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	HFD02-0011	A. BUILDING _____ B. WING _____	07/25/2008

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CAROLYN BOONE LEWIS HEALTH CARE	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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L 000	Initial Comments A licensure survey was conducted July 21 through 25, 2008. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 25 residents based on a census of 163 residents on the first day of survey and four (4) supplemental residents.	L 000		
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 25 sampled resident records, it was determined that the physician failed to complete a comprehensive medical examination and health status evaluation annually. Residents #5, 8, 14 and 16. The findings include: 1. A review of Resident #5's record revealed that the previous comprehensive medical examination and health status evaluation was completed June 7, 2007. There was no evidence in the record at the time of this review that a comprehensive medical examination and health status evaluation was completed after June 7, 2007. A face-to-face interview was conducted with Employee #5 on July 22, 2008 at 10:00 AM. He/she acknowledged that an annual medical evaluation and health status evaluation was not completed for June, 2008. The record was	L 036		

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L 036	Continued From page 1 reviewed July 22, 2008. 2. A review of Resident #8's record revealed that the previous comprehensive medical examination and health status evaluation was completed June 24, 2007. There was no evidence in the record at the time of this review that a comprehensive medical examination and health status evaluation was completed after June 24, 2007. A face-to-face interview was conducted with Employee #10 on July 23, 2008 at 11:00 AM. He/she acknowledged that an annual medical evaluation and health status evaluation was not completed for June, 2008. The record was reviewed July 23, 2008. 3. A review of Resident #14's record revealed that the previous comprehensive medical examination and health status evaluation was completed June 30, 2007. There was no evidence in the record at the time of this review that a comprehensive medical examination and health status evaluation was completed after June 30, 2007. A face-to-face interview was conducted with Employee #5 on July 22, 2008 at 4:30 PM. He/she acknowledged that an annual medical evaluation and health status evaluation was not completed for June, 2008. The record was reviewed July 22, 2008. 4. A review of Resident #16's record revealed that the previous comprehensive medical examination and health status evaluation was completed March 13, 2007.	L 036	Residents #5, #8, #14 and #16 #1, #2, #3 and #4 1. Primary physician for resident #5 and #8 was called on 8/14/08 to complete annual H&P and H&P was completed on 8/24/08 for resident #5 and 8/27/08 for for resident #8. Resident #14 and #16 H&P was in the clinical record with a completion date of 2/1/08 for resident #14 and 6/14/08 for resident #16. 2. All other resident's identified clinical records were reviewed for H&P compliance and was corrected as needed. 3. All unit secretaries were inserviced by the Unit managers on 8/14/08 on chart audits and physicians notification on past due and upcoming H&P. 4. History and Physicals will be monitored by Unit Secretaries and findings reported in Quarterly CQI.	09/08/08

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L 036	Continued From page 2 There was no evidence in the record at the time of this review that a comprehensive medical examination and health status evaluation was completed after March 13, 2007. A face-to-face interview was conducted with Employee #3 on July 23, 2008 at 12:20 PM. He/she acknowledged that an annual medical evaluation and health status evaluation was not completed for 2008. The record was reviewed July 23, 2008.	L 036		
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	Continued From page 3 This Statute is not met as evidenced by: Based on staff interview and record review for eight (8) of 25 sampled residents, it was determined that the charge nurse failed to: initiate and update care plans with appropriate goals and approaches for: three (3) residents for the potential for adverse drug reactions for the use of nine (9) or more medications, one (1) resident with skin impairment, one (1) resident for psychotropic medications behaviors, one (1) resident for behavior, one (1) resident's care plan for communication, one (1) resident's for dialysis and one (1) resident's for hospice care; and Residents # 2, 4, 10, 11, 15, 18, 20, and 21. The findings include: 1. The charge nurse failed to update Resident # 2's care plan with appropriate goals and approaches for behavior. A review of the resident's clinical record revealed the followings: A "Nursing Care Plan Notes" dated May 14, 2008, "...Had [two] 2 episodes of inappropriate behavior toward [two] 2 residents ..." A "Social Progress Notes" dated May 14, 2008, " Care Plan Progress Note:...Resident has had incidents during this assessment period where she scratched another resident in the face and another resident on the left breast. Resident has episodes of agitation and other behavioral concerns that require [Psychiatric evaluation] ..." A review of " Resistive Behavior Care Plan " dated May 8, 2008 lacked evidence that additional goals and approaches were initiated after aforementioned episodes of agitation and	L 051	#1. Residents #2 1. Unit manager updated resident #2 behavior care plan with the appropriate goals and approaches on 7/25/08. 2. All other residents identified with behavior care plans clinical records were reviewed and updated as indicated. 3. Unit managers were inserviced by DON on 8/25/08 on Updating Behavior Care Plans after each unusual occurrence and monthly. 4. Random care plan audits by unit managers and MDS Coordinator and report in quarterly CQI.	09/08/08

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L 051	Continued From page 4 inappropriate behavior. A face to-face interview was conducted with employee # 3 on July 23, 2008 at approximately 2:30 PM. He/she acknowledged that the clinical record lacked evidence that the resident ' s care plan was updated with additional goals and approaches after the aforementioned episodes of agitation and inappropriate behavior. The record was reviewed on July 23, 2008. 2. The charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #4. A review of the clinical record for Resident #4 revealed physician orders dated and signed May 5, June 4, and July 2, 2008 that included the following medications: "Acetaminophen, Ascorbic Acid, Docusate liquid, Ferrous Sulfate, Furosemide, Hydralazine, Metoprolol Tartrate, Multivitamin Liquid, Ranitidine Hydrochloride, Simvastatin, and Insulin Novolin." There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On July 23, 2008 at approximately 3:55 PM, a face-to-face interview was conducted with Employee #3. He/she acknowledged that the record lacked a care plan for the potential adverse reactions for the use of nine (9) or more medications. He/she said, "I must have missed that." The record was reviewed on July 23, 2008. 3. The charge nurse failed to initiate care plans	L 051	#2, #3B and #4 Residents #4, 10 and 11 1. Unit manager initiated adverse reaction care plan for nine or more medications on Resident #4, 10 and 11 on 7/23/08. 2. All other residents identified on nine or more medications clinical records were reviewed for nine or more medications and care plan initiated as indicated. 3. Unit managers were inservice on initiating care plans for adverse drug reaction of nine or more medication by DON on 8/25/08. 4. Monthly review of POSs and MARs by the charge nurses during MAR check/ changeover and report in quarterly CQI.	09/08/08

