Revised to 4/4/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT PARK CARE CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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L 000	Initial Comments An annual licensure survey was conducted on February 3 through 11, 2008. The following deficiencies were based on observations, record reviews, and facility staff interviews. The sample included 30 residents based on a census of 242 residents on the first day of the survey and 32 supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for 14 of 30 sampled residents and three (3)supplemental resident, it was determined that	L 051	**L 051 3210.4 Nursing Facilities** 1. Resident #W4's PT/PTT/INR was repeated on 2/5/08, 2/6/08, 2/7/08 and 2/8/08. The MD was notified of laboratory results for all dates listed and new orders were noted. 2.Chart reviews will be conducted on residents receiving coumadin to ensure physician notification and follow through. 3. Licensed nursing staff will be reeducated on PT/PTT/INR lab results and documentation. Laboratory requests will be reviewed daily by the Director of Nursing or designee as part of the nursing administration meeting to ensure all ordered labs have been drawn. Nurse Managers will QI monitor daily X 2 weeks and then weekly to ensure ordered PT/PTT/INR orders have been drawn. 4. Findings will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months. #2 1. Resident W7 has been reassessed and an elopement care plan has been initiated. 2. A resident review will be conducted to identify residents at risk for elopement and to ensure care plans have been initiated and updated appropriately. 3. Licensed nursing staff and non-licensed staff will be reeducated on elopement risk assessment, elopement prevention and the elopement process. The nurse managers or designee will QI monitor daily X 2 weeks, weekly X 4 weeks, then monthly to ensure new admits are appropriately assessed for elopement risk and interventions are put in place for resident safety. 4. Results will be submitted to the facility Risk Management/Quality Improvement committee monthly X 12 months.	02/07/08 03/27/08 03/27/08 03/27/08 02/09/08 03/27/08 03/27/08 03/27/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 5-14-08

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L 051	Continued From page 1 the charge nurse failed to: notify the physician of PT/PTT/INR levels as ordered for one (1) resident, ensure that nursing interventions were implemented to provide adequate supervision for one (1) resident who eloped, ensure that Dialysis communication forms were completed and initiate and/or update the care plan with approaches and goals for one (1) resident who refused showers, one (1) resident for pain, one (1) resident for wandering, one (1) resident with a pacemaker, one (1) resident with fluctuating weights, one (1) resident with dehydration, two (2) residents with weight changes, one (1) resident for anemia, one (1) resident after the initial admission care plan, two (2) residents for behaviors, and one (1) resident for Coumadin and Aspirin and after physical assaults toward residents; and ensure that 10 residents were reweighed after a change in weight. Residents W4, W7, 4, 5, 7, 10, 13, 15, 17, 19, 20, 23, 24, 25, 26, 27 and W1. The findings include: 1. The charge nurse failed to notify the physician of PT/PTT/INR levels as ordered for Resident W4 with a recent history of vaginal bleeding. A review of Resident W4' s record revealed the following physician's telephone orders: January 22, 2008 at 3:15, " Appointment scheduled on Feb 1st @ 12:00 noon with [Doctor]. due vaginal bleeding @ [hospital name and address] " . January 22, 2008 at 1800 [6:00 PM], " (1) Increase Coumadin to 7.5 mg PO QD due to INR of 1.02 drawn today 1/22/08. (2) Repeat PT/PTT/INR in 3 days, call MD with results". The consultation for vaginal bleeding was done on February 1, 2008 and the assessment was	L 051	#3 1. Resident #4 has been re-weighed and the weight has been documented on the weight record. The Dietitian has taken action to address weight loss/gain for this residents. 2. A record review will be conducted on residents that have experienced weight gain or loss to ensure resident weights have been taken and documented on the weight record. 3. Licensed nursing staff and Dieticians will be reeducated on when to re-weigh residents and document on the weight record. The Dietitian will QI monitor weekly weights to ensure that re-weights have been completed and documented. 4. Findings will be submitted to the Risk Management/Quality Improvement Committee monthly X 12 months. #4A 1. Resident #5's Dialysis communication forms have been completed to include medications administered in dialysis on 12/6/07, 12/13/07, 12/15/07, 12/20/07, 1/8, 1/10, 1/12, 1/15, 1/17, 1/19, ,1/29 and 2/2/08. 2. A review of dialysis residents will be conducted to ensure dialysis communication forms are complete. Deficient forms will be returned to the Dialysis center for immediate correction. 3. Licensed nursing staff will be reeducated on effective dialysis communication as it relates to dialysis providing a complete listing of medications administered during dialysis. QI monitoring will be conducted by nurse managers/designee daily X 2 weeks, then weekly to ensure communication forms are completed properly. 4. Findings will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 2 Postmenopausal bleeding. The PT/PTT/INR was drawn on January 25, 2008. The levels were as follows: PT- 30.2 [normal range 12.2 -15.01] PTT - 41.6 [normal range 23.5 - 36] and INR - 2.77 [normal range 2.0 -3.0]. On January 25, 2008 the physician was not notified of the PT/PTT/INR results. There were no routine or standing orders for further PT/PTT/INR levels. A face-to-face interview was conducted with Employee #11 on February 8, 2008 at 10:15 AM. He/She stated, " Those are the evening supervisor's initials [written on the January 25, 2008 laboratory form]. The nurse would note on the lab [form] that the MD was made aware " . He/She acknowledged the absence of a notation on the laboratory form of notification of the physician and no orders for further PT/PTT/INR levels. A review of the record revealed that the physician was notified of all previous PT/PTT/INR levels and new orders for PT/PTT/INR levels were given at the time of notification. The physician wrote an order on February 4, 2008 as follows: "PT, PTT, INR in AM call MD/NP (Nurse Practitioner) with results " . The PT/PTT/INR levels were drawn on February 5, 2008. A nurse's progress note dated February 5, 2008 at 1:25 PM revealed, "Writer called NP and reported lab results PT - 76.6 PTT - 92.2 INR 9.21 - new orders given ... "	L 051	#4B 1. The care plan for refusal of showers was initiated on 2/8/08 for Resident #5. 2. Nursing will conduct a review of ADL worksheets to determine if other residents have refused showers. Residents identified will have care plans initiated to address refusal of shower. 3. Nursing staff will be reeducated on the process of caring for residents that refuse showers and initiating care plans for refusal of showers. The unit managers will conduct reviews of ADL sheets to ensure that residents who have refused showers have care plans and appropriate interventions in place. The Unit Manager, or designee, will QI Monitor daily X 2 weeks, weekly X 4 weeks and Monthly X 12 months. 4. Findings from the review will be reported to the Risk Management/Quality Improvement Committee for Review X 12 months. #5 1. Resident #7 has been discharged from the facility. 2. Nursing has conducted a review of residents who have complained of pain to ensure that a pain management care plan has been initiated. 3. Licensed Nursing Staff and Interdisciplinary Care Team members will be reeducated on the facility Pain Management policy and how to thoroughly complete a pain assessment/ observation and pain management care plans. The unit managers will QI Monitor pain management care plans to ensure care plans are effective and updated timely daily, M-F, X 2 weeks, weekly X 4 weeks, and monthly X 12 months. 4. Results of the review will be submitted to the Risk Management/Quality Improvement Committee for Review X 12 months.	02/08/08 03/27/08 03/27/08 03/27/08 02/18/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 3 The physician's telephone order on February 5, 2008 at 4:00 PM directed: "(1) Hold Coumadin until further notice (2) Give Vit K 10 mg IM x 1 dose now for PT - 76.6, INR 9.21 called in from the lab. (3) Repeat PT/INR daily x 3 days (4) Call NP/MD before resuming Coumadin (5) Monitor for bleeding/bruising, if any bleeding noted, send to Hospital (6) Monitor V/S (vital signs) q (every) shift x 3 days ". There had been no evidence of vaginal bleeding or bleeding from any other source since January 22, 2008. The record was reviewed on February 8, 2008. 2. The charge nurse failed to ensure that nursing interventions were implemented to provide adequate supervision for Resident W7 who had cognitive impairment and eloped from the facility. Resident W7's record revealed the following nurses' progress note: February 8, 2008 at 11:00 PM, "Resident left [facility] without the knowledge of staff. He/she was found at [street name] by security staff and brought to [facility] at 10:30 PM. Resident was assessed by writer. No visible injury observed at the time of assessment. V/S (vital signs) T (temperature) 98.4, P (pulse) 89, R (respirations), BP (blood pressure) 148/90 ... " The resident was admitted to the facility on December 7, 2007. The nurse's admission progress note dated December 7, 2007 at 10:00 PM included, "Alert, oriented to name, place and time." The resident was ambulatory. According to the admission Minimum Data Set assessment, the resident was coded in Section	L 051	#6 1. The care plan for Resident #15 has been updated to reflect the discontinuation of the Ferrous Sulfate. The care plan has also been discontinued. 2. A review will be conducted on residents who have medications that are discontinued. The care plans for these residents will be reviewed to make appropriate updates. 3. The licensed nursing staff will be reeducated on identifying residents who have discontinued medications and updating care plans as needed. QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months reviews by the nurse manager or designee to confirm compliance. 4. Findings from the review will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months. #7 1. The Dietitian has reviewed the medical record and the care plan for Resident #17 was updated on 3/8/08 to address the resident's weight gain. 2. A review will be conducted on residents experiencing significant weight gain to ensure care plans are updated to reflect weight gain. 3. The Dietitians and Interdisciplinary Care Plan Team members will be reeducated on the development and implementation of care plans to address weight gain. The Dietitian will complete QI Monitoring weekly X 4 weeks and monthly X 12 months to ensure weight gains have been care planned. 4. Findings from QI Monitoring will be submitted to the Risk Management/Quality Improvement committee X 12 months.	02/08/08 03/27/08 03/27/08 03/27/08 03/08/08 03/17/08 03/27/08 03/27/08

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L 051	Continued From page 4 B, "Cognitive Patterns" as having short term memory problems and modified independent cognitive skills for daily decision-making; Section G, " Physical Functioning and Structural Problems " as ambulating independently. A care plan dated December 8, 2007 included the problem, "Resident has Cognitive Impairment as evidenced by: Memory problems - short term, impaired ability to make daily decisions." A nurse's progress note dated December 8, 2007 at 3:30 PM included, "Resident alert but confused. He/she states that he/she is just visiting the facility and will be going home today. At dialysis he/she removed the tubing from the graft before the nurse could do so." The social service progress notes revealed the following: December 8, 2007 at 11:30 AM, "...He/she is alert but exhibits slight confusion. He/she ambulates independently ... He/she will be a long term resident secondary to need for supervision ..." January 1, 2008 at 2:50 PM, "Care conference held on this date with resident and his/her [family member] via phone. It was agreed that resident is not able to manage alone in his/her apt. therefore, he/she will vacate his/her apt. and become a long term resident at [facility]." The "Incident/Accident" Report dated February 8, 2008 included the following: "Resident's condition before incident/accident - confused .... 6:30 PM Resident left [facility] without signing out. Resident stated that he/she was going to work. Resident returned at 10 by [facility] security. A&O (alert and oriented) x 2."	L 051	#8 1. Resident #19 has been discharged from the facility. 2. Nursing will conduct a review of medical records to ensure care plans address the residents' current diagnoses. 3. Licensed nursing staff and Interdisciplinary Care Plan Team Members will be reeducated on the development of care plans with goals and approaches for residents with multiple medical problems. Nurse managers or designee will QI Monitor medical records daily, M-F, X 2 weeks, Weekly X 4 weeks, and monthly X 12 months to ensure care plans appropriately address residents with multiple problems. 4. Results of the review will be submitted to the Risk Management/Quality Improvement Committee for Review X 12 months. #9 1. A care plan was initiated for Resident #20 to address wandering. 2. A review of records for residents exhibiting wandering behavior will be conducted to verify care plans are in place to address wandering behavior. 3. Licensed nursing staff will be reeducated on identifying wandering behavior and initiating care plans with appropriate goals and approaches. Nursing managers or designees will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months of residents identified as wanderers to ensure care plans are in place. 4. Findings from the QI Monitoring will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 02/06/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 5 A face-to-face interview was conducted with Employee #4 on February 8, 2008 at approximately 12:00 PM. He/she stated, "[Resident] went home, was discharged but [he/she] wasn't taking [his/her] medications and was readmitted. [He/she] was found near the subway station by a security guard who was riding by and though [he/she] looked familiar. [Security guard] called out his/her name and [resident] responded to [his/her] name." There was no evidence that facility staff initiated interventions to increase the monitoring of Resident W7, after identifying that the resident was cognitively impaired, confused and had stated that he/she was " going home " prior to the resident ' s elopement. The record was reviewed on February 8, 2008. 3. The charge nurse failed to update Resident #4's care plan with goals and approaches after weight loss. A review of Resident #4's record revealed the "Weight Record" which included the following weights: August 15, 2007 - 148.2 pounds (lbs) September 19, 2007 - 132 lbs October 10, 2007 - 143 lbs The resident's weight loss was 8.9% in September, 2007 and weight gain of 9.2% in October 2007. The care plan included the problem, " Resident at Risk for Aspiration Due to Resident Receiving Nutrition By: G/T (Gastrointestinal Tube) was dated March 16, 2007. One of the approaches listed was " 3) Monitor weight q (every) month	L 051	#10 1. A care plan was developed to address the pacemaker for Resident #24 on 2/18/08. 2. Nursing will conduct a review of residents with pacemakers to ensure an appropriate care plan is in place to address the device. 3. Nursing Staff and Interdisciplinary Care Plan Team members will be reeducated on ensuring care plans are in place for residents with pacemakers. Nurse managers and designee will conduct QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months to ensure residents with medical devices such as pacemakers have care plans in place. 4. Findings from the review will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months. #11 1. The care plan for Resident #26 was updated with new approaches. 2. Social services staff will complete review of charts on residents who have had aggressive behavior to ensure that care plans are current and that they show a progression of goals and intervention. 3. Social services staff will be reeducated on the importance of keeping care plans current and up to date. Social services will perform QI Monitoring of aggressive behavior care plans to ensure that they reflect current goals and approaches, daily, M-F, X 2 weeks, weekly X 4 weeks, and monthly X 12 months. 4. Findings from QI Monitoring will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	02/18/08 03/27/08 03/27/08 03/27/08 02/10/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 6 and prn, report loss or gain of 5% to M.D. and R.P " The care plan was signed as last reviewed on September 20, 2007 with an entry, "Feeding status unchanged." A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 10:22 AM. He/She acknowledged that the care plan was not updated after the weight loss. The care plan was not updated to include the weight loss or the recommended addition of DiabetaSource AC, at 5:00 AM initiated September 2007 to prevent weight loss. The record was reviewed on February 4, 2008. 4. The charge nurse failed to ensure that Dialysis communication forms were completed and develop a care plan for Resident #5 who frequently refused showers. A. A review of the resident's Dialysis communication forms revealed the following: The forms were not consistently completed for medications administered at the dialysis center on the following dates: December 6, 13, 15 and 20 2007. January 8, 10, 12,15,17,19, and 29 2008 and February 2, 2008. A face-to-face interview was completed with employee #13 on February 5, 2008 at approximately 10:45 AM. He she acknowledged that facility staff failed to ensure that the dialysis center completed the communication log for Resident # 5.	L 051	#12 1. A care plan to address Resident #27's fluctuating weight was initiated on 2/10/08. 2. The Registered Dietitian will complete an review of residents that have experienced recent fluctuations in weight verify the weight problem has been care planned. 3. The Dietitian and licensed nursing staff will be reeducated on how to create and implement effective care plans for residents with fluctuating weights. QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months will be conducted by the nurse managers to ensure care plans are in place for residents with fluctuating weights. 4. Results from the reviews will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months. 13 A 1. The resident identified in this report as Resident W1 is Resident W2. Resident W2 has been seen by the psychiatrist on 2/7/08. Resident was placed on one to one monitoring during waking hours (approximately 16 hours/ day) X 1 week, until psychiatrist review determined 1:1 no longer necessary for resident safety, instead resident to be monitored with frequent checks. 2. Social services staff will complete review of charts on residents who have had aggressive behavior to ensure that care plans are current and that they show a progression of goals and intervention. 3. Social services staff will be reeducated on the importance of keeping care plans current and up to date. Social services will perform QI Monitoring of aggressive behavior care plans to ensure that they reflect current goals and approaches, daily, M-F, X 2 weeks, weekly X 4 weeks, and monthly X 12 months. 4. Findings from QI Monitoring will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	02/10/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 7 B. On February 6, 2007 at 9:10 AM, Resident #5 was observed in the doorway of his/her room crying out refusing his/her shower. A face-to-face interview was conducted with Employee #13 on February 6, 2008 at 9:12 AM. He/She stated,"[Resident] refuses showers. Today is his/her shower day. I told the CNA to give him/her a bed bath. [Resident] doesn't like sitting on the chair. It s not showers, it's the chair. That's it, it's not the bath. [Resident] said okay to the bath." Employee #13 acknowledged that there was no care plan developed for the resident's refusals of showers. The Activities of Daily Living Care Records for September, October, November and December 2007 and January and February 2008 included two (2) showers given to the resident, September 28, 2007 and February 2, 2008. A review of the record failed to show documented evidence of development of a care plan with goals and approaches for the resident's refusal of showers. The record was reviewed on February 6, 2008. 5. The charge nurse failed to develop a care plan for Resident #7 for the management of pain. A review of Resident #7's record revealed that the resident was admitted to the facility on February 1, 2008. The History and Physical dated February 2, 2008 included the following diagnoses: Breast Cancer with metastasis, Chronic Obstructive Pulmonary Disease, Pulmonary Embolus, Obesity, Diabetes Mellitus, Hypertension and Dyslipidemia.	L 051	13B. 1. The care plan for Resident W2 has been updated to include Warfarin and the discontinuation of Aspirin. 2. A record review of all residents at risk for increased bleeding was conducted by the nurse managers or designee to ensure care plans were updated to reflect changes in physician orders for blood thinning agents. 3. The licensed nursing staff will be reeducated on identifying residents who are at risk for increased bleeding and updating care plans following order changes for blood thinning agents. QI Monitoring will be conducted daily X 2 weeks, weekly X 4 weeks and monthly X 12 months by the nurse manager or designee to confirm compliance. 4. Findings from the review will be submitted to the Risk Management/Quality Improvement Committee for review X 12 months. 14. 1. Residents #4, #5, #10, #13, #17, #23, #24, #25, #27 and W1 have been re-weighed and the weight has been documented on the weight record. The Dietitian has taken action to address weight loss/gain for these residents. 2. A record review will be conducted on residents that have experienced weight gain or loss to ensure resident weights have been taken and documented on the weight record. 3. Licensed nursing staff and Dieticians will be reeducated on when to re-weigh residents and document on the weight record. The Dietitian will QI monitor weekly to ensure that re-weights have been completed and documented. 4. Findings will be submitted to the Risk Management/Quality Improvement Committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 051	Continued From page 8 The nurse's progress note [admitting note] dated February 1, 2008 at 2200 [10:00 PM] included, " ...Pt (patient) c/o (complained of) pain in the (Lt) rib cage and (Rt) shoulder. Pt on Morphine sulfate 15 mg for pain ..." The initial care plan dated February 2, 2008 included interventions checked for fall risk reduction and skin. Pain management was also included on the aforementioned care plan. However, no interventions were checked for pain management. A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 12:30 PM. He/She acknowledged that a care plan was not developed for pain management. The record was reviewed on February 4, 2008. 6. The charge nurse failed to update Resident #15's care plan after a change was made in the medication regimen. Resident #15's care plan included the problem, " History of Anemia: Resident currently takes iron supplement " . A review of the physician's order form for February 2008 which was signed by the physician on February 1, 2008 did not include an order for an iron supplement. A consultation report from the pharmacist dated May 11, 2007 recommended: " D/C (discontinue) ferrous sulfate " . The Nurse Practitioner signed the consultation on May 18, 2007 and wrote " D/C Ferrous Sulfate " . A face-to-face interview was conducted with Employee #15 on February 4, 2008 at	L 051		

