STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	11/08/2007

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SPECIALTY HOSPITAL OF WASHINGTON-HAL	4601 ML KING AVE SW WASHINGTON, DC 20032

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L 000	Initial Comments An annual licensure survey was conducted November 6 through 8, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 15 residents based on a census of 61 residents on the first day of survey and four (4) supplemental residents.	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to ensure that one (1) of six (6) newly hired employees had a current Nurse Aide certification on record. The findings include: Facility staff failed to ensure that a Certified Nurse Aide (CNA) had a certification when hired by the facility. According to 22 DCMR 3203.2, "A list of employees, with the appropriate current license or certification numbers shall be on file at the facility and available to the Director." A Certified Nurse Aide (CNA), Employee #13, was hired at the facility on April 14, 2007. During the review of certifications on November 7, 2007, it was observed that Employee #13's record lacked a current District of Columbia Nurse Aide certificate.	L 012		

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L 012	Continued From page 1 The review of the staffing for the week of November 4 through 10, 2007, revealed that Employee #13 worked on November 4 and 6, 2007, day shift (7:00 AM to 3:30 PM). He/she was on duty on November 7, 2007, day shift, and was relieved of his/her duties after it was revealed that a certificate was not on record. Present in the employee's record was a copy of a receipt from the post office that documented that an application for a District of Columbia CNA certification was mailed on March 16, 2007. There was no further information in the employee's record regarding the status of the application for certification. On November 7, 2007, at approximately 10:30 AM, a face-to-face interview was conducted with Employee #2 who indicated that Employee #13 had applied for the DC certification, but had not followed up on the application.	L 012	Answer L 012 & L 033 1. No resident affected by this practice. On November 7, 2007, Employee #13 was relieved of duty until this employee followed up with the DC C.N.A Certification. 2. The Human Resources Manager, DON or designee will verify all licensed and unlicensed personnel to ensure that all care-givers certifications are valid and up-to-date prior to beginning employment. 3. The Human Resources Manager and all hiring managers will verify all licensed and unlicensed personnel to ensure that all care-givers certifications are valid and up-to-date on a monthly basis. 4. A current list of active licenses/certifications will be provided to the DON and Administrator during Monthly QA Meetings as well as employee orientation. 5. Completion by 12-22-07	
L 033	3207.8 Nursing Facilities Each physician shall adhere to the written policies and regulations that govern the health services provided in the facility. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 15 sampled resident, it was determined that the physician failed to sign and date monthly orders. Residents #1 and 8. The findings include: A review of the facility's policy titled "Medical Staff Attending Physicians" and effective August 10, 1992 in Section V (1): "Resident Care Policies" revealed the following: "Documentation of the medical supervision of each resident shall	L 033		

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L 012	Continued From page 1 The review of the staffing for the week of November 4 through 10, 2007, revealed that Employee #13 worked on November 4 and 6, 2007, day shift (7:00 AM to 3:30 PM). He/she was on duty on November 7, 2007, day shift, and was relieved of his/her duties after it was revealed that a certificate was not on record. Present in the employee's record was a copy of a receipt from the post office that documented that an application for a District of Columbia CNA certification was mailed on March 16, 2007. There was no further information in the employee's record regarding the status of the application for certification. On November 7, 2007, at approximately 10:30 AM, a face-to-face interview was conducted with Employee #2 who indicated that Employee #13 had applied for the DC certification, but had not followed up on the application.	L 012		
L 033	3207.8 Nursing Facilities Each physician shall adhere to the written policies and regulations that govern the health services provided in the facility. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 15 sampled resident, it was determined that the physician failed to sign and date monthly orders. Residents #1 and 8. The findings include: A review of the facility's policy titled "Medical Staff Attending Physicians" and effective August 10, 1992 in Section V (1): "Resident Care Policies" revealed the following: "Documentation of the medical supervision of each resident shall	L 033	1. The physician signed and dated The missing monthly orders on 11-09-07 2. No other resident affected by this practice. The physician was counseled by the DON and the surveyor on 11-09-07. 3. Medical Records and the Unit secretary will audit adherence to completion of monthly orders. 4. Results of audit will be discussed at the quarterly QA meeting. 5. Completed 11-09-07	