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L 051	Continued From page 5 for Resident #10 for skin impairment and potential adverse drug reactions for the use of nine (9) or more medications. A. Facility staff failed to initiate a care plan for impaired skin integrity for Resident #10. Review of Resident #10 record revealed a "Nursing Admission Assessment Form" dated April 21, 2008. Under "Skin Assessment" a Stage II open blister was identified on the right forearm. A treatment order was obtained on April 21, 2008 and according to the April and May 2008 Treatment Assessment Record (TAR), the treatment was applied daily until May 5, 2008. On May 5, 2008 it was documented on the TAR that the wound was healed. There was no evidence that a care plan for impaired skin integrity with appropriate goals and approaches was initiated on April 21, 2008. The skin assessment dated April 21, 2008 was incomplete. On July 23, 2008 at 11:04 AM, a face-to-face interview was conducted with Employee #4. He/she acknowledged that a care plan for skin integrity should have been initiated. The record was reviewed on July 23, 2008. B. The charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications. A review of Resident #10's record revealed physician's 30 day orders dated July 2, 2008 to include the following medications: Ascorbic Acid, Aspirin, Diovan, Lipitor, Lisinopril, Lovenox, Metoprolol, multivitamin and Prevacid.	L 051	#3A Resident #10 1. Retrospectively unable to correct this error for resident #10. Unit manager inserviced on 7/25/08 by DON on initiating skin impairment care plan as indicated. 2. All other residents identified with potential for skin impairment clinical records were reviewed and an impaired skin integrity care plan was initiated as indicated. 3. Unit managers were inserviced on initiating skin impairment care plans on 8/26/08 by DON. 4. Random chart audits by Unit managers and MDS Coordinator for impaired skin integrity care plan report in quarterly CQI.	09/08/08

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L 051	Continued From page 6 There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On July 23, 2008 at 11:04 AM, a face-to-face interview was conducted with Employee #4. He/she acknowledged that a care plan for a potential adverse drug reaction for the use of nine (9) or more medications should have been initiated. The record was reviewed on July 23, 2008. 4. The charge nurse failed to initiate a care plan for potential adverse drug reactions for the use of nine (9) or more medications for Resident #11. A review of the clinical record for Resident #11 revealed physician orders dated and signed May 11, June 14, and July 12, 2008 that included the following medications: "Amlodipine Besylate, Antacid, Ascorbic Acid, Aspirin, Caduet, Clonazepam, Folic acid, Lisinopril, Metoclopramide, Multivitamin plus iron, Pantoprazole, Zinc Sulfate, and Selenium sulfide" There was no evidence in the record that a care plan with appropriate goals and approaches was initiated for the potential for adverse drug reactions for the use of nine (9) or more medications. On July 23, 2008 at approximately 3:55 PM, a face-to-face interview was conducted with Employee #3. He/she acknowledged that the record lacked a care plan for potential adverse drugs reactions for the use of nine (9) or more medications. He/she said, "I must have missed	L 051		

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L 051	Continued From page 7 that." The record was reviewed on July 23, 2008. 5. The charge nurse failed to update a care plan with goals and approaches for Resident #15, who was receiving a psychotropic medication. Signed and dated "Physician's Order Forms" revealed the following: May 5, 2008 - "Seroquel 25 mg 1 tablet by mouth every day for agitation behavior." June 4, 2008 - "Seroquel 25 mg 1 tablet by mouth every day for agitated behavior." July 2, 2008 - "Seroquel 25 mg po [By Mouth] 4 x weekly X 6 weeks than... Seroquel 25 mg 2 x weekly x 4 weeks start July 31, 2008 then D/C [discontinue after] 4 weeks." A review of the May, June, and July 2008 Medication Administration Record revealed that Seroquel 25 mg was initialed by the nurse [indicating that the medication was administered to the resident] as ordered. A review of the record lacked evidence that a care plan was developed with goals and approaches for Resident #15's use of a psychotropic medication. A face-to-face interview was conducted with Employee #3 on July 23 2008 at approximately 4:05 PM. He/she acknowledged that a care plan was not developed for the use of a psychotropic medication. The record was reviewed July 23, 2008. 6. The charge nurse failed to update care plan for an emergency dialysis plan for Resident #18. Physician's orders signed July 2, 2008, directed, "Dialysis on Tue, Thurs, Sat"	L 051	#5 Resident #15 1. Unit manager updated the psychotropic medication care plan for resident #15 on 7/23/08. 2. All other residents identified on psychotropic medications clinical records were reviewed and psychotropic medication care plan was updated as indicated. 3. Unit managers were inserviced on 8/26/08 by DON on updating care plan for residents with psychotropic medication. 4. Random chart audits by unit managers and MDS Coordinator for psychotropic medication care plan update and report in quarterly CQI. #6 Resident #18 1. Unit manager updated resident #18 dialysis care plan on 7/23/08 and placed an emergency dialysis kit at resident's bedside on 7/23/08.	09/08/08

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L 051	Continued From page 8 On July 23, 2008, at approximately 3:45 PM, the resident was observed sitting at beside in a wheelchair. There were no emergency devices in the room at the time of the observation. A review of the care plan "Renal Disease" last updated on July 3, 2008, lacked evidence of goals and approaches to address any emergency care or procedures. A face-to-face interview was conducted on July 23, 2008 at 3:50 AM with Employee #23. He/she acknowledged that resident did not have any emergency devices at the bedside. The record was reviewed on July 23, 2008. 7. The charge nurse failed to revise the care plans to meet Resident # 20's communication needs. A review of the clinical record revealed an "Alteration in Communication" care plan initiated December 19, 2007 and last updated June 25, 2008 as follows: "Problem Statement: Alteration in communication related to Language Barrier (from Africa) as evidenced by not speaking English. Goal #1: Resident will make needs known by using verbal and/or nonverbal communication, through next 90 days. Goal # 2: Resident will successfully make needs/wishes known: 90% of the time...". The approaches/Interventions for the two (2) goals are: "1. Use a variety of communication techniques	L 051	#6 cont. 2. All other residents identified receiving dialysis clinical records were reviewed and updated as indicated and an emergency dialysis kit was placed at bedside. 3. All licensed staff were inserviced by the Unit managers on 7/23/08 on an emergency dialysis plan and placing an emergency dialysis kit in resident's room and initialing on MAR. 4. Random dialysis care plan audit for present dialysis resident and new admission. Weekly room rounds by charge nurse to Ensure emergency dialysis kit is present and report in quarterly CQI. #7 Resident #20 1. A list of the most common ADL care needs words were interpreted into resident #20 native language and place on communication care plan 8/25/08 and placed on a communication card for everyday use by staff. 2. All other residents identified with communication/language barrier clinical records were reviewed and care plan was updated as indicated. 3. All staff inserviced on 8/25/08 by the Unit managers on Communicating with Residents with Communication/language barrier. 4. All new admissions will be assessed for communication/language barrier and a care plan initiated and staff inserviced on new admission's communication requirement in a timely manner report in quarterly CQI.	09/08/08 09/08/08