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L 051	Continued From page 9 approximately 12:30 PM. He/She acknowledged that the care plan was not updated to include the discontinuation of the Ferrous Sulfate. The record was reviewed on February 5, 2008. 7. Facility staff failed to update Resident #17's care plan after changes in his/her weight. A review of the care plan problem, " Resident is on a Therapeutic Diet as evidenced by: N.A.S (no added salt) and low fat/cholesterol) " dated October 10, 2007 included the following approach: " 4) Weigh q mo./prn (every month/whenever necessary) - report 5% loss/gain to M.D. and R.P. " The " Weight Record " included the following weights: October 1, 2007 - 189 pounds (lbs) November 1, 2007 - 210.3 December 1, 2007 - 210.4 January 1, 2008 - 218.1 The resident's weight gain in November 2007 was 9% and 9.6% in January 2008. The care plan was last reviewed on January 7, 2008. However, there was no updates to include the changes in the resident's weight: 21.3 pound weight gain in November 2007 and a 7.7 pound weight gain in January 2008. 8. The charge nurse failed to develop care plans for Resident #19. Resident # 19 was admitted to the facility on December 17, 2007 with diagnoses of ESRD (End Stage Renal Disease), DM 2 (Diabetes Mellitus Type 2), HTN (Hypertension), Glaucoma, Colon Cancer and MRSA (Methicillin Resistant	L 051		

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L 051	Continued From page 10 Staphylococcus Aureus). An initial care plan dated December 17, 2007 was noted on the record. This care plan was checked for minimizing the risk of skin impairment and achieving a comfort level. Additional care plans were initiated for bowel and bladder incontinence dated February 4, 2008, There was no evidence that care plans with goals and approaches were initiated for the aforementioned diagnoses. A face-to-face interview was conducted with Employee #14 at approximately 3:00 PM on February 7, 2008. He/she acknowledged that there were no care plans identifying goals and interventions for the care of the resident. The record was reviewed on February 7, 2007. 9. The charge nurse failed to initiate a care plan for a resident that wandered within the facility. Resident #20. On February 4, 2008 at approximately 11:20 AM, Resident #20 was observed on the elevator and exiting on the first floor. When the elevator arrived at the first floor, the resident stepped off of the elevator. He/she was observed by facility staff and escorted back onto the elevator to be returned to the appropriate floor. A review of the psychiatric evaluation dated September 29, 2007 revealed, " ...Other Somatic Problems: ... Wandering- yes, within the facility ... " A review of the care plans last reviewed December 12, 2007 lacked evidence that a care plan was initiated with goals and approaches to	L 051		

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L 051	Continued From page 11 address the resident's wandering behaviors. A face-to-face interview was conducted with Employee #14 on February 6, 2008 at 10:15 AM. He/she acknowledged that the care plan was not amended to address the residents wandering behavior. The record was reviewed on February 6, 2008. 10. The charge nurse failed to develop a care plan for Resident #24 who had a pacemaker. The History and Physical dated May 11, 2007 included, " ...S/P Pacemaker ..." The January 2008 physician order sheet, signed by the physician on January 4, 2008, included, " F/U (follow up) ICD (Internal Cardiac Defibrillator [pacemaker]) check in 3 months due 2/28/08 ..." A review of the record failed to show documented evidence of the development of a care plan for the pacemaker. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at 2:50 PM. He/She acknowledged that there was no care plan developed for the pacemaker. The record was reviewed February 6, 2008. 11. The charge nurse failed to update Resident # 26's care plan with appropriate goals and approaches for the resident's agitated behavior. A review of the resident's record revealed the following nurses' notes: November 7, 2007 at 12:30 PM: "Resident remains alert and verbally responsive, noted with severe agitation ..." November 22, 2007 at 0700 (7:00 AM): "Resident	L 051		

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L 051	Continued From page 12 alert and verbally responsive. Severely agitated this [morning]. Cursing staff members and other residents." November 25, 2007 at 2:25 PM: "Writer called to assess resident's behavior. Resident hit [another resident] on the head ... " December 5, 2007 at 8:00 AM: "Resident alert and verbally responsive. Noted with agitation (calling residents and staff [names]) ...attempting to hit staff/residents ..." December 4, 2007 at 2:45 PM: "Resident remains alert and verbally responsive. Noted with severe agitation, running after staff/residents to hit ... " December 11, 2007 at 0600 (6:00 AM): "Resident alert and verbally responsive ...severely agitated during this shift. Pulled Fire alarm, hit writer on the right side of the head ...Ativan 1 ml IM [intramuscular] given ...per [physician] order, effective..." A review of the care plan problem dated July 30 and November 25, 2007 documented respectively: "Resident was physically abusive to staff and others ...Resident was physically abusive to other residents ... " The care plan was reviewed on July 30 and November 5, 2007 and January 21, 2008. The care plan lacked evidence that goals and approaches were implemented after each behavior incident. A face-to-face interview was conducted with Employees #4 and 15 on February 7, 2008, at approximately 2:30 PM. They acknowledged that	L 051		

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L 051	Continued From page 13 the resident's care plan lacked the initiation of goals and approaches after each of the above cited behavior incidents. The record was reviewed on February 7, 2008. 12. The charge nurse failed to initiate a care plan for Resident #27's fluctuating weights. A review of Resident #27's record revealed the following weights according to the " Weight Record:" September 1, 2007 182.9 pounds October 1, 2007 179.1 November 1, 2007 199.9 January 2, 2008 165.6 According to the December 11, 2007 dietary progress note, the resident's weight in December 2007 was 192 pounds. Re-weights were initially requested by the dietician in the December 11, 2007 dietary progress note. There was no evidence that a care plan was initiated with goals and approaches to address the resident's fluctuating weights. A face-to-face interview was conducted with Employee #13 on February 5, 2008 at 3:15 PM. He/she acknowledged that there was no record of re-weights. The record was reviewed February 5, 2008. 13. Facility staff failed to update Resident W1's care plan after he/she physically assaulted two (2) residents and after a change in the medication regimen. A. A review of Resident W2' s record revealed the following diagnoses in the annual Minimum	L 051		

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L 051	Continued From page 14 Data Set (MDS) dated May 19, 2007: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Missing limb, Schizophrenia and Glaucoma. The record included the following nurse's progress notes: December 13, 2007 at 8:15 AM, "It was reported to said writer by the activity director that one of his staff reported to him that this resident hit another resident [Resident S4] from the 2nd floor on 12/11/07 in the evening shift at approximately 7 PM. Spoke with resident this AM in bed, he stated that the resident from the 2nd floor took his $4. He stated that he slapped him. The resident was informed to notify someone in charge the next time he has this type of problem and also not to give money to other residents. Social worker to be made aware. To F/U with MD and attorney (RP) to notify them. Will suggest psych consult to evaluate his behavior. Resident refused to have V/S (vital signs) taken at this time, was awaken up by writer." There were no social worker progress notes after this incident. A physician' s telephone order dated December 13, 2007 at 9:00 AM directed, "...Psych consult to monitor behaviors" . On December 24, 2007, eleven days later, the psychiatric Nurse Practitioner wrote the following order, " Psychiatric Service Start Risperdal 0.5 mg BID - Agitation " . The record did not include documentation of a psychiatric consult for December 24, 2007. A review of the Behavior Data Collection form dated December 13, 2007 revealed the following: "New behavior: See below. Behaviors(s):	L 051		

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L 051	Continued From page 15 Verbal and physical abuse towards staff and residents. Patterns: Frequency: Unpredictable, no pattern. Duration: few moments. Behavior problem leads to resistance to care: yes (Refusing tests, procedures). Behavior problem causes difficulties in dealing with people & coping in facility. Intervention: Redirect resident to appropriate intervention - Effectiveness: Still being monitored. Intervention: Do not confront residents or give them money - Effectiveness: Still being monitored. Medication for treatment of behavior symptoms: Risperdal 0.5 mg BID - Date started 12/24/07." Nurse's progress notes revealed the following: January 31, 2008 at 3:00 P, "Reported to writer that resident hit resident in [room #] [Resident W6] in the face. Charge nurse to F/U. Will notify MD, RP and Social Worker for possible relocation to another unit. Has had several of these episodes" . January 31, 2008 at 5:30 PM, " Resident was taken to the police dept for hitting a resident in her face because she was in his way ..." A physician' s telephone order dated January 31, 2008 at 5:15 PM revealed, " Psych evaluation Stat upon return to facility for aggressive behavior " . There was no documentation of a psychiatric consult found in the record after January 31, 2008. The care plan dated May 19, 2007 and last reviewed on January 31, 2008 revealed the problem "Resident has moods that are easily altered by staff interventions as evidenced by: Repetitive anxious concerns regarding schedules and things occurring with other residents". Some of the approaches listed were as follows: " 1.	L 051		

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L 051	Continued From page 16 Listen to resident when they are upset and try to resolve the issue. 2. Encourage resident to participate in activities. 3. Inform all staff of the interventions that are effective in altering the resident ' s mood [there were no interventions listed]. 4. Document interventions in the clinical record [there were no interventions documented] ... 6. Notify the police department of any assault towards others done by resident. 7. Family members need emergency care conference to discuss resident' s behavior..." There were no interventions listed in the care plan that would be effective in altering the resident's mood. Facility staff failed to update Resident W2's care plan with appropriate interventions after he/she physically assaulted Resident S4 and subsequently physically assaulted Resident W6. B. A review of the care plan problem, "High risk for increase bleeding R/T (related to) Blood Thinning Agent" dated May 24, 2007 and last reviewed on November 19, 2007 included: Aspirin. The physician order sheet for October 2007 included, "Warfarin 2.5 mg 1 tab po daily for atrial fibrillation " . The most recent physician order sheet dated February 2008 and signed by the physician on February 1, 2008 included, "November 4, 2007 [origination date], Warfarin 2 mg 1 po daily for A-Fib." Aspirin was not included on this order sheet. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at 2:50 PM. He/She acknowledged that the care plan was not updated to include Warfarin and discontinuation	L 051		

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L 051	Continued From page 17 of Asprin. The record was reviewed on February 6, 2008. 14. The charge nurse failed to ensure that 10 residents were reweighed as per the facility policy. Residents 4, 5, 10, 13, 17, 23, 24, 25, 27 and W1. The "Nursing Procedure Manual" revised October 2005 included, " Weights. Purpose: To maintain accurate information about weight change ...7. Note weight reading. If a weight change is noted, re-weigh the resident/patient to verify accuracy before reporting ... Record weight on the Weight Record. Report weight changes to nursing supervisor ... " A. A review of the "Weight Record" for Resident #4 revealed the following: September 19, 2007 - 132 pounds (lbs) October 10, 2007 - 143 lbs There was no reweight entered for October 10, 2007. A face-to-face interview was conducted with Employee #11 on February 4, 2008 at 10:22 AM. He/She acknowledged that there was no reweight after an 11 pound weight loss. The record was reviewed on February 4, 2008. B. A review of the "Weight Record" for Resident #5 revealed the following: March 1, 2007 - 88.8 lbs March 19, 2007 - 81.6 lbs May 16, 2007 - 82.5 lbs May 24, 2007 - 76.6 lbs June 2007 - 88.7 lbs July 2007 - 104 lbs	L 051		

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L 051	Continued From page 18 August 6, 2007 - 83 lbs August 17, 2007 - 93.6 lbs September 8, 2007 - 97.4 lbs October 1, 2007 - 83.6 lbs November 1, 2007 - 88.2 lbs January 4, 2008 - 105.8 lbs There was no evidence of reweights on the weight record. A face-to-face interview was conducted with Employee #5 on February 6, 2008 at 10:00 AM. He/She stated, "Once weights are done for the month, they are given to the dietician and they generate a sheet of 5% or more. Usually around the 10th they [dietician] ask for a reweight. " He/She acknowledged that they were no reweights done. The record was reviewed on February 6, 2008. C. A review of Resident #10's record "Weight Record" revealed the following: June 18, 2007 - 235 lbs July 30, 2007 - 222.8 lbs There was no evidence of a reweight for the resident in the record. A face-to-face interview was conducted with Employee #11 on February 4, 2008. He/She acknowledged that there was no reweight for the resident in the record. The record was reviewed on February 4, 2008. D. A review of Resident #13' s "Weight Record" revealed the following: July 1, 2007 - 128.2 lbs August 1, 2007 - 114.6 lbs September 1, 2007 - 123.4	L 051		

