Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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L 000	Initial Comments The annual licensure survey was conducted on August 31 through September 2, 2010. The following deficiencies are based on observations, staff and resident interviews and record review. The sample size was 15 residents based on a census of 58 on the first day of survey. There were seven (7) supplemental residents.	L 000		
L 024	3206.3 Nursing Facilties Policies shall be reviewed by the committee at least annually with written notations, signatures, and dates of review. This Statute is not met as evidenced by: Based on document review, personnel file review and staff interview, it was determined that facility staff failed to: review and revise generic abuse policies to reflect their facility practice The findings include: On August 31, 2010 when the facility policy on abuse was requested, facility staff presented this writer with a Policy and Procedure book developed by [Company Name]. A review of this manual lacked documented evidence that the abuse policy presented had been reviewed/ revised or signed off by facility staff. Face-to face interviews were held with Employees #1, #2 and #17 on August 31, 2010 in the late afternoon. The above findings were acknowledged by these employees.	L 024	**L 024** The facility policy on abuse has been revised, reviewed, and signed off to reflect facility practice on abuse. The policy will be reviewed on an annual basis to ensure it reflects correct regulations and facility practices.	11/5/10
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by:	L 036		

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L 036	Continued From page 1 Based on staff interview and record review for three (3) of 15 sampled residents, it was determined that facility staff failed to comply with District of Columbia regulations as evidenced by failing to complete a history and physical examination for three (3) resident. Residents #4, 8, and 11. The findings include: 1. A review of Resident #4's clinical record revealed that the last history and physical examination was documented on May 30, 2009. Further review of the resident's clinical record revealed physician progress notes dated May 12, 2010, June 22, 2010, July 5, 2010, and August 13, 2010. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #4 on September 2, 2010 at approximately 10:00 AM. After reviewing the resident's clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident's thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2, 2010. 2. A review of Resident #8's clinical record revealed that the last history and physical examination was documented on October 10, 2008. Further review of the resident's clinical record revealed physician progress notes dated October	L 036	**L 036** 1. Residents #4, #8, and #11 have current H&Ps, October 2010 2. A chart audit was conducted to determine if any other residents were out of compliance with current H&Ps. Any charts found to be non-compliant will be brought to the attention of the attending physician for immediate correction. If the attending does not respond in a timely manner, the Medical Director will be notified to complete the H&P. 3. The MDS coordinator will identify the Residents requiring annual MDS Assessment and notify the Unit Managers. Unit Managers will audit those charts identified for all annual assessments including H&P, Nursing assessments. 4. The MDS Coordinator or designee will audit charts due for annual MDS Assessment to assure all annual Assessments are completed prior to submitting MDS to CMS.	11/5/10

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L 036	Continued From page 2 27, 2009, November 30, 2009, and December 29, 2009. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #4 on September 2, 2010 at approximately 10:00 AM. After reviewing the resident's clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident's thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2, 2010. 3. A review of Resident #11's record revealed that the last history and physical examination was documented on November 17, 2008. Further review of the resident's clinical record revealed physician progress notes dated June 22, 2010, July 5, 2010 and August 8, 10, 2010. However, there was no evidence of a history and physical examination. A face-to-face interview was conducted with Employee #10 on September 2, 2010 at approximately 9:30 AM. After reviewing the resident's clinical record, he/she stated, "Physical exams are done once a year. I thought it was done. I will check the thinned records." Further review of the resident's thinned clinical during the survey period lacked documented evidence of a history and physical examination. The record was reviewed on September 2, 2010	L 036		

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L 051	Continued From page 3	L 051	**L 051** 1. The MDS for resident #3 could not be corrected because the MDS for that assessment was a quarterly MDS, and the two subsequent MDS were coded correctly for allergies and falls.	
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 of one (1) of 15 sampled residents, it was determined that the charge nurse failed to develop a care plan with appropriate goals and approaches for a resident with an intolerance to sulfa. Resident #9. The findings include: A review of the August 2010 Physician 's Order Form dated and signed by the physician on August 19, 2010 revealed in the allergy section"	L 051	2. MDS 3.0 effective Oct. 1, 2010. No longer address allergies on the assessment. MDS coordinator and unit managers will continue to assess for allergies to assure care plans are complete and in the medical record. 3. MDS coordinator will review with the DON or designee all falls that occurred prior to assessment period for the resident to obtain and verify that all falls have been documented. 4. DON or designee will randomly audit the MDS to assure complete and accurate information is being assessed and documented on the MDS.	10/1/10