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L 051	Continued From page 9 appropriate to the resident: Signals and gestures, yes or no question. 3. Encourage expression of feelings, and encourage initiation of conversation by: Nonverbal gestures. 4. Validate meaning of nonverbal communication, examples: [No examples were given.] 5. Increase resident's opportunities for communication with others by: encouraging group participation." Approach #6 was added on March 25, 2008: "Utilize any/all staff (if avail) who speak same dialect." [No employee was identified on the care plan who spoke the same dialect.] The evaluation of the goals was first documented on March 25, 2008, "Resident's needs are being met ... Sometimes understanding poses a challenge - Continue care plan." The evaluation of the goals on June 25, 2008 documented, "Needs continue to be met despite no oral communication. Understands gestures and cues. Continue care plan. " A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on July 24, 2008. He/she acknowledged that the "Alteration in Communication" care plan lacked goals and interventions to determine whether the resident understood and/or was able to participate in planning his care or meeting his needs. The record was reviewed on July 24, 2008. 8. The charge nurse failed to update Resident # 21's care plan with appropriate goals and approaches for hospice.	L 051	#8 Resident #21 1. Unit manager updated resident #21 with the appropriate goals and approaches for Hospice care on 7/24/08. 2. All other residents identified on hospice care, care plans were updated as indicated.	

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L 051	Continued From page 10 A review of Resident #21's record revealed that the resident was admitted to the facility on June 10, 2008. The Physician Order Sheet and Plan of Care dated June 11, 2008 indicated "Do Not Resuscitate" under diagnosis and "Hospice Care" under discharge plan. A "Death with Dignity, Comfort and Support Care Plan" was initiated on June 10, 2008" . A telephone order dated June 23, 2008 indicated "Patient admitted to [...Hospice...]. A physician's progress note of June 24, 2008 stated, "Continue with Hospice care". There was no evidence in the record that the care plan was updated with additional approaches and interventions indicated on the signed admission order. A face-to-face interview was conducted with Employee #3 on July 24, 2008 at approximately 3:30 PM. He/she acknowledged that additional goals and approaches were not initiated after the resident was admitted to hospice care. The record was reviewed on July 24, 2008.	L 051	#8 cont. 3. All staff was inserviced on hospice care and care plans 8/20/08 by the Community Hospice Coordinator. 4. Unit managers and DON will review all resident's clinical records placed on hospice care to ensure hospice has provided a care plan within 72 hours of placement on hospice and report quarterly CQI.	09/08/08
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:	L 052		

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L 052	Continued From page 11 (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, staff interview and record review for four (4) of 25 sampled residents, it was determined that sufficient nursing time was not	L 052		

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L 052	Continued From page 12 provided to residents as evidenced by failing to: schedule a pacemaker check for one (1) resident, provide nectar thickened liquids for one (1) resident, and administer medication as per physician's order for two (2) residents. Residents #1, JH1, JH2 and JH3. The findings include: 1. The facility staff failed to follow physician's order for pacemaker checks for Resident #1. A review of Resident #4's record revealed a physician's order dated July 7, 2007 for "Pacemaker Check every six (6) months Jun and Jan by [name of company]." There was no evidence in the record that a pacemaker check had been performed since January, 2008. During a face-to-face interview with Employee #4 was conducted on July 23, 2008 at 3:07 PM. He/she acknowledged that the pacemaker check had not been done in June of 2008. The record was reviewed July 23, 2008. 2. Facility staff failed to provide nectar thick liquids in accordance with the physician's order for Resident JH2. On July 21, 2008, at approximately 9:20 AM, during the medication pass, the nurse was observed administering medications which included KCl 10 mEq capsule, Multivitamin tablet, Ferrous Sulfate tablet, Furosemide tablet and Lisinopril 40 mg tablet to Resident JH2, along with a cup of plain water. On July 21, 2008, at approximately 2:00 PM,	L 052	Resident #1 #1 1. Unit manager ensured that resident #1 pacemaker was checked on 7/25/08. 2. All other residents identified with pacemakers clinical records were reviewed for pacemaker check compliance and corrected as indicated. 3. Licensed staff and unit secretaries were inserviced on 7/23/08 by Unit manager on pacemaker check schedule and compliance. 4. Pacemaker resident names are to be listed on Unit manager's monthly audit form and report in quarterly CQI. #2 Resident #JH2 1. Charge nurse provided resident #JH2 medication draw with nectar/thickened liquid supplement for the next medication pass on 7/21/08. Charge nurse was inserviced 7/21/08 on following physician's orders and the physician was made aware the resident did not receive the nectar/ thickened liquid no adverse reaction to the resident. 2. All other residents identified with orders for nectar/thickened liquid medication draw was stocked with the supplement as ordered for	09/08/08

medication pass.

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L 052	Continued From page 13 during the reconciliation of the medication pass, a physician's order signed July 2, 2008 directed, "Start nectar thick liquid." A face-to-face interview was conducted with Employee #20 on July 25, 2008 at approximately 12:00 PM. He/she acknowledged that the medication was not given with nectar thickened liquids. The record was reviewed on July 21, 2008. 3. The facility staff failed to follow physician's orders for the administration of Lovenox injection for Resident JH2. On July 21, 2008, at approximately 10:00 AM, during the medication pass, the nurse was observed administering Lovenox injection to Resident JH3. Employee #21 was observed giving the entire amount of medication in the Lovenox syringe to the resident. During the reconciliation of the medication pass, it was discovered that the amounts of Lovenox injection given to resident JH3 was incorrect. The July 2008 physician's order form, signed June 28, 2008 directed "Lovenox 60 mg/0.6 syringe, Inject 0.5 ml (50 mg) sub-q every 12 hours for Deep Vein Thrombosis.". A face-to-face interview was conducted on July 21, 2008, at approximately 3:10 PM with Employee #21. After reviewing the resident's Medication Administration Record (MAR), Employee #21 stated that the physician ordered 60 mg/0.6 ml and the wrong amount of Levonx was administered to the resident. The chart was reviewed on July 21, 2008.	L 052	#2 cont. 3. All licensed staff was inserviced on 7/22/08 by the Unit manager on following the physician's orders on nectar/thickened liquids. 4. Random medication cart check for the presence of nectar/thickened liquids and report in quarterly CQI. #3 Resident #JH3 1. DON and Unit manager call pharmacy on 7/21 and 7/22, 2008 to clarify the correct dosage of Lovenox for resident #JH3. Charge nurse was inserviced on 7/21/08 on following the physician's orders and the physician was made aware of medication error on 7/21/08 and that there was no adverse reaction to the resident. 2. All other residents identified on Lovenox MARs were reviewed for the correct dosage and clarified as indicated. 3. Licensed staff was inserviced by the Unit manager on 7/21 and 7/22,2008 on the correct medication dosage administration. Licensed staff was observed during a medication pass for the correct dosage administration of Lovenox on 7/28/08 by DON, Unit manager and Inservice Coordinator. 4. Random medication pass observation by the Inservice Coordinator and report in quarterly CQI.	09/08/08 09/08/08