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L 051	Continued From page 19 There was no evidence of a reweight on the weight record. A face-to-face interview was conducted with Employee #15 on February 4, 2008 at 10:10 AM. He/She acknowledged that there was no reweights for the resident in August or September 2007. The record was reviewed on February 4, 2008. E. A review of Resident #17' s " Weight Record " revealed the following: May 2007 - 209.8 lbs June 2007 - 189.2 lbs October 1, 2007 - 189 lbs November 1, 2007 - 210.3 lbs December 1, 2007 - 210.4 lbs January 1, 2008 - 218.1 lbs There was no evidence of reweights on the weight record for June 2007, November 2007 and January 2008. A face-to-face interview was conducted with Employee #15 on February 5, 2008 at 11:20 AM. He/She acknowledged that reweights were not done for the aforementioned months. The record was reviewed on February 5, 2008. F. A review of Resident #23's "Weight Record" Revealed the following: July 1, 2007 - 204.5 lb August 1, 2007 - 199.0 lb September 1, 2007 - no weight recorded October 1, 2007 - 190.6 lb November 1, 2007 - 206.1 lb December 1, 2007 - 182.6 lb January 1, 2007- 206.9 lb	L 051		

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L 051	Continued From page 20 There was no evidence of re-weights for the aforementioned dates. A face-to-face interview was conducted with Employee # 23 on February 11, 2007 at approximately 9:00 AM. He/she stated that he/she had asked the nurses to reweigh the resident but it was never done. The record was reviewed on February 7, 2008. G. A review of Resident #24' s " Weight Record " revealed the following: December 1, 2007 - 169.5 lbs January 1, 2008 - 179.6 lbs There was no evidence of a reweight for January 2008. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at approximately 2:00 PM. He/She acknowledged that a reweight was not done for January 2008. The record was reviewed on February 6, 2008. H. A review of Resident #25's " Weight Record " revealed the following: April 2007 - 175.5 lbs May 2007 - 165.5 lbs December 1, 2007 - 160.7 lbs January 1, 2008 - 172.4 lbs There was no evidence of reweights on the weight record for May 2007 and January 2008. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at approximately 2:00 PM. He/She acknowledged that a reweight was not done for May 2007 and January 2008. The record was reviewed on February 6, 2008.	L 051		

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L 051	Continued From page 21 I. A review of Resident #27 ' s record revealed the following weights according to the " Weight Record: " September 1, 2007 - 182.9 pounds October 1, 2007 - 179.1 November 1, 2007 - 199.9 January 2, 2008 - 165.6 According to the December 11, 2007 dietary progress note, the resident's weight in December 2007 was 192 pounds. Dietary progress notes were written on September 28, October 31, November 11, and December 11, 2007. Re-weights were initially requested by the dietician in the December 11, 2007 dietary progress note. There was no evidence that the resident was re-weighed in October, November or December 2007. The record was reviewed February 5, 2008. J. A review of Resident W1' s " Weight Record " revealed the following: September 1, 2007 - 119.6 lbs October 1, 2007 - 127.7 lbs There was no evidence of a reweight on the weight record for October 2007. A face-to-face interview was conducted with Employee #15 on February 6, 2008 at approximately 2:00 PM. He/She acknowledged that a reweight was not done for October 2007. The record was reviewed on February 6, 2008.	L 051		

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L 052	Continued From page 22	L 052		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (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	L 052	**L 052 3211.1 Nursing Facilities** #1 1. Resident #5 PT/PTT/INR was drawn on 3/10/08. The physician's order has been clarified and the PT/PTT/INR lab will be drawn every 6 months. 03/10/08 2. A record review will be conducted on residents with PT/INR labs to ensure labs have been drawn as requested by the physician, labs are present on the chart and physician has taken action to address abnormal lab values. 03/27/08 3. The nursing staff will be reeducated on how to follow PT/PTT/INR orders. The nurse managers or designee will QI monitor daily X 2 weeks, then weekly, PT/INR orders for residents on blood thinning agents to verify compliance. 03/27/08 4. Findings from QI monitoring will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 #2 1. Resident #7 has been discharged from the facility. 02/16/08 2. A review of medical record will be conducted on new admissions to ensure medications administered had/have a physician order in place prior to administration. 03/27/08 3. Licensed nursing staff will be reeducated on obtaining a physicians order prior to medication administration. The nurse managers or designee will QI monitor daily X 2 weeks, then weekly X 4 weeks, then monthly X 12 months, the medical record and MARs to ensure compliance. 03/27/08 4. Findings will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 052	Continued From page 23 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 record review and staff interview for three (3) of 30 sampled residents and one (1)supplemental resident, it was determined that facility staff failed to ensure that PT/INR levels were monitored as ordered for two (2) residents; obtain a physician's order prior to administration of a medication for one (1) resident and administer insulin per physician's orders for one (1) resident. Residents 5, 7, 22 and S5. The findings include: 1. Facility staff failed to monitor Resident # 5's International Normalized Ratio (INR) as ordered by the physician. According to the November 2007 Physician's Order Form signed by the physician on November 4, 2007, directed, "PT/PTT/INR q week." PT/PTT/INR laboratory values were present in the record for November 12, 2007. There was no evidence in the record that additional PT/PTT/INR laboratory studies were drawn for November 2007. According to the December 2007 Physician's Order Form, signed by the physician on December 9, 2007, the following order was included: "...PT / INR, PTT on 12/3/07, then	L 052	#3 1. The sliding scale for Insulin Novolin Regular has been clarified by the physician order the insulin is being administered correctly to Resident #22. 2. A review of sliding scale orders will be conducted by the nurse managers to ensure insulin is administered in accordance with the physician's order. 3. Licensed nurses will be reeducated on medication administration, clarification of physician orders and the proper administration of insulin. The nurse managers will QI monitor medical records and MARs for residents on sliding scale to verify compliance daily X 2 weeks, weekly X 4 weeks and monthly thereafter. 4. Findings from the reviews will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months. #4 1. The PT/PTT/INR for Resident S5 has been drawn as ordered by the physician. 2. A review of residents on coumadin will be conducted to ensure requests for PT/PTT/INR are drawn per physician order. 3. Licensed nursing staff will be reeducated on PT/PTT/INR lab results and documentation. Nurse Managers will QI monitor daily X 2 weeks and then weekly to ensure ordered PT/PTT/INR orders have been drawn. 4. Findings will be submitted to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 02/09/08 03/27/08 03/27/08 03/27/08

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L 052	Continued From page 24 monthly - November 21, 2007." A review of Resident # 5's record revealed PT/PTT/INR results for December 12, 2007. There was no evidence in the record that the PT/PTT/INR was obtained on December 3, 2007. A face-to-face interview was conducted with the Employee #13 on February 5, 2008, at approximately 10:45 AM. He / She acknowledged that the resident's INR was not monitored as ordered. This record was reviewed February 5, 2008. 2. Facility staff failed to ensure that there was a physician's order for Tylenol prior to administration and order a pain medication from the pharmacy timely for Resident #7. A. Facility staff failed to ensure that there was a physician's order for Tylenol prior to administration. Resident #7 was admitted to the facility on February 1, 2008. The nurse' s admission progress note dated February 1, 2008 at 10:00 PM included the following: "...Patient complained of pain in the LL (lower left) rib cage and right shoulder. Patient on Morphine Sulfate 15 mg for pain. MD to be ask [ed] for breakthrough pain meds order ... Tylenol 500 mg two tabs was given for pain..." According to the Medication Administration Record (MAR), Tylenol 500 mg two (2) tabs was given on February 1, 2008. There was no time noted for the administration of Tylenol. The physician' s admission orders did not include an order for Tylenol for pain.	L 052		

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L 052	Continued From page 25 B. Facility staff failed to order a pain medication timely for Resident #7. A review of the admission orders dated February 1, 2008 included, " ...MS Contin 15 mg po (by mouth) Q (every) 12 h (hours) ... " During an interview with Resident #7 on February 3, 2008, it was determined that the MS Contin had not arrived from the pharmacy. A face-to-face interview was conducted with Employee #11 on February 4, 2008 at approximately 10:00 AM. He/She stated, " The nurse said that he/she sent the C2 (controlled medication prescription) on Friday (February 1, 2008) and again on Sunday (February 3, 2008). I need to find the fax [confirmation] form. The Morphine was delivered on Sunday [February 3, 2008] at 4:30 PM." Employee #11 was again interviewed on February 5, 2008 at approximately 2:30 PM and stated, "He/She [nurse] said she didn't send it [C2] Friday." The record was reviewed on February 4, 2008. 3. Facility staff failed to administer insulin in accordance with the physician's orders for Resident #22. The January 2008 physician orders signed by the physician on December 31, 2007 revealed, " ...Sliding Scale: Check blood sugar [BS]... 201-250= 2 units, 251-300= 5 units, 301-350=7 units, 351-400=10 units, greater than 400= 12 units and call MD, If BS < 60 or > 400 call MD ... " A review of the January 2008, MAR revealed the	L 052		

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L 052	Continued From page 26 following: January 11, - blood sugar reading = 436, 12 units administered- the record lacked evidence that the physician was notified January 14- blood sugar reading = 400, 12 units administered January 16 - blood sugar reading = 400, 12 units administered January 19-blood sugar reading = 400, 9 units administered January 30-blood sugar reading = 400, 0 units administered A review of the January 2008, MAR lacked evidence that on January 11, 14, 16, 19 and 30, 2008 Insulin Novolin Regular 100 was given in accordance with the sliding scale per the physician's order. A face-to-face interview was conducted with Employee #14 on February 6, 2008 at 10:15 AM. He/she acknowledged that the insulin was not administered in accordance with the physician's order. The record was reviewed on February 6, 2008. 4. Facility staff failed to obtain PT/PTT/INR blood levels as ordered by the physician for Resident S5. A review of Resident S5's record revealed a physician's order dated February 3, 2008, "...PT/PTT/INT STAT in AM (February 4, 2008)..." A review of the resident's laboratory reports revealed that there was no evidence in the record that PT/PTT/INR blood levels were drawn for February 4, 2008. A face-to-face interview was conducted with	L 052		

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L 052	Continued From page 27 Employee #13 on February 8, 2008 at 10:45 AM. He/she stated, "It just wasn't done." The record was reviewed February 8, 2008.	L 052		
L 054	3211.3 Nursing Facilities To meet the requirements of subsection 3211.2, facilities of thirty (30) licensed occupied beds or more shall not include the Director of Nursing Services or any other nursing supervisor employee who is not providing direct resident care. This Statute is not met as evidenced by: Facility staff failed to maintain nursing staffing levels at 3.5 nursing hours per resident per day. The findings include: The "Nursing Daily Staffing" sheets were reviewed with Employee #4 for February 3, 4, 5, and 6, 2008. The number of nursing hours per resident per day were as follows: Date — Nursing Hours February 3, 2008 — 3.37 February 4, 2008 — 3.4 February 5, 2008 — 3.3 February 6, 2008 — 3.6 Facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day for three (3) of four (4) days reviewed. A face-to-face interview with Employee #4 was conducted on February 6, 2008 at 11:30 AM. He/she stated, "We just can't get the people."	L 054	**L 054 3211.3 Nursing Facilities** 1. Facility will maintain minimum staffing requirements. 2. Facility will review staffing at daily Stand Up meeting to ensure staffing is meeting minimum standards. Facility will increase base rate of pay for PRN staff in an effort to enhance recruitment efforts. 3. Nursing staffing coordinator and unit managers will be reeducated on mandated staffing requirements and how to calculate daily staffing hours. Facility will review during daily Stand Up meeting to ensure that staffing is meeting minimum requirement. Facility will be advertising for vacant nursing positions and holding weekly orientations until staffing is stabilized. 4. Findings from daily staffing meeting will be submitted to facility Risk Management/Quality Improvement Committee monthly X 12 months.	03/17/08 03/17/08 03/27/08 03/27/08
L 100	3219.2 Nursing Facilities	L 100		

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L 100	Continued From page 28 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 and competent staff to ensure that cooking vessels were properly sanitized. These observations were made in the presence of Employees #1, 2, and 8 on February 3, 2008 at 3:40 PM. The findings include: 1. Facility staff to ensure that a certified food handler was present in the dietary department during hours of operation. Upon initiation of the inspection of the kitchen on February 3, 2008 at 2:15 PM, it was determined that a certified food service handler was not present in the dietary department. The dietary schedule and personnel records were reviewed. Employee #2 stated at the time of this review, "We have two certified food handlers right now. One works from 5:30 in the morning and one works from 12:30 in the afternoon until 8 o'clock, or when the kitchen closes. We are training [Employee #1] as a supervisor, but [he/she] has not taken [certified food handler ' s course]. Employee #6] hasn ' t been to the class yet. " A face-to-face interview was conducted with Employee #6 at 2:30 PM on February 3, 2008. He/she stated, " I took the course and took my test and passed. I haven't got my card yet." When	L 100	**L 100 3219.2 Nursing Facilities** #1 1. A certified food handler is present in the dietary department during hours of operation. 2. The Food Services Director shall ensure that certified food handlers on staff are replaced following resignation/termination of employment to prevent other residents from being affected. 3. The Assistant Food Services Director shall revamp the daily schedule to clearly reflect the certified food handler present on each shift. Six members of the dietary department have been scheduled to attend a safe food handling and sanitation course. 4. The Food Services Director shall review/ review the schedule weekly to ensure a certified staff member reported for each shift as scheduled. Copies of the weekly reviews shall be submitted to the Risk Management/ Quality Improvement committee on a monthly basis for review and comment. #2 1. Employee #5 has been trained on how to properly sanitize cooking vessels. 2. Pots and pans were rewashed and properly sanitized. 3. Food Services staff shall be reeducated on the proper sanitation of cooking vessels . The Food Services Director or his/her designee shall conduct reviews daily X 2 weeks, weekly X 4 weeks, then monthly X 12 months, of the three (3) compartments sink station to verify staff compliance with sanitation guidelines. 4. Copies of the review shall be submitted to the Risk Management/Quality Improvement Committee each month for review X 12 months.	03/20/08 03/20/08 03/13/08 03/27/08 02/03/08 02/03/08 03/21/08 03/27/08

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L 100	Continued From page 29 asked when he/she took the course, Employee #6 stated, "I took the course some time in 2004 or 2005. It's been a couple of years." 2. Facility staff failed to ensure that competent staff was available to ensure that cooking vessels were properly sanitized. On February 3, 2008 at 3:15 PM, it was observed that litmus paper to test the pH of the sanitizer was not immediately available to Employee #5, who was washing cooking vessels at the three (3) compartment sink. After locating litmus paper, Employee #5 was not able to state the color the litmus paper should be when the sanitizing water was tested or the concentration of the sanitizer in the water (parts per million). Employee #5 acknowledged that he/she had not participated in training that covered this information. Employee #5 stated that he/she had been working at the facility about one (1) year.	L 100		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations of a test tray, it was determined that facility staff failed to serve cold foods at 45 degrees Fahrenheit (F) or below and hot foods at 140 F or above. The findings include: A test tray was conducted on February 5, 2008 at 1:10 PM. The following temperatures were	L 108	**L 108 3220.2 Nursing Facilities** 1. Tray line temperatures are being maintained at proper temperatures. 02/05/08 2. Tray line temperatures were checked at the beginning, middle and the end of the meal service to ensure safe temperatures. Facility food services department will take delivery temperatures three times weekly on the nursing units to ensure compliance. 03/27/08 3. The food services and nursing staff will be reeducated on the importance of maintaining safe temperatures and serving food to residents after the food trucks arrive on the nursing units. The Food Services managers or designee will QI monitor daily X 2 weeks, then weekly to ensure compliance. 03/27/08 4. Findings from the QI Monitoring will be submitted to the Facility Risk Management/ Quality Improvement committee monthly X 12 months. 03/27/08	immediately