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L 051	Continued From page 4 Sulfa (Sulfonamide Antibiotics); SULFA CAUSES NAUSEA/VOMITING NOT ALLERGIC BUT INTOLERANT" Original order date June 10, 2010. Review of the June 2010 MAR (Medication Administration Record) revealed the aforementioned statement. Review of the care plans last updated June 22, 2010 lacked evidence of a care plan for Sulfa intolerance. A face-to-face interview was conducted with Employee # 10 on September 1, 2010 at approximately 10:30 AM. After review of the clinical record he/she acknowledged that the record lacked evidence of a care plan with appropriate goals and approaches for an intolerance to Sulfa. The record was reviewed on September 1, 2010.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair:	L 052	L 052 Staff will be in-serviced on correct feeding methods for Residents. Charge Nurses will monitor meal times to ensure proper feeding techniques. Any findings of issues will be reported to the QA Committee for further discussion.	11/05/10

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L 052	Continued From page 5 (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j) Prompt response to an activated call bell or call for help. Based on observation and staff interview for one (1) of 15 sampled residents, it was determined that sufficient nursing time was not given to promote dignity during lunch for Resident #9. The findings include: On August 31, 2010 at approximately 1:05 PM, lunch was observed being served to residents in	L 052		

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L 052	Continued From page 6 the dining area on the lower level. Employee #13 stood over the resident while assisting the resident with eating his/her lunch. A face-to-face interview was conducted with Employee #10 at approximately 2:30 PM. He/she stated Employee #13 should have been sitting when assisting the resident to eat his/her lunch.	L 052		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations made during the environmental tour of the facility on September 1 and 2, 2010, it was determined that the facility failed to store linen in accordance with current infection control practices. The findings include: The linen was stored uncovered in the clean linen room on the lower and upper levels. This observation was done in the presence of Employee #7 who acknowledged the findings at the time of the observation.	L 091	**L 091** 1. Curtains are being installed on the shelving in the clean linen room. Until such time all linen will be stored on covered carts. 2. In-service will be held with Laundry and Nursing staff to make sure they understand this practice. 3.Laundry and Nursing staff will continuously monitor as they go in and out of linen room to make sure curtain is closed and cart is covered. Periodically Nursing Supervisor will check the linen room to ensure compliance with regulations.	11/5/10
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal	L 099	**L 099** 1. Slices of cake were immediately covered and dated 2. In-service training was conducted with the dining staff on 09/12/2010 on how to properly cover and date all food items prior to putting food in the refrigerator. 3. Daily inspections are conducted by the chef's and dining room supervisors to ensure all food items are properly covered and dated 4. Continuous reminders are made at daily stand up meetings 5. No residents were found to be affected by this event.	