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L 052	Continued From page 14 4. The nursing staff failed to follow a physician's order for the administration of Senna-Gen (Senokot) tablets for Resident JH1. On July 22, 2008, at approximately 9:50 AM, during the medication pass, the nurse was observed administering one (1) Senna-Gen tablet to Resident JH1. On July 22, 2008, at approximately 2:20 PM, during the reconciliation of the medication pass, it was discovered that the incorrect medication was given. The physician's order form signed July 21, 2008 directed, "Senna w/Docusate (Pericolace) 8.6 mg / 50 mg, 1 tab by mouth every day for bowel regimen." A face-to-face interview was conducted with Employee #22 on July 22, 2008, at approximately 2:30 PM. He/she acknowledged that the incorrect medication was given to the resident. The record was review on July 22, 2008.	L 052	#4 Resident #JH1 1. Charge nurse was inserviced on 7/22/08 on following the physician's order for resident #JH1 and the physician was made aware of medication error on 7/22/08 and that there was no adverse reaction to the resident. 2. All other residents identified on Senekot medication draw were reviewed for the presence of the correct medication in the medication cart and pharmacy called as needed. 3. Licensed staff was inserviced by the Unit manager on 7/22,2008 on administrating the correct medication. Licensed staff was observed during a medication pass for the correct medication administration of Senekot and other medications on 7/28/08 by DON, Unit manager and Inservice Coordinator. 4. Random medication pass observation by the Inservice Coordinator and report in Quarterly CQI.	09/08/08
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 25 sampled residents, it was determined that the clinical record lacked evidence that a pillow paw protector [hand mitten] was the least restrictive device for Resident #10. The findings include: On July 23, 2008 at approximately 11:40 AM,	L 080	Resident #10 1. Unit manager called physician on 7/24/08 for clarification of the pillow-paw order for resident #10 and the order was discontinued. 2, All other residents identified prone to scratching themselves orders/MARS/care plan were reviewed and updated as needed or discontinued.	

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L 080	Continued From page 15 Resident #10 was observed lying in bed in his/her room with the pillow paw protector on the night stand next to the resident's bed. A face-to-face interview with Employee #17 was conducted on July 23, 2008 at 9:58 AM. He/she stated, "I don't apply the hand mitts, the nurses do. But [Resident #10] wears them every day." According to the "Restraint Use" policy and procedure No. 908, effective 09/19/00, "Orders for restraints will read as follows: Apply (type of restraint) for (reason) while (under what condition) for 90 days. Check for proper placement of restraint and condition of resident every 30 minutes. Release every two hours for at least ten minutes. Re-evaluate and document need for restraints every ninety (90) days." A telephone order dated May 2, 2008 and signed by the physician May 7, 2008, directed the following: "Pillow paw protectors to hands to prevent self-inflected scratches." The order was renewed on the July 2008 physician's orders signed July 2, 2008. There was no evidence that the physician addressed the following in the May 7 or July 2, 2008 orders regarding the pillow paw protectors: under what conditions, checking for proper placement of restraint, condition of resident every 30 minutes, and release (of restrained limb) every two hours for at least ten minutes A review of the July 2008 Treatment Administration Record [MAR] revealed that the physician's order for pillow paw protectors was documented as " FYI" (for your information) and not signed by the nurse to indicate that the pillow	L 080	3. All licensed staff was informed that pillow-paws are a form of restraints and inserviced on the Restraint Policy and Procedure on 7/24/08. 4. Residents with restraints are to be placed on the Unit manager's monthly audit form and reported in quarterly CQI.	09/08/08

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L 080	Continued From page 16 paw protectors were applied to the resident's hands. According to the "Restraint Authorization" policy and procedure No. 906, effective 09/19/00, " I give permission ... physically restrained due to ... I understand that the reevaluation of the need for this restraint will be done every ... to determine if continued restraint is necessary ... resident or the legal representative signature and date ..." The record lacked evidence that the "Restraint Authorization" was completed for the use of the pillow paw protector. The record lacked evidence of the following: there was no Interdisciplinary team [IDT] assessment for the resident's use of the pillow paw protector that the resident was unable to release/remove; there was no care plan developed with goals and approaches to address the use of the pillow paw proctor; there were no other devices and/or interventions that were tried prior to obtaining an order for a pillow paw protector to determine if the device was the least restrictive and no on-going attempts to reduce the restraint. On July 23, 2008 at approximately 11:04 AM, a face-to-face interview was conducted with Employee #4. He/She acknowledged that an IDT assessment was not done, the order was not clarified to include under what conditions the restraint was to be used, checking for proper placement of restraint and condition of resident every 30 minutes, release every two hours for at least ten minutes, re-evaluation and documentation need for restraints every ninety (90) days, no authorization from the legal representative, and no care plan to address the	L 080		

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L 080	Continued From page 17 use of the pillow paw protector. The record was reviewed on July 23, 2008.	L 080		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by soiled kitchen appliances. A tour of the kitchen was conducted on July 21, 2008 from 8:45 AM to 11:45 AM in the presence of Employee #8 and the findings were acknowledged at the time of the observations. The findings include: The following appliances were observed soiled in the main kitchen: A. Gas stove in one (1) of one (1) stove observed; B. Ovens in two (2) of two (2) ovens observed; C. Deep fryer in one (1) of one (1) deep fryer observed; D. Steamer in one (1) of one (1) steamer observed; E. Ice Machine in one (1) of one (1) ice machine observed.	L 099	1. All areas (ABCD) have been cleaned; the ice machine has been replaced and was installed on July 25, 2008. 2. Because other areas have the potential to be affected therefore other equipment items were inspected to ensure cleanliness and corrected as needed. 3. Cleaning schedules were instituted for the kitchen equipment. Inservice was done on 8/26/08 by Dietary supervisor on cleaning of appliances and ice machine. A. Gas stove top and tray will be cleaned after each meal and the supervisor will check daily before closing. B. Ovens will be cleaned weekly. C. Deep fat fryer will cleaned after each use and checked daily by the supervisor. D. Streamer will be cleaned daily and checked by the supervisor. E. Ice machine will be cleaned/inspected. 4. Cleaning schedules have been instituted to monitor equipment/areas. An audit of the system checks will be maintained by the Food Service Manager to ensure equipment/areas are in compliance. Results of the findings of the audits will be reported in the Quarterly CQI meeting.	09/08/08