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L 108	Continued From page 30 recorded: rice - 130.1 F, orange juice - 54.9 F, milk - 47.7 F and strawberry whipped topping dessert - 47.4 F.	L 108		
L 109	3220.3 Nursing Facilities If a resident refuses food, appropriate substitutions of comparable nutritive value shall be offered at the same mealtime. This Statute is not met as evidenced by: Based on a review of menus, staff interview and observation, it was determined that facility staff failed to provide meal substitutes of similar nutritional value to the residents. The findings include: The current week's menu was reviewed. There was no listing of alternate foods for the meal offered on the menu. A face-to-face interview was conducted with Employee #6 on February 3, 2008 at 1:45 PM regarding alternate foods available to residents. He/she stated, " I choose a meat, starch and vegetable each day. It depends on what is in the freezer. We always can make grilled cheese, peanut butter and jelly and cold cut sandwiches. " A face-to-face interview was conducted with Employee #2 on February 3, 2008 at 2:15 PM regarding alternate foods for the meal available to residents. Employee #2 stated, " The cook chooses what the alternate will be. A meat is a meat, a starch is a starch and a vegetable is a vegetable. We use corporate menus and the substitutes are what the cook chooses. The dietician is not involved. "	L 109	**L 109 3220.3 Nursing Facilities** 1. A listing of alternate foods approved by the Registered Dietitian has been included on the menu for each meal offered to residents. 2. A review of weekly menus posted throughout the facility was conducted by the Food Services Director to ensure alternates food choices are listed and the signature of the Registered Dietitians approval was present. 3. The Registered or Licensed Dietitian will reeducate the Food Services Director on the importance of including a listing of alternate foods for each meal offered on the menu. The Food Services Director or Registered Dietitian shall QI monitor daily X 2 weeks, then weekly reviews of the daily alternates offered to ensure meal substitutes of similar nutritional value are offered to the residents. 4. Copies of the weekly reviews shall be submitted to the Risk Management/Quality Improvement committee on a monthly basis for review X 12 months.	02/03/08 02/03/08 03/27/08 03/27/08

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L 161	Continued From page 31	L 161		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations of the facility's medication storage areas, it was determined that expired medications were not removed from the emergency box. The findings include: On Wednesday, February 6, 2008, at approximately 1:00 PM, during the inspection of the facility's medication storage areas, the Emergency Box #5S on unit 5 South was observed locked. The expiration date on the exterior of the box was January 1, 2008. When opened, it contained two (2) Dextrose 50% injection, 50 ml syringes which expired January 1, 2008. On Wednesday, February 6, 2008, at approximately 1:10 PM, a face-to-face interview was conducted with Employee #21. He/she acknowledged that the date on the exterior of the emergency box was January 1, 2008.	L 161	**L 161 3227.12 Nursing Facilities** 1. Emergency box on 5 South was replaced with a current Emergency Medication Box by Pharmacy. 2. Review of emergency medication boxes for current dates has been completed. 3. Licensed nurses reeducated on checking emergency medication boxes expiration dates. Third shift nurses will check emergency box nightly to ensure it is in date. Nurse Managers will QI monitor emergency medication boxes monthly X 12 months. 4. Findings of the QI monitoring will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/07/08 03/27/08 03/27/08 03/27/08
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations for six (6) of eight (8) medication carts and staff interview, it was determined that the facility staff failed to date and initial 12 of 12 multi-dose medication vials when	L 168	**L 168 3227.19 Nursing Facilities** 1. Undated multi-dose vials were discarded and reordered. 2. Multi-dose medication vials were reviewed and any opened, undated vials were discarded and reordered. 3. Licensed nurses reeducated on dating multi-dose vials when opened. The third shift nurses are responsible for checking multi-dose vials for dating nightly. Nurse managers will QI monitor dating of multi-dose vials daily X 2 weeks, weekly X 4 weeks, and then monthly X 12 months. 4. Findings of the QI monitoring will be reported to the Risk Management/Quality Improvement committee X 12 months.	02/6/08 03/27/08 03/27/08 03/27/08

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L 168	Continued From page 32 first opened. The findings include: On Wednesday February 5, 2008, between 1:30 PM and 4:30 PM and Thursday, February 6, 2008, between 9:00 AM and 12:00 PM, the medication carts and refrigerators were inspected on each unit. The facility staff failed to date and initial opened multi-dose medication vials. The medication included: 3N -Xalatan ophthalmic drops, two (2) vials 3S - Xalatan ophthalmic drops, four (4) vials 4N - Foradil Aerolier, one (1) vial 5N -Xalatan ophthalmic drops, four (4) vials 5S - Foradil Aerolier, one (1) vial Employees #15, 17, 19 and 20 acknowledged that the vials listed above were not dated and/or initialed at the time of the observations.	L 168		
L 179	3229.1 Nursing Facilities The facility shall provide social services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on record review and staff and resident interviews for seven (7) of 11 residents identified by facility staff with a history of assaultive, aggressive and/or inappropriate behaviors towards residents and/or staff and illicit drug use, it was determined that facility staff failed to provide appropriate treatment and services for:	L 179		

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L 179	Continued From page 33 three (3) residents who physically assaulted residents and/or staff, one (1) resident for inappropriate sexual behaviors, three (3) residents for drug use, and five (5) residents for verbal aggression. Residents W2, #26, #2, 3, S1, S2 and S4. The findings include: 1. Facility staff failed to implement appropriate social service interventions for Resident W2 after he/she physically assaulted two (2) residents. A review of Resident W2' s record revealed the following diagnoses in the annual Minimum Data Set (MDS) dated May 19, 2007: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, Missing limb, Schizophrenia and Glaucoma. The record included the following nurse's progress notes: December 13, 2007 at 8:15 AM, "It was reported to said writer by the activity director that one of his staff reported to him that this resident hit another resident [Resident S4] from the 2nd floor on 12/11/07 in the evening shift at approximately 7 PM. Spoke with resident this AM in bed, he stated that the resident from the 2nd floor took his $4. He stated that he slapped him. The resident was informed to notify someone in charge the next time he has this type of problem and also not to give money to other residents. Social worker to be made aware. To F/U with MD and attorney (RP) to notify them. Will suggest psych consult to evaluate his behavior. Resident refused to have V/S (vital signs) taken at this time, was awaken up by writer." There were no social worker progress notes after this incident.	L 179	**L 179 3229.1 Nursing Facilities** **#1** 1. Resident W2 was placed on "Line of sight" one on one monitoring X 3 days, until psychiatric evaluation and clearance. A care conference was held with resident, his guardian and the ombudsman to address resident's behavior and voluntary entry into an anger management program. Resident W2 agreed to enter an anger management program on 2/27/08. 2. Facility has reviewed residents with abusive/aggressive behavior to determine if they need to be reassessed and evaluated for new interventions and treatment protocols. 3. Facility social services staff will be re-educated on behavior Management Crisis Escalation. Facility will develop library of periodicals and magazines that will assist in education of staff that target aggressive behaviors in LTC setting. Social services will utilize the following approaches to address residents who display abusive/aggressive behavior. a. Social Services will meet with the family and solicit the family's support in encouraging the resident to enroll in an appropriate anger management program. b. Arrange psych referrals for residents with a history of aggressive behavior when there is a change in the resident's mood or behavior. c. Social Services staff will establish weekly One to One visits with the resident to discuss any mood or behavior issues that might trigger aggressive behavior and perform basic "Touch Therapy". d. Social Workers will work with resident and family to identify community based group housing, assisted living, or independent living arrangements that would be suitable for the resident's care needs. 4. Social Services staff will QI monitor resident records with abusive/aggressive behaviors daily M-F X's 2 weeks, weekly X's 4 weeks, and monthly X's 12 months.	02/27/08 03/27/08 03/27/08 03/27/08

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L 179	Continued From page 34 A physician' s telephone order dated December 13, 2007 at 9:00 AM directed, "...Psych consult to monitor behaviors" . On December 24, 2007, eleven days later, the psychiatric Nurse Practitioner wrote the following order, " Psychiatric Service Start Risperdal 0.5 mg BID - Agitation " . The record did not include documentation of a psychiatric consult for December 24, 2007. A review of the Behavior Data Collection form dated December 13, 2007 revealed the following: "New behavior: See below. Behaviors(s): Verbal and physical abuse towards staff and residents. Patterns: Frequency: Unpredictable, no pattern. Duration: few moments. Behavior problem leads to resistance to care: yes (Refusing tests, procedures). Behavior problem causes difficulties in dealing with people & coping in facility. Intervention: Redirect resident to appropriate intervention - Effectiveness: Still being monitored. Intervention: Do not confront residents or give them money - Effectiveness: Still being monitored. Medication for treatment of behavior symptoms: Risperdal 0.5 mg BID - Date started 12/24/07." Nurse's progress notes revealed the following: January 31, 2008 at 3:00 P, "Reported to writer that resident hit resident in [room #] [Resident W6] in the face. Charge nurse to F/U. Will notify MD, RP and Social Worker for possible relocation to another unit. Has had several of these episodes" . January 31, 2008 at 5:30 PM, " Resident was taken to the police dept for hitting a resident in her face because she was in his way ..."	L 179	#2 1. We are seeking a support group to help Resident #2 manage his anger. Psychiatrist has evaluated resident to assist with initiation of behavior treatment plan. 2. Social Services staff will review resident sexual behavior, inappropriate exposure, agitation behavior incidents to determine if facility social services staff has appropriately addressed and implement interventions to address behaviors. 3. Social Services staff will be re-educated on importance of addressing resident sexual behavior, inappropriate exposure, agitation behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display sexual behavior, inappropriate exposure, agitation behavior to ensure that appropriate interventions and action plans are in place to address this behavior. 4. Findings from QI Monitoring will be submitted to Facility Risk Management/Quality Improvement Committee monthly X 12 months.	02/15/08 03/21/08 03/21/08 03/27/08

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L 179	Continued From page 35 A physician' s telephone order dated January 31, 2008 at 5:15 PM revealed, " Psych evaluation Stat upon return to facility for aggressive behavior " . There was no documentation of a psychiatric consult found in the record after January 31, 2008. The care plan dated May 19, 2007 and last reviewed on January 31, 2008 revealed the problem "Resident has moods that are easily altered by staff interventions as evidenced by: Repetitive anxious concerns regarding schedules and things occurring with other residents". Some of the approaches listed were as follows: " 1. Listen to resident when they are upset and try to resolve the issue. 2. Encourage resident to participate in activities. 3. Inform all staff of the interventions that are effective in altering the resident ' s mood [there were no interventions listed]. 4. Document interventions in the clinical record [there were no interventions documented] ... 6. Notify the police department of any assault towards others done by resident. 7. Family members need emergency care conference to discuss resident' s behavior..." There were no interventions listed in the care plan that would be effective in altering the resident's mood. Social services progress note revealed the following: There was no social service progress note following the December 2007 incident. February 1, 2008 at 6:30 AM, "Progress Note: Resident seen by a CNA hitting a female resident [named] in the face. According to nurse, he/she hit [resident] because he/she was in his/her way. The police were called and arrested him/her	L 179	#3 1. Resident 26 has been enrolled in Day Break program beginning 3/19/08. 2. Social Services staff will review resident behavior incidents to determine if facility social services staff has appropriately addressed and implement interventions to address aggressive behaviors. 3. Social Services staff will be re-educated on importance of addressing resident behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display aggressive behavior to ensure that appropriate interventions and action plans are in place to address this behavior. 4. Findings from QI Monitoring will be submitted to Facility Risk Management/Quality Improvement Committee monthly X 12 months.	03/19/08 03/21/08 03/21/08 03/27/08

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L 179	Continued From page 36 The incident occurred on the evening 1/31/08." February 4, 2008 at 10:20 AM, "Resident returned to [facility] on the evening of 2/1/08. Charges were not filed after the hearing. He/She was counseled re: his/her behavior and it was explained that if he/she hits another the police will be called." A face-to-face interview was conducted with Employee #14 on February 7, 2008 at 9:45 AM. He/She stated, "The social worker spoke with him/her, so [social worker] had a 1:1 with [resident]. We talked to [resident] and the other resident. The last incident [resident] spoke with Employee #3. [Resident] has had no problems since. [Resident] has been quiet." A face-to-face interview was conducted with Resident W2 on February 6, 2008 at 2:00 PM. He/She stated, "I don't want to talk to you. I don't know why everybody wants to come and see me. You all need to leave me alone". A face-to-face interview was conducted with Resident W6 on February 8, 2008 at 9:02 AM. Resident W6 was asked about the incident. He/She stated, " I was more frightened and was caught off guard. [Resident W2] asked me to move and I didn't [move] fast enough. I took one roll backward [in my wheelchair]. [Resident W2] said he wanted me to move up. I didn't move where he/she wanted and [Resident W2] attempted to kick the wheelchair and it tilted on one wheel. [Resident W2] pulled his/her fist back and he/she was going to hit me. When [Resident W2] threw his/her punch, it just brushed my cheek. [Resident W2] started yelling and screaming at me. Since then he/she came by here and said he/she was going to kick my ass. I	L 179	#4 1. Resident #3 was evaluated by psychiatrist on March 3, 2008 to address sexual behavior, inappropriate exposure, agitation and oppositional behavior. Care plan session was held with resident and responsible party to discuss interventions and appropriate placement of resident. 2. Social Services staff will review resident behavior incidents to determine if facility social social services staff has appropriately addressed and implemented interventions to address behavior. 3. Social Services staff will be reeducated on importance of addressing resident behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display aggressive behavior to ensure that appropriate interventions and action plans are in place to address behavior. 4. Findings from QI Monitoring will be submitted to Facility Risk Management/ Quality Improvement Committee monthly X 12 months.	03/05/08 03/21/08 03/21/08 03/27/08

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L 179	Continued From page 37 didn't report it. I prefer to stay out of [Resident W2's] way. I'm already scared. I don't feel comfortable around him/her. [Resident W2] has been in other situations before me. I feel they [facility] should have stepped up to the plate when those other incidents happened." The record was reviewed on February 6, 2008. 2. Facility staff failed to implement appropriate social service interventions for Resident #2 after he/she physically and verbally assaulted staff and resident, exhibited sexual deviant behavior and was observed smoking marijuana in the facility. A review of the resident's record revealed the following nursing notes: August 29, 2007 at 1900,"Resident alert and oriented x 3, was verbally abusive to staff members while assisting resident in [resident] room..." September 11, 2007 at 2130, "...Resident was in front of writer using profanity such as M...F ...abusive to staff but still kept abusing verbally..." September 21, 2007 at 9:30 AM, "A meeting was held today with [resident] R/T [related to] ...sexual behavior...with...staff and...residents" November 8, 2007 at 1400, "Report given to writer by the unit clerk that the resident was observed by the DON [Director of Nursing] smoking marijuana ...police was called ... " November 23,2007 at 1435, "This resident was reported to have hit a staff on her breast last weekend on 11/18/07...Resident stated I'm sick and tired of staff not doing things for me when I ask them to."	L 179	#5 1. Resident S1 has qualified for social security benefits and the facility will assist resident in transitioning to a more appropriate level of care in the community. The resident's care plan was updated to address verbal and physical aggressive behaviors and drug use on 2/19/08. No other residents have been harmed by this resident's inappropriate behavior. 2. Social services staff will complete review of charts on residents who have had instances of inappropriate behavior related to alcohol abuse or drug abuse to ensure that interventions are put in place to address the resident behavior. 3.Social services staff and nursing staff will be reeducated on importance of early and timely interventions when residents exhibit inappropriate behavior. Reeducation will also cover various types of interventions that staff could implement to monitor residents. Social Services staff will QI Monitor resident records who have exhibited inappropriate behavior related to alcohol or drug abuse to determine if interventions are being implemented immediately appropriately, daily, M-F, X 2 weeks, weekly X 4 weeks, and monthly X 12 months. 4.Findings from the QI Monitoring will be reported to the Risk Management/Quality Improvement committee for Review monthly X 12 months.	03/27/08 03/27/08 nursing received 3/28/08 03/27/08 03/27/08