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L 099	Continued From page 7 Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations that were made during a tour of the dietary services on August 31, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by five (5) of five (5) slices of cake and two (2) of two (2) pound cakes that were not dated or covered, a crawling pest, two (2) of five (5) drain lines that offered no air gap to the drain, One (1) of three (3) ice machines that was not functioning , a damaged area on the kitchen floor and one (1) of one (1) soiled grill and one (1) of one (1) soiled tilt skillet, and outdated tray tickets that were used to verify residents diet orders. The findings include: 1. Slices of cake were not covered or dated in refrigerator #4 and two (2) of two (2) pound cakes were not labeled or covered in the walk-in freezer. 2. A crawling pest was observed on the kitchen wall. 3. Drain lines from the vegetable sink in the main kitchen and from the ice machine on the first floor kitchen provided no air gap from the drain. 4. The ice machine located on the first floor kitchen was not functioning and a repair or replacement work order had not been submitted. 5. The kitchen floor was damaged in front of the walk-in freezer. 6. The grill and the tilt skillet were soiled and in need of cleaning. 7. Freezer temperatures exceeded allowable limits of zero (0) degrees Fahrenheit (F) during the months of April thru August 2010. 8. Lunch tray tickets dated August 29, 2010 were used to serve residents meals on August 31, 2010. These observations were made in the	L 099	1. A service call was made to Ecolab Pest Control Company for immediate treatment treatment. Pest control treatment was conducted on the evening of 9/1/2010 2. No residents were found to be affected by this treatment 3. Daily kitchen inspections are being conducted by the Chefs for any evidence of roaches. 4. Monthly pest control treatments are scheduled and are being conducted by Ecolab Pest Control Company. 5. No evidence of roaches has been found in the kitchen. 1. A work order was submitted to maintenance to repair the sinks drain pipe to provide an adequate air gap between the pipe and the floor drain. Repairs completed. 2. A work order was submitted to maintenance to repair the ice machine drain pipe to provide an adequate air gap between the pipe and the floor drain. Repairs completed 3. No evidence of any floor drain backups into the sink and ice machine drain pipe. 4. Repairs were made to both the ice machine and sink floor drain. 5. No residents were found to be affected by this deficiency 1. An out of order sign was placed on the ice machine 2. A work order was submitted to maintenance to repair the ice machine 3. Maintenance repaired the ice machine and it is in good working condition 4. Daily inspections are made by the chefs and dining room supervisors to ensure the ice machine is in proper working condition. If not, they have been instructed to place an out of order sign on the ice machine and submit a work order for repair to the maintenance department.	11/04/10 10/29/10

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L 099	Continued From page 8 presence of Employee #6 who acknowledged the findings during the survey.	L 099	The two floor tiles are constructed to facilitate draining in front of the walk-in freezer. These tiles are not dented or bulked and do not need to be replaced or repaired. No resident is affected by this issue.	
L 116	3222.1 Nursing Facilities Each menu, as planned and served, shall be filed and retained for one year. This Statute is not met as evidenced by: Based on record review and staff interview of one (1) of 15 sampled residents it was determined that facility staff failed to administer the influenza vaccine as per physicians order. Resident #11. The findings include: Review of the Physician ' s Order Form for August 2010 revealed in the " Immunizations " section FLU Vaccine 0.5ML X (time) 1 dose annually - October ... " original date November 15, 2008. Review of the resident's immunization record revealed that the last Influenza vaccine was last administered October 11, 2008. The immunization record lacked evidence of the FLU Vaccine given October 2009. A face-to-face interview was conducted with Employee #10 on September 1, 2010 at approximately 10:30 AM. After review of the immunization records the Employee #10 indicated that "we do not give the immunizations every year and that there needs to be a new consent form". There was no real clear answer given as to why the influenza was not given in October 2009. The record was reviewed on September 1, 2010.	L 116	1. In-service training was conducted with the culinary staff on 09/15/10 how to properly clean the grill and tilt skillet after each use. 2. Daily inspections are being conducted by the chef's to ensure all equipment is being properly cleaned after each use 3. Continuous reminders about properly cleaning equipment are made at daily stand up meetings 4. No residents were found to be affected by this event 5. Evidence of proper cleaning procedures have been noted on the quarterly culinary audits of the kitchen. 1. No residents were found to be affected by the incorrect readings of the freezer thermometers. 2. New thermometers were placed into service on 9/3/10 that are capable of reading to zero (0) degrees Fahrenheit or below. 3. Thermometers and now in the coldest spot inside of the freezer to ensure proper temperature readings. 4. Temperature readings are conducted by looking at the internal thermometer not the external thermometer. 5. The freezer temperatures are taken at least 2 times daily and all readings are under zero (0) degrees Fahrenheit	9/15/10 9/3/10

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L 128	Continued From page 9	L 128	**L 099 (cont'd)**	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to acknowledge the pharmacist's recommendation for Resident #2. The findings include: A review of the clinical record for Resident #2 revealed a Medication Regimen Review [MRR] report from the pharmacist. The report was	L 128	1. A service call was placed to the Tray Tracker computer software company. 2. On 9/20/10 the dietician downloaded the current version of the Tray Tracker software. 3. Daily inspections are made by the dietician and/or dining room supervisor to ensure the correct dates on the ticket. 4. With the current version of the software tray tickets can be printed the night before to properly prepare for the breakfast meal. 5. No residents were affected by this event. **L 116** 1. Resident #11 was given the flu vaccine in October 2010. The facility has an Immunization policy that is in adherence with current recommendations of the Advisory Committee on Immunizations Practices (ACIP) as set forth by the Centers for Disease Control and Prevention (CDC). 2. Unit Managers will audit all resident's charts for Immunization consent form or orders for immunization of flu vaccine prior to the start of the flu season. Residents without consent forms will be obtained per facility policy. a. The resident or legal representative will receive education regarding the benefits and potential side effects of flu immunization and this will be documented in the medical record. b. The resident will either receive the flu vaccine or not due to medical contraindications or refusal, and this will be documented in the medical record. 3. Manager will audit residents charts bi-monthly during the flu season to assure flu vaccines are being administered in a timely manner.	9/20/10