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L 100	Continued From page 18	L 100		
L 100	3219.2 Nursing Facilities Each facility shall employ sufficient food service employees who are competent and qualified to carry out the functions of the dietary services. This Statute is not met as evidenced by: Based on observation, staff interview and record review, it was determined that the facility failed to ensure sufficient certified food handlers were present in the dietary department during the hours of operations These observations were made in the presence of Employee #8 on July 21, 2008 at 9:30 AM. The findings include: Upon review of the dietary staff records and daily schedule, it was determined that there were insufficient certified food handlers to ensure that proper sanitary techniques were being utilized on each shift. The food service schedule was reviewed from July 1 to July 21, 2008. Certified food service handlers were not scheduled for the following days and times: July 1, 2008 from 4:00 PM to 7:30 PM July 5, 2008 from 6:00 AM to 7:30 PM July 6, 2008 from 3:00 PM to 7:30 PM July 14, 2008 from 4:30 PM to 7:30 PM July 15, 2008 from 4:00 PM to 7:30 PM July 19, 2008 from 2:30 PM to 7:30 PM July 20, 2008 from 2:30 PM to 7:30 PM A face-to-face interview was conducted with Employee #8 at 9:30 AM on July 21, 2008. At the time of this review, he/she stated, "We don't have enough certified food handlers for weekends and one (1) evening during the week. I have three (3) employees scheduled to attend training on July	L 100	1. Dietary staff attended a Food Handler's Class on July 25, 2008. A schedule has been initiated to ensure there is adequate certified handlers during meal preparation. 2. All other staff records were reviewed to ensure compliance and classes have been scheduled as needed. 3. The Food Service manager has established system that will identify when each employee is eligible for the renewal of certification. 4. The Food Service Manager will audit personnel files monthly to ensure compliance. Findings of the audit will be reported in the Quarterly CQI.	09/08/08

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L 100	Continued From page 19 23, 2008. "	L 100		
L 205	3232.3 Nursing Facilities Summaries and analysis of incidents shall be reviewed at least monthly by the Administrator or designee in order to identify and correct health and safety hazards and patterns of occurrence. This Statute is not met as evidenced by: Based on record review and staff and resident interviews, it was determined that the facility failed to operationalize policies and procedures for identification, investigation and reporting of abuse, neglect, mistreatment and misappropriation of funds as evidenced by failing to: include verbal as a type of abuse in its policy and procedures, investigate injuries of unknown origin and report incidents of alleged abuse to the State Agency. The findings include: A review of the facility's abuse training program was conducted on July 25, 2008 at 1:25 PM with Employee #15. Employee #15 stated, "On hire, we do a background and reference check and we validate that the employee has a license or certificate. In orientation, we train the new employees on abuse and residents rights. Abuse training is done annually around the employee's anniversary date." Employee #15 referenced the document, "Summation of the Completion of the Mandatory Inservice Training for February - June 2008." According to this document, 63 employees were identified as eligible for training by their hire date. 37 employees had completed abuse training. 26	L 205		

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L 205	Continued From page 20 employees were beyond their annual hire date and had not attended an abuse training class at this time of this review. Employee #15 presented the following documents: " Resident Abuse, Neglect and Misappropriation of Property, Policy & Procedure No.117, 3/3/06 " , a " Resident Abuse " packet given to each employee during training, " Seven Steps to Preventing Abuse " , " Abuse Definitions " and a packet titled " Resident Abuse " including definitions and preventive actions. Types of abuse as defined in the above cited facility ' s policy included physical, psychological, sexual, financial, active neglect and passive neglect in section " IV -Identification. " Psychological abuse was defined as "The threat of injury, unreasonable confinement and punishment or verbal intimidation humiliation that may result in mental anguish such as anxiety or depression. Example- yelling, screaming or using demeaning language or ridicule. " There was no other type of abuse in the definitions that included an explanation of verbal abuse. There was no evidence in the above cited documents that indicated that verbal abuse was included as a type of abuse. In section " IV -Identification, physical abuse includes unexplained injuries or explanation inconsistent with medical findings, such as: fractures ... " There was no evidence that Resident #2's fracture of unknown origin, (reference CFR 483.13, F225 of this report) was investigated by the facility.	L 205	Residents #2, #19 and #22 1. Residents #2 Incident Report was faxed on 6/4/08, Resident #19 Incident Report was faxed on 7/25/08 and Resident #22 Incident Report was faxed on 9/09/08. Staff involved in these incidents were inserviced on these specific residents on 8/6/08. 2. All other residents identified with reported injuries of unknown origin, compliant of inappropriate verbal exchange or violation of resident's rights will be investigated and reported in the designated time frame to the Department of Health. 3. All staff was inserviced by the Inservice Coordinator on Investigating and Reporting Incidents of Alleged Abuse and Injuries of Unknown Origin on 8/6/08, 8/7/08, 8/8/09 and 8/9/08. 4. Review Incident Reports and complaints as they occur and investigate in a timely manner and report to Department of Health and report in Quarterly CQI meeting.	09/08/08

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L 205	Continued From page 21 According to section " VII: Reporting/Response 1. All alleged violations concerning abuse, neglect or misappropriation of property are reported immediately to the Administrator/Designee and other enforcement agencies, according to state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities). " The above cited incidents for Residents #2, 19, and 22 were not reported to the State Agency. The facility failed to include verbal as a type of abuse in section " IV Identification " of the abuse policy and procedures, and in all additional documents that included definitions of types of abuse. The facility failed to investigate an injury of unknown origin and report incidents of alleged abuse to the State Agency.	L 205		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff and resident interviews for five (5) of 25 sampled residents, it was determined that facility staff failed to: identify, investigate and report to the State Agency injuries of unknown origin, potential abuse violations. Residents #1, 2, 6, 19 and 22.	L 206		