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L 179	Continued From page 38 November 27, 2007 at 10:45 AM, "Resident in front of lobby threatening CNA...I'm going to F ...you up, I'm going to get your a...fired. Security witnessed the incident..." December 23, 2007 at 10:30 AM, "Another resident [complained] that resident hit his/her [wheelchair] to the resident's [wheelchair] and his / her [wheelchair] light came off..." December 26, 2007 at 2:00 PM, "Resident stated to writer that [resident] dislike CNA [Certified Nursing Assistant]. Resident stated to nurse that I'm going to hit [him/her]...face..." January 23, 2008 at 5:30 PM, "Resident...on elevator with [a staff] prior to going to his/her support group. [Resident grabbed the staff by the arm and pulled him/her...[Resident was very aggressive with this staff person..." A review of the social worker's notes revealed the following: September 21, 2007, "...Meeting with Resident along with DON, Nurse Manager and the Executive Director. Complaint from Nursing staff ...resident ' s verbal abuse, exposing self to staff and general sexual deviant behavior..." November 9, 2007 at 8:30AM: "Resident was observed smoking marijuana in the patio 11/8/07 ...Police warned resident and the possibility of going to jail. This writer offered to arrange drug treatment for...however [resident refused..." November 29, 2007 at 10:20 AM, " MDS review: ...Monitored for behavior and drug use ... " There was no evidence that the social workers	L 179	#6 1. Resident S2's care plan has been updated with new interventions that address his/her aggressive behavior and alcohol or drug abuse. 2. Social Services staff will review resident behavior incidents to determine if facility social services staff has appropriately addressed and implement interventions to address behaviors. 3. Social Services staff will be re-educated on importance of addressing resident behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display aggressive behavior to ensure that appropriate interventions and action plans are in place to address this behavior. 4. Findings from QI Monitoring will be submitted to Facility Risk Management/Quality Improvement Committee monthly X 12 months.	03/10/08 03/21/08 03/27/08 03/27/08

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L 179	Continued From page 39 initiated interventions after the aforementioned incidents. A care plan initiated July 28, 2006 and last updated, indicated "Resident continues to have angry outburst and behavior. Continue to monitor and document as per order." A face-to-face interview was conducted with Employees #13 and 16 on February 4, 2008, at approximately 2:30 PM. He/she acknowledged that appropriate social service interventions were not initiated after the aforementioned incidents of verbal and physical aggression. The record was reviewed on February 4, 2008. 3. Facility staff failed to implement appropriate social service interventions for Resident #26 after he/she physically assaulted staff and residents. A review of the resident ' s record revealed the following nursing notes: November 7, 2007 at 12:30 PM, "Resident remains alert and verbally responsive, noted with severe agitation..." November 22, 2007 at 0700 (7:00 AM), "Resident is alert and verbally responsive, severely agitated this [morning], cursing staff members and other residents." November 25, 2007 at 2:25 PM, "Writer called to assess resident's behavior. Resident extremely agitated with bizarre behavior, lashing out at the resident. Resident hit [Resident A1] on the head...Resident pacing up and down the area of the day room attacking other residents. Resident was given 1 mg of Ativan for behavior disturbance..." November 25, 2007 at 3:15 PM, "...Resident was	L 179	#7 1. Resident #S4's care plan was updated with new approaches and interventions that address alternative treatment 2. Social Services staff will review resident with aggressive behavior incidents to determine if facility social services staff has appropriately addressed and implement interventions to address behaviors. 3. Social Services staff will be re-educated on importance of addressing resident behaviors and implementing interventions. Facility social services staff will complete QI Monitoring daily X 2 weeks, weekly X 4 weeks and monthly X 12 months for residents who display aggressive behavior to ensure that appropriate interventions and action plans are in place to address this behavior. 4. Findings from QI Monitoring will be submitted to Facility Risk Management/ Quality Improvement Committee monthly X 12 months.	03/10/08 03/21/08 03/21/08 03/27/08

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L 179	Continued From page 40 quiet, [he/she] said sorry for what [he/she] did." November 25, 2007 at 3:00 PM, "Police on unit, report given to them by (Resident A1), awaiting further arrangement..." November 25, 2007 at 3:45 PM, "Resident left facility walking accompanied by two police. Resident was taken to [hospital] psychiatric division for further evaluation and assessment." December 4, 2007 at 2:45 PM, "Resident remains alert and verbally responsive. Noted with severe agitation, running after staff / residents to hit, screaming and yelling..." December 5, 2007 at 8:00 AM, "Resident alert and verbally responsive. Noted with agitation (calling residents and staff [names]...attempting to hit staff / residents..." December 11, 2007 at 0600 (6:00 AM), "Resident alert and verbally responsive...severely agitated during this shift. Pulled Fire alarm, hit writer on the right side of the head...Ativan 1 ml IM [intramuscular] given...per [physician] order, effective..." December 11, 2007 at 2:30 PM, "Resident alert and verbally responsive noted with severe agitation. Throwing things, (belongings) upside down in room. Screaming, cursing staff /residents and attempting to hit staff/resident. Ativan 1 mg given at this time..." December 29, 2007 at 1:00 PM, "...Refused due Klonopin 0.5 mg P.O. for agitation. Resident observed with agitation (cursing staff and residents) screaming. Ativan 1 mg given..."	L 179		

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L 179	Continued From page 41 January 9, 2008 at 2000 (8:00 PM), "Resident was cursing and abusive to other residents. Threw [his/her] tray on the floor..." January 12, 2008 at 11:00 AM, "Resident remains alert and verbally responsive. Resident observed with severe agitation. Throwing things and attempting to hit resident/staff. Fortunately nobody was touched or injured. Ativan 1 mg given..." January 26, 2008 at 12:00 PM, "...Observed with severe agitation yelling, loud screaming and running around. Attempting to hit staff and residents. Throwing [his/her] belongings (pocket book and clothes). Ativan 1mg IM given..." January 31, 2008 at 11:30 AM, "...Resident is throwing [his/her] clothes on other residents and screaming. Resident was taken back to room but came right out screaming. Ativan 1 mg given..." February 4, 2008 at 12:15 [AM/PM not indicated], "...Throwing [his/her] shoes on the staff. Screaming very loud and cursing other residents. Using foul language, Ativan 1 mg administered..." A review of the social service notes revealed the following: November 25, 2007 at 2:00 PM, "This writer was on the unit when [writer] observed [Resident #26] approach [Resident A1] and [Resident #26] started attacking [Resident A1]. Nursing staff quickly intervened and removed [Resident #26] to the other side of the unit...[Resident A1] advised the [he/she] was going to call the police to report [Resident #26]. [Resident #26] during the time staff was trying to calm [him/her] was hitting at nursing staff and did hit the charge nurse, who	L 179		

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L 179	Continued From page 42 sustained red welts on [his/her] arm." The next entry was a quarterly review dated January 18, 2008 at 11:15 PM, "During this review period the resident has had an incident in which [he/she] became physically abusive towards another resident and staff members..." January 21, 2008 at 4:15 PM, "Resident was observed pulling the fire alarm on 5N side. The resident became verbally aggressive towards the staff when staff attempted to redirect [him/her]...Resident calmed sometime later and stated [he/she] pulled the alarm to save [his/her] life from a fire..." A care plan initiated July 30, indicated " Resident was physically abusive to staff and others." The care plan was reviewed on November 25, 2007 with a hand written entry, "Resident was physically abusive to other residents by hitting them. No injury noted." There was no evidence that the social workers initiated appropriate social service interventions after the aforementioned incidents of verbal and physical aggressive behaviors. A face-to-face interview was conducted with Employees #4,15 and 16 on February 7, 2008, at approximately 2:30 PM. They acknowledged that interventions were not initiated after the incidents of verbal and physical aggression. The record was reviewed on February 7, 2008. 4. Facility staff failed to implement appropriate social service interventions and monitor Resident #3's progress after several outbursts of aggressive and inappropriate behavior.	L 179		

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L 179	Continued From page 43 A review of Resident #3's record revealed a diagnosis of Multiple Sclerosis in the annual Minimum Data Set (MDS) dated September 21, 2007. A review of the social services notes in the residents' record revealed the following: On June 14, 2007 under the heading of MDS review, Employee #16 wrote "Resident is alert and oriented x 3. However, he/she is easily agitated and at times becomes hostile. His/her verbalizations are often tangential and incoherent during these episodes." On August 10, 2007 the social worker documented that the resident received a letter from Metro Access requesting an interview regarding an application. Employee #16 added "He/she stated he/she did not want to attend the interview and changed his/her mind about wanting Metro Access." On August 10, 2007 the note included, "Resident was accused by a CNA of exposing himself/herself to him/her on 10/6/07. The writer discussed how inappropriate this behavior was...Resident appears to have a history of this behavior." On November 19, 2007 the MDS review note stated "He/she has occasional outbursts of anger when he/she cannot have his/her way." On January 18, 2007 the social worker wrote "Resident engaged in verbal altercation on 1/15/08 with engineering staff member. The nurse on duty contacted the police. Officer spoke with the resident and calmed the situation."	L 179		

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L 179	Continued From page 44 On February 7, 2008 the social worker wrote " Admissions Coordinator reported to the facility administrator on 2/5/08 that Resident #3 cursed out another resident as they were exiting the elevator on the 1st floor. I spoke to him/her about his/her inappropriate behavior." The documentation on February 14, 2008 included " Met with resident and with Admissions Coordinator to address his/her displaying large amounts of money and verbal altercations with staff. Resident stated he/she will handle his/her money his/her way." A review of the Interdisciplinary Care Plans revealed two (2) recommended social services interventions. 1. "Firmly approach resident that behaviors are not acceptable and document conversation and actions of resident" and 2. Inform direct care givers on methods to assist them in handling res. (resident) behaviors while providing care." These entries were entered to the care plan on October 16, 2007 and a care planning meeting was held on January 4, 2008. There was no documentation under the headings of "Date reviewed" or "Status Date" to determine if the recommendations were evaluated. The record lacked evidence of any other interventions to monitor or improve the resident's behavior. A face-to-face interview was conducted with Employee #16 on February 5, 2008 at approximately 11:00 AM. He/she stated he/she was initially working on a plan to discharge the resident but no family member was willing to take him/her. He/she acknowledged that at this time	L 179		

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L 179	Continued From page 45 there were no planned interventions to improve and/or monitor the resident s mental, physical and psychosocial behavior. The record was reviewed on February 4, 2008. 5. The social worker failed to provide interventions for Resident S1's aggressive behaviors and alcohol and drug use. According to the annual history and physical examination, completed by the physician on September 14, 2007, the resident had a "history of crack/cocaine". A review of Resident S1's record revealed the following social worker's notes: June 4, 2007 at 4:30 PM: "Resident attended funeral with a friend/resident (Resident A1) on 6/1/07. It was reported [he/she] consumed alcohol and had a confrontation with CNA (certified nurse aide) who escorted [Resident A1). According to (Resident S1), the argument was regarding (Resident S1's) actual consumption. This writer asked resident if (he/she) will attend AA meetings and (he/she) denied the invitation. On going monitoring will continue re: resident's behavior and alcohol consumption." August 30, 2007 at 4:00 PM: "Special care conference held on this date to address resident's drug activity. (He/she) denied having an addiction, however agreed to attend (outside facility) for treatment." August 31, 2007 at 2:00 PM: "Met with resident again. (He/she) changed (his/her) mind and refused to attend any treatment program." October 18, 2007 at 1:00 PM: "Resident engaged	L 179		

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L 179	Continued From page 46 in an altercation...with another resident re: drug transaction. When this writer met with resident, (he/she) denied giving (Resident S4) money for drugs. (He/she) stated (he/she) gave (Resident S4) money for cigarettes. (Resident S1) denied using drugs. However, (he/she) was offered the opportunity to participate in a program. (Resident S1) refused any treatment centers. On going monitoring will continue." December 14, 2007 at 2:00 PM: "MDS Review: Resident is alert and oriented x 3. (He/she) requires minimal assistance with ADLs (Activities of Daily Living). (He/she) ambulates with walker or wheelchair. (He/she) receives occasional visitors. (His/her) interactions have been appropriate. There has been no altercations this period. On going monitoring will continue as (he/she) remains concern." A pre-printed care plan entitled, "Behavior Management" was initiated September 2006 with a goal date of June 2007. One (1) intervention was identified under the behavior entitled, "Wanting to go 'Home'" which was "Phone call from family to offer reassurance." There were no behaviors or interventions identified by facility staff regarding verbal or physical aggressive behaviors or alcohol use. There was no evidence in the resident's record that interventions were initiated by the social worker or that the resident was referred to alternate treatment programs after refusal of the above cited program. The record was reviewed February 8, 2008. 6. The social worker failed to provide interventions for Resident S2's aggressive behaviors and alcohol and drug use.	L 179		

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L 179	Continued From page 47 According to the annual history and physical examination, completed by the physician on June 6, 2007, the resident was diagnosed with "drug addiction". A review of the resident's record revealed the following social worker's progress notes: April 18, 2007 (no time indicated): "SW met briefly to discuss the establishment of Alcohol and Substance abuse awareness group. Resident indicated that (he/she) has previous knowledge of such group, but insists that no staff be present, "only resident." Resident was told date and time of meeting." April 24, 2007 (no time): "SW offered and reminded resident of alcohol substance abuse group meeting 4/26/07 at 10:00 AM." The resident was hospitalized on April 26 through May 3, 2007 and as follows: June 8 thorough June 11, 2007. June 28 through July 4, 2007. July 16 through July 19, 2007. August 21 through August 23, 2007. The next social worker's entry was dated January 23, 2008 at 3:10 PM: "Resident encountered an altercation with security worker on 1/22/08 re: smoking in front of bldg (building). According to the report, resident cursed the employee after (he/she) was asked to move from the front of the bldg. Resident was counseled re: (his/her) behavior and reminded of the importance of following the smoking policy." A care plan problem entitled, "Res has a history of manipulative behavior, verbal aggression,	L 179		

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L 179	Continued From page 48 resistance to care" was dated December 5, 2007. There was no evidence that interventions had been initiated to address the above cited incidents. A face-to-face interview was conducted with Employee #26 on February 8, 2008 at 11:30 AM. He/she stated, " [Resident S2] came to some of the AA meetings, but not consistently. The residents' group hasn't met since the summer. " There was no evidence in the record that appropriate treatment and services were provided for verbal and physical aggression and the resident's drug use after each above cited episode. The record was reviewed February 8, 2008. 7. The social worker failed to provide interventions for Resident S4's aggressive behaviors and alcohol and drug use. A review of Resident S4 ' s record revealed the following social worker ' s notes: July 5, 2007 at 1:30 PM: " Resident was reported by nursing staff that a syringe was found in [his/her] bed. This writer spoke with resident re: the incident. [He/she] stated the syringe was not [his/hers] and [he/she] has no idea how it got there. [He/she] denied using any drugs or needing treatment for substance abuse. Staff will continue to monitor resident. " July 23, 2007 at 7:10 AM: " MDS (Minimum Data Set) review: Resident is alert and oriented x 3. [He/she] uses a wheelchair for mobility. At times [he/she] refuses care and is verbally abusive toward staff. [He/she] is suspected of substance abuse; however [he/she] denies it and refuses	L 179		

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L 179	Continued From page 49 treatment ... " January 24, 2008 at 7:50 AM: " Resident had a fall 1/22/08 and became very belligerent towards staff because [he/she] stated after calling for help on the floor it took a long time before someone assisted [him/her] ... " January 24, 2008 at 8:15 AM: " Resident agreed to accept treatment for [his/her] drug abuse. He was prescribed Methadone on 1/15/08 by the nurse practitioner. " January 24, 2008 at 9:10 AM: " MDS Review ...Resident continues to engage in occasional verbal (abuse) toward staff. " A care plan problem, " Resident has recent history of drug abuse " was initiated November 6, 2006. There was no evidence that the care plan was updated after the July 5, 2007 incident mentioned above. A hand written entry dated January 9, 2008 documented the following: " 8 1 cc syringes found at [his/her] bedside with clear substance. 1 burned teaspoon and lighter. " A care plan problem, " Resident is verbally abusive to staff, cursing to staff and old roommate " was initiated November 6, 2006. There was no evidence that interventions were initiated after the above cited episodes of verbal abuse. There was no evidence in the record that the social worker initiated interventions regarding the resident ' s drug use prior to January 24, 2008. Additionally, there was no evidence in the record that the social worker initiated interventions to address the resident ' s verbal abuse. The record was reviewed February 8, 2008.	L 179		