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L 128	Continued From page 10 dated June 2, 2010 and stated, "Resident takes Mirtazapine and Nortriptyline HCL. He/she is receiving Lorazepam 0.5mg at bedtime for anxiety." The report continued that, "a drug interaction exists between the medications with the potential for ... confusion, myoclonus, tremor, agitation, ataxia, restlessness, diarrhea, nausea, diaphoresis and tachycardia." The pharmacist's recommendation stated, "Please consider re-evaluating continued use of these medications concurrently" The review was signed by the pharmacist. Beneath the pharmacist's signature was an area titled "Physician's Response." There were three [3] statements under the area designated for the physician's response. The first statement was "I accept the recommendation(s) above. Please implement as written." The second statement stated, "I accept the recommendation(s) above with the following modification(s) and the third stated, "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below: Rationale:" Neither statement was checked nor the area allocated for the physician's signature was left blank. A review of the physician's orders last signed by the physician on August 12, 2010 revealed orders for Mirtazapine and Nortriptyline May 21, 2010 and Lorazepam dated June 23, 2010. No adjustment was made to either medication between the date of the MRR [June 2, 2010] and the date of the survey [September 1, 2010]. A face-to-face interview was conducted with Employee #9 at approximately 11:00AM on September 1, 2010. He/she acknowledged being aware that the physician failed to respond to the pharmacist's MRR report. He/she added, "The	L 128	**L 116 (cont'd)** 4. Manager will review residents charts to verify consent forms and administration of flu vaccine or declination. **L 128** 1. Resident #2 pharmacy recommendation was reviewed by the attending and adjustments were made. 2. The DON or designee will monitor the monthly pharmacist report to assure timely compliance of recommendations to attending physicians. 3. All pharmacy recommendations will be forwarded to attending physicians and to consultant physicians and other disciplines as needed. 4. The DON will consult with unit Managers weekly regarding status of pharmacy recommendations until resolved. Recommendations not resolved by attending Physician will be referred to Medical Director for resolution.	11/05/10 11/5/10

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L 128	Continued From page 11 report was addressed to the psychiatrist and when he/she failed to respond to it, we referred it to the primary physician but he/she has not responded either. We are developing a new process for handling the MRR reports which will eliminate the problem." The record was reviewed on August 31, 2010.	L 128		
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 and staff interview, it was determined that facility staff failed to remove expired and discontinued medications from the medication carts on the Upper Level and Lower Level floor nursing units. The findings include: Expired and discontinued medications observed on the Upper Level and Lower Level floor unit were as follows: Upper Level Team 1 cart Twenty-four Oxycodone 5mg/325mg tablets discontinued August 27, 2010 Four (4) Tylenol 325mg tablets expired November 30, 2009 Team 2 cart Seventeen Lorazepam 0.5mg tablets expired June 30, 2010 Four (4) Tylenol 325mg tablets expired August 8	L 168	L 168 1. All expired and discontinued meds were removed from the medication carts on the upper and lower levels. 2. The charge nurses on the 3-11 shift will be responsible for removing all expired and discontinued medications from the carts daily. 3. The RN supervisor will assure the 3-11 Charge Nurse has checked the Med carts and all expired and discontinued meds have been removed and sign checklist verifying this has been done. 4. Managers will randomly check the Check-list to assure this is being done daily.	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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L 168	Continued From page 12 2010 Lower level Team 1 cart Three (3) Genebs 325mg tablets expired November 15, 2009 Fourteen Trazadone 50mg tablets expired May 31, 2010 Team 2 cart Fifteen Tylenol 325mg tablets expired December 31, 2009 Thirty-five Tylenol 325mg tablets expired October 31, 2009 Seven (7) Tylenol 325mg tablets expired August 15, 2010 Thirty Senna Plus 8.6mg tablets expired August 31, 2010 The above findings for both the Upper Level and Lower Level floor unit were acknowledged by Employees #9 and #15 on August 31, 2010 between 12:15 AM and 2:10 PM.	L 168		
L 292	3243.3 Nursing Facilities Each ramp, stairway, and corridor that is used by a resident shall be equipped with firmly secured handrails or banisters on each side. This Statute is not met as evidenced by: Based on observations made during the environmental tour of the facility on September 1 and 2, 2010, it was determined that the facility staff failed to ensure that handrails are firmly attached to the wall. The findings include: Handrails located next to the clean linen room on	L 292	**L 292** The handrails were secured to the walls. All other handrails were checked to ensure that they are firmly secured to the walls. Handrails will be randomly spot checked by the Maintenance department weekly and a log will be kept of any loose railings found. Findings will be reported at the monthly Quality Assurance meeting for discussion.	11/03/10

