 and 16, 2010, it was determined that the facility failed to provide an environment that is free from accident hazards as evidenced by the lack of a stopper to prevent a window from fully opening in a resident room. The findings include: The window in room #228 lacked a stopper to prevent the window from fully opening. These observations were made in the presence of Employees # 14 and # 15 who acknowledged this finding during the survey.	L 214	3234.1 NURSING FACILITIES 1. The window stopper missing in room 228 was immediately installed on the day of inspection. 2. All windows were inspected and stoppers installed as necessary. 3. All windows will be inspected quarterly as part of the preventative maintenance plan 4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting	9/15/10 11/29/10 11/29/10 Ongoing
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a) Be accessible to each resident, indicating	L 306		

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L 306	Continued From page 23 signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b) In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c) Be of a quality which is, at the time of installation, consistent with current technology; and (d) Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during environmental tours of the facility on September 15, and 16, 2010, it was determined that the facility failed to provide effective maintenance services as evidenced by a call bell not functioning in one (1) residents room. The findings include: The call bell was not functioning in room #229. These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey.	L 306	3245.10 NURSING FACILITIES 1. The call bell in room 229 was repaired on the day of inspection. 2. All call bells were inspected and repaired if necessary on the day of inspection. 3. The Nursing staff will check call bells daily and will report all issues to call center for repair. All resident rooms will be inspected quarterly as part of the preventative maintenance plan. 4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. 3256.1 NURSING FACILITIES 1. 1. Dusty bathroom vents identified were removed and power washed 2. Housekeeping Manager inspected all vents throughout the facility 3. Outer portion of bathroom vents will be cleaned weekly by housekeeping. Vents will be inspected by the Housekeeping Manager, during daily rounds. 4. Bathroom vents will be inspected monthly by the Housekeeping supervisor/designee to insure compliance. Findings will be reported to the QA/QI Committee quarterly. 2. 1. The main exhaust fan was not working causing the bathroom vents to not operate. The electrical panel was checked and a trip breaker had tripped. The breaker was reset.	9/17/10 9/17/10 11/29/10 On-going 9/16/10 9/17/10 9/17/10 On-going 9/17/10
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:	L 410		On-going

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L 410	<p>Continued From page 24</p> <p>Based on observations made during environmental tours of the facility on September 15, and 16, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms: Bathroom vents were dusty in seven (7) of 70 resident rooms, Bathroom vents were not functioning in nine (9) of 70 resident rooms, walls were marred in seven (7) of 70 rooms, and call bell buttons (used at bedside by the residents) were stuck in the inward position once pressed in six (6) of 70 resident rooms and call bells were missing the reset button in four (4) of 70 resident rooms.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Bathroom air vents were dusty in rooms # 509, 511, 516, 545, 547, 431 and 429. 2. Bathroom vents were not functioning in rooms #155, 255, 409, 411, 451, 535, 545, 547 and 553. 3. Walls were marred or soiled in rooms # 125, 149, 301, 303, 315, 436 and 454. 4. Call bell buttons (used at bedside by the residents) were stuck in the inward position once pressed in rooms #214, 309, 333, 346, 404 and 455. 5. Call bells were missing the reset buttons in rooms #214, 309, 323, and 333. <p>These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey.</p>	L 410	<p>3256.1 NURSING FACILITIES (continued)</p> <ol style="list-style-type: none"> 2. All exhaust fans and bathroom vents will be checked and repaired where applicable. 12/3/10 3. All exhaust fans will be checked and receive Preventative maintenance 3 times annually. 12/3/10 4. Exhaust fans will be inspected by the CM Maintenance Supervisor/designee three times annually to insure compliance. The results submitted at the quarterly QA/QI meeting. On-going <p>3.</p> <ol style="list-style-type: none"> 1. All cited rooms will be painted. 12/3/10 2. All resident rooms will be inspected and painted where applicable. 12/3/10 3. All resident rooms will be inspected quarterly as part of the preventative maintenance plan. 12/3/10 4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. On-going <p>4.</p> <ol style="list-style-type: none"> 1. The call bell reset buttons that stuck inward were functional, however, they were immediately replaced in all the cited rooms. 9/17/10 2 All call bell buttons were inspected and corrected where applicable. 9/17/10 3. The Nursing staff will check call bells daily and will report all issues to call center for repair All resident rooms will be inspected quarterly as part of the preventative maintenance plan 12/3/10 4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. On-going 	

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L 426	Continued From page 25	L 426		
L 426	<p>3257.3 Nursing Facilities</p> <p>Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by:</p> <p>Based on observations made during the environmental tour of the facility on September 15, and 16, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility.</p> <p>The findings include:</p> <p>Crawling and flying insects were observed on the second and fifth floor.</p> <p>These observations were made in the presence of Employees # 14 and # 15 who acknowledged these findings during the survey.</p>	L 426	<p>3256.1 NURSING FACILITIES (continued)</p> <p>5.</p> <ol style="list-style-type: none"> 1. The call bells missing reset buttons were replaced 9/17/10 2 All call bell buttons were inspected and corrected where applicable. 9/17/10 3. The Nursing staff will check call bells daily and will report all issues to call center for repair All resident rooms will be inspected quarterly as part of the preventative maintenance plan 12/3/10 4. Preventative maintenance will be done quarterly to ensure compliance by the CM Maintenance Supervisor/designee. Findings will be reported to the quarterly QA/QI meeting. On-going <p>3257.3 NURSING FACILITIES</p> <ol style="list-style-type: none"> 1. Areas identified were immediately treated. 9/16/10 2. All units were inspected for crawling and flying insects. 9/16/10 3. A communication book was placed on each nursing unit to document pest and insects. Trash will be removed from the lounge areas three times daily. Ecolab representative will conduct bi-weekly treatment throughout the building which includes facility identified targeted areas. 9/16/10 4. Monthly audits will be conducted by the Housekeeping Manager/designee insure Compliance. The findings will be reported quarterly to the QA/QI Committee. Ongoing 	