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L 179	Continued From page 50 There was no evidence in the resident's record that interventions were initiated by the social worker or that the resident was referred to alternate treatment programs after refusal of the above program. The record was reviewed February 8, 2008.	L 179		
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 environmental observations, it was determined that facility staff failed to maintain a safe and hazard free environment as evidenced by: boxes stored on the top of closets, an unsecured scatter rug in a resident's room, eye guards missing from television antennas, broken electrical outlet covers, a burner on the gas oven lit with a paper towel, excessive water in shower rooms and the dish machine room, electrical outlet in the kitchen covered with duct tape, a mop handle on the floor in the kitchen doorway, extension cords in resident's rooms and unsecured oxygen tanks. These environmental observations were made on February 3 through 11, 2008 from 7:30 AM through 4:00 PM in the presence of Employees #1, 2, 3, 5, 6, 7, 8, 9, and 10. The findings include: 1. Boxes stored on top of closet in rooms 323 and 503. 2. Scatter rug unsecured in room 517 next to	L 214	**L 214 3234.1 Nursing Facilities** #1 1. Boxes were removed from the top of closets in resident rooms. 2. Environmental rounds were conducted to identify rooms where items were on top of closets and appropriate actions taken based on findings. 3. Maintenance and Nursing staff will be reeducated on keeping the top of closets clear of boxes. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure tops of closets remain free of boxes. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08

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L 214	Continued From page 51 resident's bed. 3. Eye guards were observed missing from televisions in the following areas: 2S and 2N dining rooms; 3N and 3S dining rooms, 4S dining room and 4S living room in six (6) of 16 televisions observed in common areas. 4. Broken electrical outlet covers were observed damaged in the following areas: A. Kitchen near the walk-in refrigerator on February 3, 2008 at 3:10 PM in the presence of Employees #2 and 7. B. 3 North hallway between rooms 317 and 318. 5. During the initial tour of the kitchen on February 3, 2008 at approximately 2:45 PM, it was observed that Employee #6 attempted to light a burner on the gas stove with a paper towel. 6. Excessive water was observed in the dish machine room and in the shower room. A. Excessive water was observed on the floor of the dish machine room coming from two (2) leaks, one (1) from the dish machine and one (1) from the intake water filter near the door. A bucket was placed under the filter and was observed overflowing onto the dish machine room floor on February 3, 2008 at 2:30 PM. B. Excessive water was observed on the floor of the 5N men's bathing/shower room in front of the shower stall on February 5, 2008 at approximately 4:00 PM 7. An electrical outlet between the tilt grill and the gas oven was observed covered with duct tape on February 3, 2008 at 3:10 PM.	L 214	#2 1. The scatter rug was removed from room 517. 2. Scatter rugs were removed from resident rooms. 3. Maintenance and Nursing staff will be reeducated on the inappropriateness of scatter rugs in the long term care environment and notifying maintenance when a scatter rug is discovered. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to scatter rugs are not present in resident rooms. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months. #3 1. The eye guards for the television antennas in 2 south and north dining rooms, 3 north and south dining rooms, and 4 south dining and living room will be replaced. 2. Review of resident televisions will be completed to ensure that resident's television antennas have eye guards present. 3. Maintenance will be reeducated on ensuring that television antennas have eye guards. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly X 4 weeks, then monthly to ensure television antennas have eye guards. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 214	Continued From page 52 8. A bucket of water and a mop was observed near the door by the dish machine room in the kitchen with the mop head laying across the bucket and the handle on the floor on February 3, 2008 at 2:25 PM. 9. Extension cords were observed in rooms 422 and 503, and in the general dining room on the first floor. 10. Clean utility room on 5 South contained four (4) unsecured oxygen tanks, three (3) empty and one (1) full. Employees #1, 2, 3, 5, 6, 7, 8, 9, and 10 acknowledged these findings at the time of the observations.	L 214	#4 1. Broken electrical outlet cover in kitchen near walk-in freezer and the cover on 3 north between rooms 317 and 318 were replaced. 2. Review of broken electrical outlet covers will be completed to ensure that outlet covers are intact. 3. Maintenance will be reeducated on the noting and repairing of outlet covers. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure that outlet covers remain intact. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08
L 389	3254.5 Nursing Facilities The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy. This Statute is not met as evidenced by: Based on staff interview, it was determined that the facility failed to maintain the linen par level at three (3) times the amount needed for licensed occupancy. The facility's licensed occupancy is 296 beds. The findings include: A face-to-face interview was conducted with Employee #10 on February 5, 2008 at 11:30 AM. He/she stated, " We [the facility] have enough linen for today only. We do not have a par level. Linen has been ordered. When it arrives we will have the par level needed. "	L 389	**L 389 3254.5 Nursing Facilities** 1. The Facility Housekeeping/Laundry Director ordered enough linen to bring the facility's linen inventory up to the required par level. The facility continues to place monthly linen orders. 2. The facility Housekeeping/Laundry Director will complete a linen inventory to ensure that there is ample enough linen to meet the state requirements as well as the needs of our residents. 3. The Housekeeping/Laundry Director will be reeducated on ensuring that the linen inventory is maintained as required by 22 DCMR 3254. The Housekeeping/Laundry Director will QI Monitor weekly X 4 weeks, then monthly X 12 months linen inventories to ensure required PAR levels. 4. Findings from the linen inventory will be presented to Facility Risk Management/Quality Improvement committee monthly X 12 months.	02/06/08 03/17/08 03/09/08 03/27/08

Received 4/4/08 LS

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L 214	Continued From page 53	L 214	#5 1. Employee #6 has been reeducated that he/she cannot light burners on the stove and must notify the Maintenance Director and the Food Services Director when burners on the stove are not working. Employee #6 understands that he/she may not attempt to make any repairs to the kitchen equipment. 2. The Food Services Director has completed a review throughout the kitchen to identify any other equipment that is not functioning and his/her findings have been forwarded to the Maintenance Department for appropriate action/resolution. 3. The Food Services staff will be in-serviced that they cannot light burners on the stove and they must notify the Maintenance Director and Food Services Director whenever major equipment fails to operate/function properly. Food Services Director, or designee, will QI monitor weekly X 4 weeks, then monthly X 12 months to ensure maintenance is contacted when kitchen equipment fails to function properly. #6 A & B 1. The leaks from the dish machine, the intake water filter, and the 5 north men's shower room were repaired. 2. Maintenance staff will review the building to locate leaks for repair. 3. Maintenance will be reeducated checking for leaks in the facility and prompt repair. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure leaks are found and repaired. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 214	Continued From page 53 A	L 214	#7 1. The electrical outlet between the tilt grill and the electrical oven was replaced. 2. Review of broken electrical outlet will be completed to ensure that outlet are intact. 3. Maintenance will be reeducated on the noting and repairing of outlet. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure that outlet remain intact. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months. #8 1. The mop was placed upright and returned to its storage area. 2. Review of kitchen was made to ensure mops were stored properly. 3. Kitchen staff were reeducated on proper mop storage. Dietary Manager, or designee, will QI monitor daily X 2 weeks, then weekly to ensure mop is stored in proper position and location. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 214	Continued From page 53 B	L 214	#9 1. The extension cords in room 422, 503 and the first floor dining room have been removed. 2. Review of facility will occur to ensure that no extension cords are present 3. Maintenance will be reeducated on the importance of removing extension cords from the facility. Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure that facility remain free from extension cords. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months. #10 1. The four oxygen tanks in the clean utility room on 5 South were properly secured behind a chain. 2. The Maintenance Director or Designee will complete a facility wide inspection of all utility rooms, resident rooms and common areas to ensure all oxygen tanks are placed behind a chain or inside an appropriate oxygen tank holder. 3. The nursing staff will be reeducated on the importance of securing oxygen tanks behind a chain when not in use and inside an appropriate oxygen tank holder when in use. The Maintenance Director, or designee, will QI monitor daily X 2 weeks, then weekly to ensure all oxygen tanks are stored properly within the facility. 4. Findings will be submitted to facility Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 02/11/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 53	L 410		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and staff interview during the environmental tour, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, and homelike environment for residents as evidenced by: soiled furniture, walls, floors, privacy curtains, windows, return vents, Heating, Ventilation and Air Conditioning (HVAC) units, cornice boards, overbed lights, stairwells and elevator tracks; marred/scarred/damaged furniture, walls, windows, HVAC, doors, chairs, baseboards, panels, television stands, and ceiling tiles; non-functional equipment, odors and room clutter. The findings were observed in the presence of the director of Employees #9 and 10 on February 3, 2008 from 2 PM through 6 PM and February 4, 2008 from 8:45 AM through 4:15 PM Additionally, dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: soiled floors, baseboards, tilt grill, gas oven, deep fryer, cooking hood filters, caulking above the pot and pan sink, drains, hand washing sinks, ceiling tiles; ice scoop stored on top of the ice machine; marred and scarred doors; dish machine leaking; transportation food carts missing doors and rubber on wheels; non-functioning burners and missing knobs on the gas stove; cabinet door under the steamer broken; pests by the pot and	L 410	**L 410 3256.1 Nursing Facilities** 1A. Furniture 1. The three chairs in the 2 South living room, the sofa and four chairs in the 2 North living room, the two sofas and two chairs in the 3 South living room, the three chairs in the 3 North living room, the two sofas in the 4 South living room, the three chairs and two sofas in the 4 North living room, the soiled arm chair and sofa in the 5 South dining room, the two sofas and three chairs in the 5 North living room and the chair in Room 536 have been cleaned. 2. Sofas and chairs throughout facility were inspected and soiled furniture were cleaned. 3. The housekeeping staff will be reeducated on spot checking and cleaning soiled chairs and sofas daily. The Housekeeping/Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly of common areas and resident rooms to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/17/08 03/17/08 03/13/08 03/27/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT PARK CARE CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 410	Continued From page 54 pan wash area; an unused detergent processor in cook's preparation (prep) area and cooking vessel not sanitized. These observations were made in the presence of Employees #1, 2, 3, 5 and 6 during the initial tour of the main kitchen on February 3, 2008 between 2:15 PM and 3:45 PM and February 4, 2008 at 1:30 PM. The findings include: Environmental Tour 1. The following soiled items were observed: A. Furniture 2 S: Three (3) of three (3) chairs in the living room. 2N: One (1) of one (1) sofa and four (4) of four (4) chairs in the living room. 3S: Two (2) of two (2) soiled sofas, two (2) of two (2) soiled chairs in the living room. 3N: Three (3) of three (3) chairs in the living room. 4S: Two (2) of two (2) sofas in the living room. 4N: Three (3) of three (3) chairs and two (2) of two (2) sofas in the living room. 5S: One (1) of one (1) soiled arm chair in the living room and one (1) of one (1) sofa in the dining room. 5N: Two (2) of (2) sofas and three (3) of three (3) chairs in the living area and one (1) of one (1) chair in room 536. B.Walls 1st Floor: Four (4) of four (4) walls in the main dining room, 2S: Dining room and living room walls in one (1) of one (1) dining and living rooms observed. 2N: Dining room and living room walls in one (1)	L 410	1B. Walls 1. The four walls in the main dining room on the 1st floor, the dining room and living rooms walls on 2 South, the dining room and living room walls on 2 North, the dining room walls on 3 South, the dining room walls on 3 North, the dining room walls on 4 South, the dining room and living room walls on 4 North, the dining room walls on 5 South, Rooms 536, 528, 527 and the dining room and living room walls on 5 North have been cleaned 2. Walls throughout the facility have been inspected and soiled walls have been cleaned. 3. The housekeeping staff will be reeducated on spot checking and cleaning soiled walls as well as notifying the maintenance if walls are in need of repair or painting. The Housekeeping/ Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly of common areas and resident rooms to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/20/08 03/18/08 03/13/08 03/27/08