Revised POC JR 9/9/08

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L 206	Continued From page 22 The findings include: 1. Facility staff failed to investigate injuries of unknown origin and to report them to the State Agency for Resident #1. A review of Resident #1's clinical record revealed the following: Review of the nurses' progress notes: May 11, 2008 at 6:00 PM: "...Resident noted with superficial scratches on the (RT) [right] forearm and hematoma on (RT) [right] hand ..." May 17, 2008, no time noted: "...Residents showing S/S [signs and symptoms] of pain about 5:00 PM. Resident's son was the one that reported Tylenol 160 mg/ml was given as per order for pain. MD [Medical Doctor] made aware. Order received for X-ray to (L) site of ribs." May 19, 2008 at 3:00 PM: "Radiology [name] called and reported X-ray revealed FX [fracture of (L) [left] 7th Rib." June 3, 2008 at 9:30 PM: " ... writer was called by CNA observe an old bruise under the ® eye of the resident ..." A physician's order dated May 19, 2008 at 3:00 PM directed "... Bone density test ...R/O [rule out] Osteoporosis." The bone density test was completed May 27, 2008 with results documented as "Within Normal Limits." According to a Nurse Practitioner's progress note dated June 4, 2008 at 12:00 Noon, "....asked to evaluate resident with newly developed bruise under ® [right] eye ... R [right] eye secondary?	L 206	#1, #2, #3, #4 and #5 Residents #1, 2, 6, 19 and 22 1. Resident #1 Incident Report was faxed on 6/4/08. Resident #2 Incident Report was faxed 7/25/08. Resident #6 Incident Report was faxed 7/22/08. Resident #19 Incident Report was faxed on 9/09 /08 and resident #22 Incident Report was faxed on 9/09/08. Staff involved in these incidents were inserviced on these specific residents on 8/6/08. 2. All other residents identified with reported injuries of unknown origin, compliant of inappropriate verbal exchange or violation of resident's rights will be investigated and reported in the designated time frame to the Department of Health.. 3. All staff was inserviced by the Inservice Coordinator on Investigation and Reporting Incidents of Alleged Abuse and Injuries of Unknown Origin on 8/6/08, 8/7/08, 8/8/09 and 8/9/08. 4. Review Incident Reports and complaints as they occur and investigate in a timely manner and report to Department of Health and report in Quarterly CQI meeting.	09/08/08

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L 206	Continued From page 23 X-ray of ® orbital bone; Hold Plavix X 5 days; CBC, PT (prothrombin time)/INR (international normalized ratio) in am; Ice Pack Q Shift for 5 minutes X 5 Days." June 5, 2008 PT result was 10.8 [range 9.6-12.7 secs] and the INR result was 1.0 [range .8-1.1]. Resident observed lying in bed on July 24,2008 at 11:00 AM. Resident and bedding were clean. Resident was not responsive to verbal communication. The resident was restless and flayed his/her hands when touched by staff attempting to replace his/her arm band. Face-to-face interview with Employee #17 was conducted on July 24, 2008 at 11:10 AM. Employee #17 stated, "The resident does not move in bed. [The resident] is a fighter and does not like to be touched. [Resident #1] will kick and fight." When asked if staff had received training on handling difficult residents, Employee # 17 responded: "When a resident is combative at least 2 people are to provide care." A face-to-face interview was conducted on July 24, 2008 at 3:07 PM with Employees #4. Employee #4 stated, "I talked to the staff regarding the above incidents but did not document the investigation. I was concerned about the number of injuries so I started to give all the staff inservices on abuse." Employee #4 could not confirm that reports of the above incidents were sent to the State Agency either by facsimile, electronic mail or letter mail. The record was reviewed on July 24, 2008. 2. Facility staff failed to report an injury of unknown origin for Resident #2 to the State Agency.	L 206		

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	HFD02-0011	A. BUILDING _____ B. WING _____	07/25/2008

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L 206	Continued From page 24 A review of Resident #2's clinical record revealed the following: A nurse's note dated April 25, 2008 at 4:45 PM documented " ...CNA [Certified Nursing Assistant] assisted resident with ADLs [Activities of Daily Living] observed Left thumb to be swollen [with] redness and painful. No skin breaks to the thumb or surrounding areas. Hand warm to touch. Placed call to PMD [Primary Medical Doctor]. Orders given Motrin PRN, X-rays. Place call to RP [Responsible Party] ..." April 25, 2008 at 5:00 PM,"X-ray results...fracture of the left thumb. MD was called ..." An incident investigation completed by Employee #3 on April 29, 2008, and was reviewed. The report was addressed to the attention of the State Agency. There was no evidence in the record that the above cited injury was reported to the State Agency. An interview was conducted on July 25, 2008 at approximately 10:00 AM with Employees #1, 2, and 3. These employees could not confirm the report was sent to the State Agency either by facsimile, electronic mail or letter mail. The record was reviewed on July 25, 2008. 3. Facility staff failed to report an injury of unknown origin to Resident #6 to the State Agency. A review of Resident #6's clinical record revealed the following: A nurse's note dated July 21, 2008 at 10:30 AM documented " Res. noted with bruising (L) knee	L 206		

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L 206	Continued From page 25 and (R) thigh with dark appearance. No opening/drainage noted. PMD [Private Medical Doctor] notified, labs ordered - family notified." A face-to-face interview was conducted with Employee # 2 at approximately 2:00 PM on July 23, 2008. He/she acknowledged that the report was not sent to the State Agency. The record was reviewed on July 23, 2008 4. Facility staff failed to identify and investigate Resident # 19's right swollen hand (from wrist to finger) as an injury of unknown origin and report the injury to the State Agency. A review of Resident #19's clinical record revealed the following nurses' notes: May 31, 2008 at 7:00 PM:"...Resident noted with right swollen hand from wrist to finger ...no redness noted, verbalized no pain at this time. ROM WNL [Range of Motion Within Normal Limit]....order received for X-ray to be done." June 1, 2008 at 10:30 PM:"...Stable and verbally responsive. X-ray result read negative for fracture. Resident denied pain." A review of the facility's incident/ unusual occurrence reports failed to reveal that the resident's swollen right hand and fingers were documented or investigated. A face-to-face interview was conducted with Employee #3 on July 23, 2008 at approximately 2:30 PM. He/she stated, "I did not consider this as an unusual incident/occurrence." 5. Facility staff failed to identify, report and investigate potential verbal abuse towards	L 206		