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L 292	Continued From page 13 the upper level, rooms #199 and #090 were loose. This observation was made in the presence of Employee #7 who acknowledged the findings at the time of the observation.	L 292		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 1 and 2, 2010, it was determined that the facility staff failed to provide effective maintenance services in residents' rooms as evidenced by seven (5) of 12 dusty bathroom vents and window sills in residents' rooms, one (1) of two (2) missing eyewash solution bottles, questionable temperature log values in rehab, and one (1) soiled medication room. The findings include: 1. Bathroom vents and/or window sills were dusty in rooms # 171, 173, 182, the clean linen room and bathing room. 2. The eyewash solution bottle was not available in the clean linen room on the lower level. 3. The temperature of the ice pack equipment in rehab was noted to be zero (0) to five (5) degrees Fahrenheit (F) for the month of August 2010 while the thermometer used to verify that temperature could only measure down to twenty-five degrees F.	L 410	**L 410** 1. All vents and window sills were cleaned on 9/2/2010. Housekeeping checked to ensure that other vents and window sills were cleaned and dust free. The Housekeeping Supervisor will randomly audit vents and sills on a monthly basis. Findings will be reported at the monthly QA meetings. 2. The eye wash solution bottle was replaced on 9/2/2010. All other eye wash stations were checked to make sure all bottles were in place and had not reached there expiration dates. The Housekeeping Supervisor will randomly audit the eye wash stations on a monthly basis. Findings will be reported at the monthly QA meetings. 3. No residents were found to be affected by the defective thermometer. The thermometer was replaced the day of the survey. Rehab department replaced the thermometer with a new thermometer that measures to zero (0) degrees Fahrenheit. The temperature of the freezer will be taken daily with the thermometer that measure to zero degrees. The temperature will be logged daily.	9/2/2010 9/2/2010 09/02/10

Health Regulation Administration

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L 410	Continued From page 14 4. The floor in the medication room on the upper level was soiled. These observations were done in the presence of Employee #7 who acknowledged the findings at the time of the observation.	L 410	**L 410 (cont'd)** The floor was cleaned by the Housekeeper on 8/31/10. Medication rooms will be monitored for cleanliness on a monthly basis by the Housekeeping Supervisor. All findings will be reported at the monthly QA meetings.	8/31/10
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: During an observation of the dining area made on August 31, 2010 facility staff failed to keep the dining area free of pest. The findings include: During a dinning observation on August 31, 2010 at approximately 12:31PM, one (1) of six (6) tables was observed with a crawling black and brown colored pest. After the pest was removed, Employee#11 at 12:50 PM entered the dining area, removed the table cloth and replaced it with a new one. A face-to-face interview was conducted with Employee #1 on September 2, 2010 at approximately 11:00 AM. After review of the circumstances Employee #1 indicated that pest control was called. The observation was made August 31, 2010	L 426	**L 426** After the pest was removed, the table cloth Areas noted were treated on 9/1/10 on an Emergency treatment request. Treatment for the kitchen and pantries remain ongoing, twice monthly. The rest of the facility is treated for pest every Wednesday. No residents were affected by this finding.	9/1/10