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L 410	Continued From page 55 of one (1) dining and living rooms observed 3S: Dining room walls in one (1) of one (1) dining room observed 3N: Dining room walls in one (1) of one (1) dining room observed 4S: Dining room walls in one (1) of one (1) dining room observed 4N: dining room and living room walls in one (1) of one (1) dining and living rooms observed 5S: Three (3) of 13 observed resident rooms, 536, 528, 527 and dining room in one (1) of one (1) dining room observed. 5N: dining and living room walls in one (1) of one (1) dining and living rooms observed C. Floors 1st Floor dining room floor in one (1) of one (1) dining room observed 2S: Dining room, and rooms 223, 229, 233 and 234 in four (4) of seven (7) resident rooms observed. 2N: Dining room and rooms 210 and 211 in two (2) of eight (8) resident rooms observed. 3S: Dining room and hallway areas 3N: Dining room and hallway areas 5S: Dining and living rooms and rooms 529, 532, 535 in three (3) of six (6) resident rooms observed. 5N: Dining and living rooms and room 518 in one (1) of seven (7) resident rooms observed 20 of 20 hallway floors observed, this included in front of the elevators and all floors on the 1st, 2nd, 3rd, 4th and 5th floors. D. Privacy Curtains 2S: Room 236 in one (1) of seven (7) resident rooms observed.	L 410	1C. Floors 1. The 1st floor dining room floor, the 2 South dining room floor, floors in Rooms 223, 229, 233 and 234, the 2 North Dining room floor, floors in Rooms 210 and 211, the 3 South Dining room and hallway floors, the 3 North Dining room and hallway floors, the 5 South Dining and living room floors, floors in Rooms 529, 532, 535, the 5 North Dining and living room floors, floors in Room 518 and the hallway floors, including the area in front of the elevators and hallway floors on the 1st, 2nd, 3rd, 4th and 5th floors have been cleaned and/or stripped and waxed. 2. Floors throughout the facility have been inspected by the Housekeeping/Laundry Director and a stripping and waxing schedule has been developed to address deficient areas. 3. The floor technicians will be reeducated on maintaining clean floors through adherence to the stripping and waxing schedule. The Housekeeping/Laundry Director will complete QI monitoring daily X 2 weeks, then weekly of common areas and resident rooms to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 56 3S: Room 329 A and B and room 335 missing in three (3) of seven (7) resident rooms observed. E. Windows 1st Floor; Glass double doors in the dining room in one (1) of one (1) glass door observed. 2N: Rooms 205 and 209 in two (2) of eight (8) resident rooms observed. 3S: Room 333 in one (1) of seven (7) rooms resident observed. 3N: Rooms 301 and 309 in two (2) of seven (7) resident rooms observed. 4N: Room 403 in one (1) of seven (7) resident rooms observed. F. Return Vents in public areas 2N: One (1) in the dining room and one (1) in the living room in two (2) of two (2) vents observed. 3N: One (1) in the dining room in one (1) of two (2) vents observed. 5N: One (1) in the dining room in one (1) of two (2) vents observed. G. HVAC Units 3S: Dining room in one (1) of one (1) HVAC unit observed. 5S: Dining room in one (1) of one (1) HVAC unit observed. H. Cornice Boards 2S: Room 210 in one (1) of one (1) cornice observed in resident's room. 2N: Room 229 in one (1) of one (1) cornice observed in resident's room. I. Overbed Lights	L 410	1D. Privacy Curtains 1. Clean privacy curtains have replaced the soiled curtains found in Room 236 and the missing curtains in Room 329A and B and Room 335. 03/04/08 2. Privacy curtains throughout the facility have been inspected by the Housekeeping/Laundry Director to identify areas with soiled or missing curtains in need of replacement. Appropriate actions taken from findings. 03/17/08 3. The housekeeping staff will be reeducated on spot checking and notifying the Housekeeping supervisor when curtains are soiled or missing. The Housekeeping/Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly of privacy curtains to ensure compliance. 03/13/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 1E. Windows 1. The glass double doors in the dining room on the 1st floor and the windows in Rooms 205 and 209 on 2 North, Room 333 on 3 South, Rooms 301 and 309 on 3 North and Room 403 on 4 North have been cleaned. The damaged window seals and screens will be corrected by replacing the windows. 03/14/08 2. Windows throughout the facility have been inspected by the Housekeeping/Laundry Director and Maintenance Director to identify windows in need of cleaning and/or replacement. The Maintenance Director will solicit vendor bids to have windows with damaged seals and screens replaced. 03/27/08 3. The Housekeeping staff will be reeducated on cleaning windows in their assigned areas and notifying the maintenance department if windows are in need of repair. The Housekeeping/Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly of windows in common areas and resident rooms to ensure compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 410	Continued From page 57 4S: Rooms 419, 422, 426 and 435 in four (4) six (6) resident rooms observed. 4N: Rooms 402, 408, 413 and 417 in four (4) of seven (7) resident rooms observed. J. Stairwells North and south soiled floors in two (2) of two (2) stairwells observed. K. Elevator tracks Three (3) of three (3) elevator cars were observed with soiled elevator tracks on five (5) of five (5) floors. 2. The following marred/scarred and damaged items were observed: A. Furniture 2S: 10 of 10 chars in the dining room, missing drawer front in room 225, missing footboard in room 229, and missing closet door in room 236 in three (3) of seven (7) resident rooms observed. 2N: 14 of 14 chairs and five (5) of five (5) tables in the dining room; missing drawer front in rooms 210 and 211 in two (2) of eight (8) resident rooms observed. 3S: Six (6) of 10 chairs in the dining room; missing dresser drawer in room 335 in one (1) of seven (7) resident rooms observed. 3N: Two (2) of two (2) chairs in the living room; missing dresser drawer in room 313 in one (1) of seven (7) resident rooms observed. 5S: Five (5) of five (5) chairs in the dining room; damaged foot board in room 529, and missing drawer in room 536 in two (2) of six (6) resident rooms observed. B. Walls	L 410	1F. Return Vents in public areas 1. The return vents in the 2 North dining room and living room, the 3 North dining room and the 5 North dining room have been cleaned. 02/15/08 2. The Maintenance staff have inspected return vents in the facility. Any soiled vents have been cleaned. 03/17/08 3. The Maintenance staff will be reeducated on the importance of inspecting and cleaning return vents as part of their daily preventative maintenance. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly of return vents to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 1G. HVAC Units 1. HVAC units in the 3 South dining room and the 5 South dining room have been cleaned. 03/27/08 2. The Maintenance staff have inspected HVAC units and any soiled units identified have been cleaned. 03/27/08 3. The Maintenance staff will be reeducated on the importance of inspecting and cleaning HVAC units daily as part of their daily preventative maintenance. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly of HVAC units to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 410	Continued From page 58 1st Floor dining room walls. 2S: Training toilet room wall tile damaged, room 211 and 213 in two (2) of seven (7) resident rooms observed. 2N: Scarred wall in rooms 223, 233, 234, 236 and outside room 220 in five (5) of eight (8) resident rooms observed and damaged wall tile in the women's bathing/shower room. 3S: Room 309 in one (1) of seven (7) resident rooms observed. 3N: Dining room wall paper peeling in one (1) of one (1) dining room on 3N observed. 4S: Room 419 in one (1) of six (6) resident rooms observed. 4N: Dining room in one (1) of one (1) dining room observed on 4N. 5S: Women's bath stall with damaged tile on one (1) of two (2) bath stalls observed. 20 of 20 hallway walls were observed marred/scarred/damaged, this includes in front of elevators and all floors 1st, 2nd, 3rd, 4th and 5th floors. C. Floors Men and womens' shower/bath rooms on 2nd, 3rd, 4th and 5th floors observed with peeling, damaged and/or cracked paint in eight (8) of eight (8) shower/bath rooms observed. D. Windows - damaged window seals and screens 2S: Room 225 in one (1) of seven (7) resident rooms observed.. 3S: Rooms 322 and 325 in two (2) of seven (7) resident rooms observed 3N: Rooms 305 and 318 in two (2) of seven (7)	L 410	1H. Cornice Boards 1. The cornice boards in Room 210 on 2 South and Room 229 on 2 North have been cleaned. 02/18/08 2. The housekeeping staff will complete a 100% review of cornice boards in the facility to correct any additional deficiencies. 03/18/08 3. The Housekeeping staff will be reeducated on the importance of checking and cleaning cornice boards as part of their daily cleaning schedule. The Housekeeping Director will perform QI monitor daily X 2 weeks, then weekly to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 1I. Overbed Lights 1. The overbed lights in Rooms 419, 422, 426 and 435 on 4 South and the lights in Rooms 402, 408, 413 and 417 on 4 North have been cleaned. 03/04/08 2. The Housekeeping staff have completed a 100% review of overbed lights in the facility to address any deficiencies in other areas. Immediate corrective action will be taken to clean any soiled lights. 03/04/08 3. The Housekeeping staff will be reeducated on the importance of checking overbed lights as part of their daily cleaning schedule. The Housekeeping/Laundry Director or designee will perform QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 410	Continued From page 59 resident rooms observed. 4S: Dining room in one (1) of one (1) dining room observed on 4S. 5S: Rooms 533 and 536 in two (2) of six (6) resident rooms observed. 5N: rooms 503 and 515 in two (2) of seven (7) resident rooms observed. E. HVAC Units 2S: Dining room and room 216 in one (1) of seven (7) resident rooms observed. 4S: Dining room in one (1) of one (1) dining room observed on 4S. F. Doors 2N: Room 204, 205 and 206 in three (3) of eight (8) resident rooms observed. 2S: Room 233 in one (1) of seven (7)resident rooms observed. 5S: Room 508 in one (1) of six (6) resident rooms observed and one (1) of two (2) bath stall doors missing in the women's bathing/shower room. Marred/scarred entry doors were observed on floors 1, 2, 3, 4 and 5, in 19 of 19 entry doors observed. G. Chairs 5S: One (1) of five (5) torn chairs in the dining room and room 518 in one (1) six (6) resident rooms observed. H. Baseboards 1st Floor: Damaged baseboards in the dining room 2S: Room 229 in one (1) of seven (7) resident	L 410	1J. Stairwells 1. The soiled floors in the North and South stairwells have been cleaned. 2. stairwells have been inspected by the Housekeeping/Laundry Director to verify stairwells are clean and in compliance. 3. The Housekeeping staff will be reeducated on the importance of cleaning the stairwells daily. The Housekeeping/Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly of stairwells to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 1K. Elevator tracks 1. The elevator tracks for Elevators 1, 2 and 3 have been cleaned. 2. The Housekeeping/Laundry Director will inspect the elevator tracks for Elevators 1, 2 and 3 to ensure tracks are cleaned thoroughly. 3. The housekeeping staff will be reeducated on the importance of cleaning the elevator tracks. The Housekeeping/Laundry Director or designee will complete a QI monitor daily X 2 weeks, then weekly of elevator tracks to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/18/08 03/18/08 03/27/08 03/27/08 03/17/08 03/18/08 03/20/08 03/27/08

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L 410	Continued From page 60 resident rooms observed and by the water fountain. 2N: Rooms 205, 211 and 216 in three (3) of eight (8) rooms observed and one (1) of one (1) janitor's closet and one (1) of one (1) dining room. 3S: Room 322 in one (1) of seven (7) resident rooms observed and near the nurse's station. 5S: Dining room in one (1) of one (1) dining room observed on 5S. 5N: Women's bathing/shower room in one (1) of one (1) shower room on 5N. I. Panels Marred/scarred/damaged panels on the front of the nursing stations in eight (8) of eight (8) nursing stations observed. Elevator panels were observed in two (2) of three (3) elevator cars. J. Television Stands Black television stands were observed marred/scarred/damaged in dining and/or living rooms on all units in eight (8) of eight (8) television stands observed. K. Ceiling Tiles 1st Floor: Dining room ceiling tiles 2S: Rooms 223, 233 and 234 in three (3) of seven (7) resident rooms observed. 2N: One (1) of one (1) stretcher storage room, one (1) of one (1) telephone equipment room, one (1) of one (1) clean utility room and one (1) of one (1) dining room. 3S: One (1) of one (1) resident lean utility room and room 333 in one (1) of seven (7) rooms observed.	L 410	2A. Furniture 1. The marred/scarred and damaged items found in the facility that included chairs in the dining room, a missing drawer front in room 225, a missing footboard in room 229 and missing closet door in room 236 on 2 South, chairs and tables in the dining room, missing drawer front in rooms 210 and 211 on 2 North, chairs in the dining room, a missing dresser drawer in room 335 on 3 South, chairs in the living room and a missing dresser drawer in room 313 on 3 North and chairs in the dining room, a damaged foot board in room 529 and missing drawer in room 536 have been repaired or replaced. 2. The Maintenance staff will conduct a review of furniture throughout the building to repair/ replace items that are marred and scarred. 3. Maintenance staff will be reeducated on the importance of identifying and repairing/ replacing marred and scarred items found throughout the facility as part of their daily preventative maintenance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 61 3N: One (1) of one (1) pantry, one (1) of one (1) telephone closet, and room 309 in one (1) of seven (7) resident rooms observed. 3. Non-Functional Lights 2N: One (1) of one (1) men's bathing/shower room, one (1) of one (1) women's bathing/shower room toilet stall and with no cover. 3S: Room 308 in one (1) of seven (7) resident rooms observed. 3N: Room 329 in one (1) of seven (7) resident rooms observed and one (1) of one (1) women's bathing/shower room. 5S: Room 518 in one (1) of six (6) resident rooms observed. 5N: Room 532 in one (1) of seven resident rooms observed and one (1) of one (1) men's bathing/shower room. 4. Non-functional Equipment 2N: leaking tub faucet in room 236 in one (1) of eight (8) resident rooms observed and one (1) of one (1) broken ice machine with no signage indicating the machine was non-functional on February 3, 2008 at 2:30 PM. 4S: Shower head in one (1) of one (1) women's bathing/shower room leaking. 5N: Men's bath tub stopper failed to release water in the tub in one (1) of one (1) men's shower/bathing room. 5. Odors During the initial tour urine and fecal odors were detected in rooms 320, 325 and 512. 6. Clutter During the initial tour, clutter was observed in 11	L 410	2B. Walls 1. Marred, scarred and damaged areas on the walls in the 1st floor dining room, training toilet wall tile, in rooms 211 and 213 on 2 South, in 223, 233, 234, 236, outside 220, and wall tiles in the women's bathing/shower room on 2 North, walls in room 309 on 3 South, peeling wallpaper in the dining room on 3 North, room 419 on 4 South, the dining room on 4 North, the damaged tile in the women's bath stall on 5 South and hallway walls have been repaired. 2. The Maintenance staff will complete an review of walls to ensure any additional marred/scarred walls are repaired. 3. The Maintenance staff will be reeducated on the importance of inspecting walls as part of their daily preventative maintenance to ensure marred and scarred walls are repaired and re-painted timely. The Maintenance Director will perform QI monitor daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 2C. Floors 1. The shower rooms in the Men and womens' shower/bath rooms on the 2nd, 3rd, 4th and 5th floors have been repaired and re-painted. 2. The Maintenance Director has inspected shower room floors in the facility to identify areas in need of repair. 3. The Maintenance staff will be reeducated on the importance of checking shower room floors as part of their daily preventative maintenance. The Maintenance Director will perform a random review monthly of shower room floors to ensure compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/05/08 03/21/08 03/27/08 03/27/08 02/09/08 03/27/08 03/27/08 03/27/08

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	095019	A. BUILDING _____ B. WING _____	02/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT PARK CARE CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 410	Continued From page 62 of 55 resident rooms observed as follows: 2nd floor- 211, 213, 220 and 233 5th floor- 503, 505, 522, 523, 527, 529, and 532 Dietary Services 1. Floors were observed soiled throughout the kitchen with damaged tiles in the dish machine room and the cook's prep area. 2. Baseboards were observed soiled throughout the kitchen and damaged in the cooks prep area, under the pot and pan sink, and in the dish machine room. 3. The exterior surfaces of the tilt grill were observed soiled with grease and debris in one (1) of one (1) tilt grill observed. 4. The interior and top surfaces of the gas oven were observed soiled with grease and debris in one (1) of one (1) gas oven observed. 5. The exterior surface of the deep fryer was observed soiled with grease and debris in one (1) of one (1) deep fryer observed. 6. Cooking hood filters were observed soiled with grease and dust in 11 of 11 cooking hoods observed. 7. The caulking above the three (3) compartment sink in the pot and pan wash area was observed soiled with dirt and mold. 8. The interior surface of drains in the dish machine room, by the sink in the cook ' s prep area and by the sink in the pot and pan wash area were observed soiled with grease and debris in three (3) of three (3) drains observed.	L 410	2D. Windows 1. The damaged window seals and screens will be corrected by replacing the windows. Bids will be collected to replace windows in room 225 on 2 South, rooms 322 and 325 on 3 South, rooms 305 and 318 on 3 North, the dining room on 4 South, rooms 533 and 536 on 5 South and rooms 503 and 515. 03/27/08 2. The maintenance staff will complete an review of windows in the facility to determine if other areas are in need of correction. 03/27/08 3. The maintenance staff will be reeducated on the importance of checking windows as part of their daily preventative maintenance. The Maintenance Director will perform QI monitor daily X 2 weeks, then weekly to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 2E. HVAC Units 1. The HVAC Units in the dining room and room 216 on 2 South and the dining room on 4 South have been repaired. 02/17/08 2. The Maintenance staff will complete a review of HVAC units in the facility to identify other deficient areas so immediate corrective action may be taken. 03/18/08 3. The Maintenance will be reeducated on the importance of checking HVAC units as part of their daily preventative maintenance to ensure that units are operable. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 03/27/08 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 410	Continued From page 63 9. The interior and exterior surfaces of two (2) of two (2) hand washing sinks were observed soiled. 10. One (1) of one (1) ceiling tile near the door labeled 122 did not fit into the frame with a gap of approximately 1 inch, with cable wires exposed. 11. The ice scoop was observed stored on top of the ice machine in one (1) of one (1) ice scoop observation. 12. Doors, thresholds and frames from the kitchen to the dining room and in the dish machine room were observed marred and scarred in two (2) of two (2) doors observed. 13. The dish machine was observed leaking from an in-line water filter and where dishes enter the machine. Both leaks caused water to accumulate onto the floor of the dish machine room. 14. Five (5) of eight (8) food carts were observed without rubber treading on at least one (1) wheel of the cart. Two (2) of eight (8) food carts had both doors missing. Three (3) of eight (8) food carts had one (1) door missing. 15. Three (3) of six (6) burners on the gas oven had knobs missing. Of the three (3) burners functioning, one (1) burner did not light. Employee #6 stated that the pilot light was "out." 16. The cabinet door under the steamer was observed separated with the internal insulation visible. 17. A roach was observed crawling up the wall by	L 410	2F. Doors 1. The marred, scarred, and damaged or missing doors in rooms 204, 205 and 206 on 2 North, room 233 on 2 South, room 508 and two bath stall doors in the women's bathing/ shower room and the entry doors on floors 1, 2, 3, 4, and 5 have been repaired and/or replaced. 2. The Maintenance staff will complete a 100% review of doors and bathroom stall doors in the facility to determine if other areas are in need of correction. 3. The Maintenance staff will be reeducated on the importance of checking marred/scarred doors and bath stall doors as part of their daily preventative maintenance. The Maintenance Director will perform a QI monitor daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 2G. Chairs 1. The torn chair in the dining room and room 518 on 5 South have been repaired or replaced. 2. The Maintenance Director will conduct a 100% review of furniture found in the facility to ensure any additional torn furniture is repaired or replaced. 3. The Maintenance staff will be reeducated on inspecting furniture in assigned areas daily to immediately correct any deficiencies. The Maintenance Director will perform random reviews of facility furniture to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 64 the pot and pan wash area. 18. An unused detergent processor box, that was part of a previous chemical system, was observed under the sink in the cook's prep area with the electrical plug sitting in the drain under the garbage disposal. Employee #7 removed the processor box when it was identified as no longer in use. 19. It was observed that Employee #5 failed to sanitize cooking vessels after washing and rinsing them in the three (3) compartment sink. Employee #5 stated that the third compartment of the sink failed to hold water and he/she had not sanitized cooking vessels washed that day or the day before.	L 410	2H. Baseboards 1. The damaged baseboards in the dining room on the 1st floor, room 229 on 2 South, rooms 205, 211, 216, the janitor's closet and the dining room on 2 North, room 322 and the nurse's station on 3 South, the dining room on 5 South and the women's bathing/shower room on 5 North have been replaced. 2. The maintenance staff will inspect baseboards throughout the facility to identify other areas in need of repair. Any damaged baseboards identified during this inspection will be replaced. 3. The Maintenance staff will be reeducated on inspecting baseboards as part of their daily preventative maintenance. The Maintenance Director will conduct QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	02/19/08 03/27/08 03/27/08 03/27/08
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, it was determined that the facility staff failed to maintain an effective pest control program as evidenced by pests observed within the facility. The findings include: During the recertification survey crawling pest were observed in the following areas: 2South mens bath, Room 325, 3S nursing station and 5North men ' s bath A roach was observed crawling up the wall by the	L 426	**L 426 3257.3 Nursing Facilities** 1. The pest control vendor was notified immediately of the sightings. Areas have been treated to control/eliminate pests. 2. The pest control vendor completed a full inspection of the kitchen to identify other areas in need of treatment. Areas have been addressed to control/eliminate pests. 3. The pest control vendor has been scheduled to inspect areas of the kitchen weekly and treat areas as needed. Staff will be in-serviced on reporting pest concerns immediately to the Food Services Director or designee for appropriate follow-up with the pest control vendor. Food Services Director, or designee, will QI monitor daily X 2 weeks, then to ensure communication of pest issues has occurred. 4. A summary of the inspections will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	02/05/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65	L 410	2I. Panels 1. The damaged baseboards in the dining room on the 1st floor, room 229 on 2 South, rooms 205, 211, 216, the janitor's closet and the dining room on 2 North, room 322 and the nurse's station on 3 South, the dining room on 5 South and the women's bathing/shower room on 5 North have been replaced. 2. The maintenance staff will inspect baseboards throughout the facility to identify other areas in need of repair. Any damaged baseboards identified during this inspection will be replaced. 3. The Maintenance staff will be reeducated on inspecting baseboards as part of their daily preventative maintenance. The Maintenance Director will conduct QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 2J. Television Stands 1. The marred, scarred and damaged black television stands in the dining and/or living rooms on units have been repaired or replaced 2. The Maintenance Director has inspected television stands in common areas to ensure the stands are in good working condition. 3. The Maintenance staff will be reeducated on inspecting television stands during their daily furniture preventative maintenance. The Maintenance Director will conduct QI monitoring daily X 2 weeks, then weekly of furniture to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	02/19/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65A	L 410	2K. Ceiling Tiles 1. Stained and/or damaged ceiling tiles in the 1st floor dining room, rooms 223,, 233 and 234 on 2 South, the stretcher storage room, the telephone equipment room, the clean utility room and dining room on 2 North, the clean utility room on 3 South and room 333 and the pantry, telephone closet and room 309 on 3 North have been replaced. 2. The Maintenance staff will complete an review of ceiling tiles in the facility. Corrective action will be taken to replace stained and/or damaged ceiling tiles in any deficient areas 3. The maintenance staff will be reeducated on the importance of checking ceiling tiles as part of their daily preventative maintenance. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. 3. Non-Functional Lights 1. Lights and light covers have been placed in the men's bathing/shower room on 2 North, the women's bathing/shower room toilet stall, Room 308, Room 329, the women's bathing/shower room on 3 North, Room 518, Room 532 and the men's bathing/shower room. 2. The maintenance staff will complete a review on lights in the facility to ensure are lit. 3. Maintenance will be reeducated on the importance of checking lights as part of their preventative maintenance to ensure lights will be repaired or replaced. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be submitted to the facility Risk Management/Quality Improvement committee monthly X 12 months.	revised received 3/19/08 02/15/08 03/27/08 03/27/08 03/27/08 02/15/08 03/18/08 03/27/08 03/27/08