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L 206	Continued From page 26 Resident #22. The following face-to-face interview was conducted on July 21, 2008 at 2:00 PM with Resident #22: He/she stated that staff didn't always talk to [him/her] in the proper way. "They [staff] try to get back at me because I speak up" The resident then presented a letter that had been written to the facility Administrator by his/her attorney and legal guardian on June 22, 2008. The letter referenced the reporting of a formal complaint to the facility Administrator, Director of Nursing and the Social Worker regarding an incident that occurred on Saturday, June 21, 2008 involving the resident , the guardian and a certified nursing assistant (CNA). The letter referenced the following: " ...On Saturday, June 22, 2008, I was visiting [Resident #22] in his/her room [#]. During my visit, I asked that [he/she] be cleaned due to a strong odor that was emanating from [him/her] as well as [his/her] roommate. The odors appeared to be Human Waste that had been on the patients for some time during the day. The nurse was contacted and in response, [Employee #16] was sent in reply. ..I indicated to [Employee #16] that [Resident #22's] Diaper needed to be changed before he/she could eat dinner. [Employee #16] indicated to me, in so many words that the odor was not human waste but [Resident #22's-] mouth, meaning bad breath, and body odor and that [his/her] diaper did not need changing and [he/she] did not need cleaning. When I insisted that [Resident #22] be cleaned, [Employee #16] refused ...After waiting more than 15 minutes [Employee #13] did	L 206		

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L 206	Continued From page 27 respond and handle the situation ..." A face-to-face interview was conducted on July 23, 2008 at 5:05 PM with Employees #1, #2 and #3. When queried regarding the above stated incident, it was determined that the facility did not investigate this incident as potential alleged abuse and did not report this incident to the State agency. Employee #1 stated, "I saw this as disrespect to the resident's attorney." Additionally, Employee #1 stated that Employee #16 left his/her assignment on June 22, 2008 and the facility when he/she found out about the letter from the resident's attorney and was later terminated for desertion. Employee #2 responded that it was investigated by HR [Human Resources] as inappropriate behavior of the CNA toward the attorney. He/she stated, "I did not view this incident as abuse." Employee #3 stated: "I feel that it was a confrontation between the CNA and the attorney and I did not do a written investigation. It was given to Human Resources for follow-up." A face-to-face interview was conducted on July 25, 2008 at 2:10 PM with Employee #13. He/she stated, " I told [Employee #16] that the customer is always right and we have to say we are sorry, even if we don't think we are wrong. [Employee #16] didn't want to say [he/she] was sorry. Employee #16 always felt that [he/she] was being disrespected. [Employee #16] finally came around cleaned the resident and shook hands with the attorney." When Employee #13 was queried regarding the	L 206		

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L 206	Continued From page 28 above incident as representative of verbal abuse, his/her response was, "The way it came to me ... I didn't view it as an abuse situation. I thought it was a communication problem. When [Employee #13] was queried as to what constitutes abuse, he/she stated, "Abuse can be verbal or physical. I didn't detect any in this situation." When asked about abuse training, Employee #13 responded, "I'm not aware that we had it." When asked about writing an incident report, Employee #13 stated, "I didn't write an incident report because I thought it was over." When asked about Employee #16's comment regarding the resident's mouth, Employee #13 replied, "I had heard that before ...it wasn't the first time I'd heard about [his/her] breath." Employee #13 was asked if the resident heard these comments. He/she replied, " Yes, these comments were made in the presence of the resident." A face-to-face interview was conducted on July 25, 2008 at 1:25 PM with Employee #15. He/she stated, "On hire, we do a background and reference check and we validate that the employee has a license or certificate. In orientation, we train the new employees on abuse and residents rights. Abuse training is done annually around the employee's anniversary date." Employee #15 was asked how many of the current staff had received abuse training. Employee #15 referenced the document, "Summation of the Completion of the Mandatory Inservice Training for February - June 2008." According to this document, 63 employees were	L 206		

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L 206	Continued From page 29 identified as eligible for training by their hire date. 37 employees had completed abuse training. 26 employees were beyond their annual hire date and had not attended an abuse training class at this time of this review. Employee #15 presented the policy and educational hand -outs that were used to train staff. Absent from the educational handouts was a definition of verbal abuse. Employees #1, 2, and 3 failed to recognize potential resident abuse in this reported incident and to investigate as potential abuse and to report this incident to the State	L 206		
L 247	3238.3 Nursing Facilities Each room that is used by a resident shall be maintained at a minimum temperature of seventy-one degrees Fahrenheit (71°F) and a maximum of eighty-one degrees Fahrenheit (81°F) at all times when the room is occupied. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility failed to maintain comfortable and safe temperature levels in the range of 71 degrees Fahrenheit (F) and 81 F. The findings include: Facility temperatures were observed as follows: July 24, 2008 at 12:30 PM the temperature was 85.6 F in the 3rd floor lounge. July 24, 2008 at 12:45 PM the temperature was 85.8 F in the 3rd floor dining room two (2) residents were eating in the dining room at the	L 247	A. 1. New Air Conditioning units were installed by the Maintenance staff on the 2nd floor and 3rd floor lounge August 27-28, 2008. 2. All other day rooms were checked by Maintenance staff to ensure compliance and corrected as needed. 3. Maintenance staff will conduct monthly rounds to ensure compliance. 4. Findings will be reported in the Quarterly CQI meeting.	09/08/08

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L 247	Continued From page 30 time of the observation. July 25, 2008 at 10:55 AM, the temperature was 85.2 F in the 3rd floor dining room at the time of this observation three (3) residents and two (2) facility staff members were present in the dining room. July 25, 2008 at 11:02 AM, the temperature was 85.1 F in the 2nd floor dining room. These observations were made in the presence of Employee #15 who acknowledged these findings at the time of the observations. A face-to-face interview was conducted with Employee #1 on July 25, 2008 at approximately 1:00 PM. He/she acknowledged that the temperatures in the 2nd and 3rd floor lounge and dining areas were high. Employee #1 stated, "We [the facility] are installing new units on the roof. The units [staff on the units] were instructed not to place residents in the dayrooms."	L 247		
L 314	3246.5 Nursing Facilities If the room is not for single occupancy, each bed shall have flameproof ceiling suspended curtains which extend around each bed in order to provide the resident total visual privacy, in combination with adjacent walls and curtains. This Statute is not met as evidenced by: Based on observation and staff interview for one (1) of 25 sampled residents, facility staff failed to promote Resident #5's dignity during a skin observation; and during the environmental tour it was observed that 18 of 27 privacy curtains in residents' rooms failed to provide complete visual privacy. These observations were made in the presence of Employees #3, 4, 5, 6, 15, and 16. The findings include:	L 314		