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L 410	Continued From page 65 B	L 410	4. Non-Functional Equipment 1. Corrective action has been taken. The leaking tub faucet in room 236 has been repaired. The broken ice machine with no signage on 2 North has been fixed. Signs will be placed on broken equipment throughout the facility. The leaking shower head in the 4 South women's bathing/shower room has been repaired. The tub stopper that failed to release water in the tub in the 5 North Men's bath tub has been repaired. 2. Maintenance staff will complete an review on faucets, ice machines, shower heads, and bath tub stoppers in the facility to ensure other residents are not affected by these deficiencies. 3. Maintenance will be reeducated on the importance of checking non-functional equipment as part of their daily preventative maintenance. The Maintenance Director will perform QI monitoring daily X 2 weeks, then weekly to ensure continued compliance. 4. Findings from the reviews will be submitted to the facility Quality Improvement committee monthly X 12 months. 5. Odors 1. Corrective action has been taken. Rooms 320, 325, and 512 have been cleaned and disinfected to eliminate the urine and fecal odors. 2. A 100% review of resident rooms will be conducted to identify other rooms with strong offensive odors. Once identified, rooms will be cleaned and disinfected to eliminate odors. 3. Housekeeping and Nursing staff will be in-serviced on maintaining a living environment for the residents that is free of offensive odors. The Housekeeping Director or designee will conduct random reviews of resident rooms daily to ensure compliance. 4. Findings from the daily reviews will be submitted to the Risk Management/Quality Improvement Committee monthly X 12 months.	02/17/08 03/18/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65 C	L 410	6. Clutter 1. The Housekeeping and Nursing Staff have eliminated the clutter found in Rooms 211, 213, 220, 233, 503, 505, 522, 523,527, 529 and 532. 2. Resident rooms throughout the facility have been inspected to identify rooms with clutter. Once located, rooms with excessive clutter will be cleaned and clutter will be removed. 3. The Housekeeping and Nursing staff will be reeducated on recognizing rooms that need to be de-cluttered and notifying the Housekeeping/Laundry or Nursing supervisor t o address the concern. The Housekeeping/ Laundry Director or designee will complete QI monitoring daily X 2 weeks, then weekly to ensure compliance. 4. Findings from reviews will be submitted to the facility Risk Management/Quality Improvement committee monthly X 12 months. Dietary Services #1 1. Floors were cleaned throughout the kitchen. 2. The Food Services Director has completed a review throughout the department to ensure floors were cleaned appropriately. Floors are to be cleaned after each meal and as needed. 3. The Food Services staff will be reeducated on the floor cleaning schedule. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for clean floors. 4. Findings from the QI monitoring will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/20/08 03/27/08 03/27/08 03/27/08 02/04/08 03/21/08 03/27/08 03/27/08

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L 410	Continued From page 65 D	L 410	#2 1. Base boards were cleaned throughout the kitchen (02/11/08). The damaged baseboards in the cooks' prep area, underneath the pot and pan sink and in the dish machine room will be replaced. 2. The Food Services Director has completed a review throughout the department to ensure base boards were cleaned appropriately. Baseboards are to be cleaned with the floor cleaning and as needed. 3. The Dietary staff will be reeducated on the proper way and frequency to clean baseboards. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly. 4. Findings will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. #3 1. The exterior surfaces of the tilt grill were thoroughly cleaned. 2. The Food Services Director completed a review of the tilt grill to ensure the exterior surfaces were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/08 03/21/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65 E	L 410	#4 1. The interior and top surfaces of the gas oven were cleaned thoroughly. 2. The Food Services Director completed a review of the gas oven in the kitchen to ensure the interior and top surfaces of the gas oven were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #5 1. The exterior surface of the deep fryer was cleaned thoroughly. 2. The Food Services Director completed a review of the exterior surface of the deep fryer to ensure the deep fryer was cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65 F	L 410	#6 1. The cooking hood filters were removed and cleaned thoroughly. 2. The Food Services Director completed an Inspection of the cooking hood filters to ensure the cooking hood filters were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #7 1. The caulking above the three compartment sink in the pot and pan wash area will be removed and replaced. 2. The Food Services Director has completed a review of the kitchen to ensure the caulking is adequate throughout the kitchen. 3. Food Services staff will be reeducated on completing maintenance repair requests to have damaged, soiled or molded caulking replaced. Food Services Director, or designee, will QI monitor daily X 2 weeks, then for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65 G	L 410	#8 1. The interior surface of the drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash area were cleaned thoroughly. 2. The Food Services Director inspected the interior surface of the drains in the dish machine room, by the sink in the cook's prep area and by the sink in the pot and pan wash area to ensure the items were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #9 1. The interior and exterior surface of the two hand washing sinks were cleaned thoroughly. 2. The Food Services Director completed a review of the two hand washing sinks to ensure the sinks were cleaned appropriately. 3. Food Services staff shall be reeducated on the cleaning schedule and cleaning procedures. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for completion of cleaning schedule. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

Revised 4/21/08 S.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/11/2008

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L 410	Continued From page 65 H	L 410	#10 1. The ceiling tile near the door labeled 122 will be replaced with a properly fitted piece to prevent the exposure of cable wires. 2. The Food Services Director has completed a review of ceiling tiles throughout the kitchen to ensure tiles are properly fitted. 3. The Food Services staff will be in-serviced on completing maintenance repair requests to have damaged, soiled or ill-fitted ceiling tiles replaced. Food Services Director, or designee, will QI monitor monthly. 4. Findings will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. #11 1. The ice scoop holders have been placed on the ice machines to store the ice scoops. 2. The Food Services Director has inspected the ice machine and validated the ice scoop holder is properly affixed to the machine and the ice scoop is placed in the holder. 3. The Food Services staff will be in-serviced on the importance of placing the ice scoop inside the ice scoop holder when not in use. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly for proper placement of the ice scoop. 4. Findings will be reported each month to the Risk Management/Quality Improvement committee X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

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L 410	Continued From page 65 I	L 410	#12 1. Marred and scarred kitchen doors will be repaired/replaced. 2. The Food Services staff will be in-serviced on completing maintenance repair requests for marred and scarred doors. 3. The Maintenance Director has conducted a review throughout the facility to ensure doors are adequate or repaired/replaced as needed. Maintenance Director, or designee, will QI monitor weekly X 4 weeks, then weekly. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #13 1. The Maintenance Director has repaired both leaks on the dish machine. 2. The Maintenance director has completed an inspection of the dish machine and performed preventative maintenance as scheduled to prevent further leaks or malfunctioning. 3. The Food Services department will be reeducated on reporting dish machine leaks and/or malfunction immediately to the maintenance department. Food Services Director, or designee, will QI weekly to ensure maintenance is contacted with dishwashing machine malfunctions. The Maintenance Director or designee will inspect the dish machine monthly and immediately upon notification of service problems/disruption to ensure optimal functioning. 4. Findings will be reported to the Risk Management/Quality Improvement committee each month X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

Revised 4/4/08

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L 410	Continued From page 65 J	L 410	#14 1. Eight (8) food carts will be repaired/ replaced. 2. Eight (8) food carts will be repaired/ replaced. 3. The Food Services Director will QI monitor the condition of the new food carts weekly to ensure equipment is serviced and maintained as needed. Kitchen Staff will be educated on the new or repaired food carts care and maintenance. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #15 1. Employee #6 has been reeducated that he/she cannot light burners on the stove and must notify the Maintenance Director and the Food Services Director when burners on the stove are not working. Employee #6 understands that he/she may not attempt to make any repairs to the kitchen equipment. 2. The Food Services Director has completed a review throughout the kitchen to identify any other equipment that is not functioning and his/her findings have been forwarded to the Maintenance Department for appropriate action/resolution. 3. The Food Services staff will be in-serviced that they cannot light burners on the stove and they must notify the Maintenance Director and Food Services Director whenever major equipment fails to operate/function properly. Food Services Director, or designee, will QI monitor weekly X 4 weeks, then monthly X 12 months to ensure maintenance is contacted when kitchen equipment fails to function properly.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

Revised PS 4/14/08

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L 410	Continued From page 65 K	L 410	#16 1. The cabinet door under the steamer has been repaired. 2. The Food Services Director has conducted a review on cabinet doors throughout the kitchen to identify other damaged/broken equipment. Maintenance repair requests will be completed to repair any broken equipment. 3. The Food Services Staff will be reeducated on completing maintenance repair requests for broken and damaged kitchen equipment. Food Services Director, or designee, will QI monitor weekly. 4. Findings will be reported to the Risk Management/Quality Improvement committee X 12 months. #17 1. The pest control vendor was notified immediately of the sightings. All areas have been treated to control/eliminate pests. 2. The pest control vendor completed a full inspection of the kitchen to identify other areas in need of treatment. Areas have been addressed to control/eliminate pests. 3. The pest control vendor has been scheduled to inspect areas of the kitchen weekly and treat areas as needed. Staff will be in-serviced on reporting pest concerns immediately to the Food Services Director or designee for appropriate follow-up with the pest control vendor. Food Services Director, or designee, will QI monitor daily X 2 weeks, then to ensure communication of pest issues has occurred. 4. A summary of the inspections will be reported to the Risk Management/Quality Improvement committee monthly X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08 03/27/08

Revised 4/4/08 g

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L 410	Continued From page 65 L	L 410	#18 1. The unused detergent box was discarded immediately. 2. The Food Services Director has completed a review in the kitchen to ensure any unused items are appropriately discarded. 3. The Food Services Director will reeducate the Food Services staff on how and when to properly discarding unused items. Food Services Director, or designee, will QI monitor daily X 2 weeks, then weekly X 4 weeks to ensure unused items have been discarded. 4. Findings will be reported to the Risk Management/Quality Improvement committee monthly X 12 months. #19 1. The sink has been repaired. 2. Pots and pans were rewashed and properly sanitized. 3. Food Services staff shall be reeducated on the proper sanitation of cooking vessels . The Food Services Director or his/her designee shall conduct reviews daily X 2 weeks, then weekly, of the three (3) compartments sink station to verify staff compliance with sanitation guidelines. 4.Copies of the review shall be submitted to the Risk Management/Quality Improvement Committee each month for review X 12 months.	03/27/08 03/27/08 03/27/08 03/27/08 02/03/08 02/03/08 03/21/08 03/27/08

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L 426	Continued From page 65 pot and pan wash area on February 3, 2008 at 3:00 PM.	L 426		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to: maintain laundry equipment needed to wash and dry residents personal laundry and facility laundry and ensure that preventive maintenance was completed for oxygen concentrators. The findings include: During a tour of the laundry area on February 5, 2008, it was observed that one (1) of four (4) personal laundry dryers was working; two (2) of four (4) personal laundry washers were working; two (2) of four (4) large dryers used for facility laundry were working and two (2) of four (4) large washers used for facility laundry were working. A face-to-face interview was conducted with the Employee #10 on February 5, 2008 at 11:30 AM. He/she stated, " The units have been down for a while. I am unable to tell how long. I took over the laundry department in November of 2007. We [the facility] have enough linen for today only. We do not have a par level. Linen has been ordered. When it arrives we will have the par level needed. " 2. Facility staff failed to ensure that preventive maintenance was completed for oxygen concentrators.	L 442	**L 442 3258.13 Nursing Facilities** #1 Laundry Equipment 1. Facility will repair or replace non-working washers and dryers. 03/27/08 2. Non-working washers and dryers will be repaired or replaced. 03/27/08 3. Maintenance Director or Designee will monitor washers and dryers to ensure that they are maintained in good working order. Maintenance director will QI monitor daily X 2 weeks, then weekly. 03/27/08 4. Maintenance Department will report to the facility Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08 Linen Par Level 1. The Facility Housekeeping/Laundry Director ordered enough linen to bring the facility's linen inventory up to the required par level. The facility continues to place monthly linen orders. 02/06/08 2. The facility Housekeeping/Laundry Director will complete a linen inventory to ensure that there is ample enough linen to meet the state requirements as well as the needs of our residents. 03/17/08 3. The Housekeeping/Laundry Director will be reeducated on ensuring that the linen inventory is maintained as required by 22 DCMR 3254. The Housekeeping/Laundry Director will QI Monitor weekly X 4 weeks, then monthly X 12 months linen inventories to ensure required PAR levels. 03/09/08 4. Findings from the linen inventory will be presented to Facility Risk Management/Quality Improvement committee monthly X 12 months. 03/27/08	

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L 442	Continued From page 66 Oxygen concentrators were observed in the following areas: There was no documented evidence of preventive maintenance provided for the above listed oxygen concentrators. a face-to-face interview was conducted with Employee #3 on February 11, 2008 at 1:00 PM. He/she stated, "We don't own the concentrators. The [company] who owns them does the maintenance. They deep the records. We don't have any records about the concentrators here at [the facility]."	L 442	#2 1. Facility has replaced the oxygen concentrators in Rooms 508, 525, 530 and 533. 2. Facility has requested paperwork to show the preventative maintenance that has been performed on oxygen concentrators. Concentrators are current in their maintenance. 3. The Maintenance staff will maintain a log book consisting of the vendor's preventative maintenance record for oxygen concentrators being used in the building. The Maintenance department will conduct weekly review of oxygen concentrator to ensure that the preventative maintenance records are available. 4. The Maintenance department will report their findings to the facility Risk Management/ Quality Improvement committee monthly X 12 months.	03/21/08 03/27/08 03/27/08 03/27/08