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L 314	Continued From page 31 A. On July 25, 2008 at approximately 10:45 AM, facility staff failed to pull the privacy curtain completely around Resident #5's bed [bed B] located near the window, to provide complete visual privacy during a skin observation. His/her roommate was seated in a chair between A and B beds at this time of the observation. Resident #5's lower body was completely exposed. A face-to-face interview was conducted with Employee #18 immediately after the procedure. Employee #18 stated, "The curtain is short and if I pulled it all the way it would have been open at the other end and the roommate would have been able to see everything from where [he/she] was sitting." He/she acknowledged that the curtain was not pulled completely around the resident's bed during the procedure. B. During the environmental tour conducted on July 22, 2008 from 9:00 AM through 11:52 AM, privacy curtains in the following rooms were observed to be too short in width to provide complete visual privacy for residents during personal care: 110 A and B beds, 111 A and B beds, 138 A and B beds, 144 A bed, 121 A bed, 211 A and B beds, 212 B bed, 213 A bed, 218 B bed, 242 B bed, 244 A bed, 310 A bed, 318 B bed and 338 B bed in 18 of 27 rooms observed. The findings were acknowledged at the time of the observations.	L 314	#A. Resident #5 1. Unit manager called housekeeping on 7/22/08 to get wider privacy curtain for resident #5. Curtain was exchanged on 7/28/08. 2. All other residents rooms were checked and privacy curtains were ordered. Privacy curtains were replaced on 9/08/08. 3. All staff was inserviced on 7/28/08 concerning Privacy and Dignity for All Residents by unit managers. 4. Unit rounds by Unit Managers and Housekeeping staff will be conducted bi-weekly to ensure proper fitting of privacy curtains and reported in Quarterly CQI. #B. 1. Privacy curtains have been ordered for the room numbers 110A and B, 111A and B 138A and B, 144A, 121A, 211A and B, 212B, 213A, 218B, 242B, 244A, 310A, 318B, and 338B that were identified during the survey. 2. All resident rooms have been checked for proper fitting curtains and replacement curtains were installed on9/08/08. 3. The Environmental Service Manager and/or Supervisor will conduct environmental rounds/audit on a bi-weekly basis to ensure Privacy curtains are in compliance. 4. Findings of environmental rounds will be reported in the Quarterly CQI meeting.	09/08/08 9/08/08
L 410	3256.1 Nursing Facilities	L 410		

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L 410	Continued From page 32 Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: damaged and/or marred/scarred baseboards, walls, shower room tiles and odors detected in resident areas. The environmental tour was conducted on July 22, 2008 from 9:00 AM through 11:52 AM in the presence of Employees #3, 4, 5, 6, 15, and 16. The findings include: 1. The following items/areas were observed marred/scarred: A. The first floor day room walls in one (1) of three (3) day rooms observed. B. Arm chairs in the first floor day room in seven (7) of seven (7) chairs observed. C. Entry doors to the first floor day room in two (2) of two (2) entry doors observed. 2. The following items/areas were observed damaged: A. Walls in the 2nd floor day room in one (1) of three (3) day rooms observed. B. Baseboards in the 2nd floor day room in one (1) of three (3) day rooms observed. C. Floor tiles were damaged in the 1st floor and 3rd floor shower room in two (2) of three (3) shower rooms observed.	L 410	1. The areas identified below as marred and scarred were corrected on 8/29/08. A. Walls have been repaired/painted. B. Chairs have been replaced. C. Entry doors have been repaired/painted. D. Floor tiles in the 1st and 3rd floor shower Rooms have been repaired. E. Baseboards in the 2nd floor dayrooms have been replaced. F. Area around the Nurses Station was cleaned and disinfected. 2. The Environmental Service and Maintenance staff has conducted a facility wide check to ensure that the walls, floors, baseboards, and equipment are in good/functional. Repairs were made as needed. 3. Maintenance staff will conduct random monthly Preventative Maintenance audits on equipment and repair as needed. The Environmental Service Manager/Supervisor will conduct monthly audits on the various areas to ensure cleanliness. 4. The findings of the audits will be submitted to the Quarterly CQI.	9/08/08

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L 410	Continued From page 33 3. Urine odors were detected on the first floor near the nurses' station on July 21, 2008 at 11:50 AM.	L 410		
L 421	3256.12 Nursing Facilities Each building, each piece of equipment, and the grounds shall be regularly maintained and attended. This Statute is not met as evidenced by: Based on observations during the inspection of the main kitchen, it was determined that the facility failed to maintain the ice machine in a safe operating condition. The findings include: On July 21, 2008 at 9:00 AM, the ice machine in the main kitchen was observed with rust build-up on the tray and chute. This ice machine provided ice for the entire facility for residents' consumption. This observation was made in the presence of Employee #8, who acknowledged the findings at the time of the observation.	L 421	1. The ice machine that in the main kitchen was replaced 7/25/08. 2. Director of Food Services has initiated a cleaning schedule for the ice machine. 3. Inservice was given by Director of Food Service to Dietary staff on 8/27/08 on Properly cleaning of the ice machine. 4. Monitoring of ice machine will be conducted monthly and findings reported to Quarterly CQI.	09/08/08
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations and staff interview during the survey period, it was determined that the facility failed to maintain a pest free environment. The findings include:	L 426		

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L 426	Continued From page 34 Pests were observed in the following areas: July 21, 2008 at 8:45 AM, gnats in the main kitchen July 21, 2008 at 9:00 AM, gnats in room 238. July 22, 2008 at 9:45 AM, gnats in room 144. July 22, 2008 at 10:46 AM, gnats in the 1st floor hallway near the dining room. July 22, 2008 at 11:59 AM, gnats in room 129. July 22, 2008 at 4:00 PM, gnats in room 318. July 23, 2008 at 10:25 AM, fly in room 242. July 24, 2008 at 11:24 AM, gnats on the 1st floor near the nurse ' s station. A face-to-face interview was conducted with Employee #16 on July 22, 2008 at 10:50 AM. He/she stated, "[A pest control company] comes to spray every week. We still have some problems with flying insects." These observations were made in the presence of Employees #3, 4, 5, 8 and 16 who acknowledged the findings at the time of the observations. This is a repeat deficiency from the re-certification and licensure survey December 6, 2007.	L 426	1. The areas identified during the survey: kitchen, Rooms 238, 144, 129,318, 242, 1st floor hallway and Nursing Station were cleaned and trash removed. The Pest Control Contractor visited during the survey for extermination purposes. 2. The Environmental Service Manager has checked other resident rooms for insect and trash removal and/or extermination. Trash cans are cleaned weekly and as Needed to prevent further occurrences. 3. The Environmental Service Manager inserviced the EMS staff 8/27/08 on trash removal, cleaning of the trash containers and proper cleaning techniques in resident rooms and other common areas. 4. Weekly rounds/audits will be conducted by Director of Environmental Services. Findings of the rounds/audits will be Reported in the quarterly CQI meeting.	09/08/08