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L 033	Continued From page 2 be evidenced by orders and progress notes in the resident ' s record, written and signed by the Attending Physician at least every 30 days." According to 22 DCMR 3207.8, "Each physician shall adhere to the written policies and regulations that govern the health services provided in the facility." 1. The physician failed to sign and date monthly orders for Resident #1. During the review of the clinical record for Resident #1, it was determined that the physician failed to sign orders for September 1, 2007, October 1, 2007 and November 1, 2007. The last orders signed and dated were noted for August 4, 2007. A nurse practitioner's progress note was present in the record for August 29, 2007. A physician's progress note was present in the record for October 6, 2007. On November 7, 2007 at approximately 8:45 AM a face-to-face interview was conducted with Employee #8 who stated that the physicians are to sign and date orders every 30 days. The record was reviewed on November 6, 2007. 2. The physician failed to sign and date monthly orders for Resident # 8. A review of Resident # 8's record revealed physician's order forms for the months of August, September and October 2007 that failed to include the physician's signature and dates. A face-to-face interview was conducted on November 7, 2007 at approximately 10:00 AM	L 033		

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L 033	Continued From page 3 with Employee # 8. He/she acknowledged that the physician failed to sign and date orders for the months of August, September and October 2007. The record was reviewed November 7, 2007.	L 033		
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 observations, staff interview and record review for one (1) of 15 sampled residents, it was determined that the charge nurse failed to amend the care plan with appropriate goals and approaches for one (1) resident on fluid restriction and one (1) resident with incontinence.	L 051	L 051 1. The appropriate goals and interventions for fluid restriction **for resident #4 were added to the care plan on November 26, 2007.** Resident F1's care plan and medications were assessed and evaluated by the IDT during our At-Risk Meeting. New interventions were implemented and the resident's physician and family members were notified. The care plan was also updated. The MDS was modified, noted and transmitted on November 27, 2007. 2. All residents with Dietary Orders for fluid restriction will be audited by the Dietician by December 22, 2007. The RCC or Designee will audit the care plan. **For our incontinent residents, the facility has instituted a bowel/bladder evaluation form on November 12, 2007** (please see attachment #V & #VI). A urinary incontinence audit will be performed by the RCC or Designee by December 12, 2007. Feedback from these assessments and evaluations will be discussed at the weekly IDT At-Risk meetings.	

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L 051	Continued From page 4 Resident #4 and F1. The findings include: 1. The charge nurse failed to amend the care plan with appropriate goals and approaches for Resident #4 on fluid restriction. A review of Resident #4's "Physicians Order Sheet" signed and Dated October 1, 2007 revealed, "Dietary Orders: ... Fluid Restriction of 1200 mls per day..." A review of the "Therapeutic Diet" care plan that was last updated on August 31, 2007, lacked evidence that the care plan was amended with goals and approaches for fluid restriction. According to the resident's record, facility staff identified that the resident received 200 ml of fluid during the night shift (11:00 PM to 7:30 AM) and 500 ml of fluid during each of the day (7:00 AM to 3:30 PM) and evening shifts (3:00 PM to 11:30 PM). A face-to-face interview was conducted on November 7, 2007 at approximately 9:35 AM with Employee #3. He/she acknowledged that the "Therapeutic Diet" care plan had not been amended to include fluid restriction. The record was reviewed on November 7, 2007. 2. Facility staff failed to amend Resident F1's care plan with appropriate goals and approaches for urinary incontinence. On November 6, 2007 at 9:20 AM and November 8, 2007 at 7:50 AM, during the environmental tour of Resident F1's room, strong urine odors were detected.	L 051	L 051 3. The Dietician will audit all orders for fluid restriction. The RCC will audit the care plans for fluid restriction. The facility has instituted a bowel/bladder evaluation form. The information received from the evaluation will be used to revise and create a plan of care that addresses incontinence. 4. Results from the bowel/bladder evaluation form, urinary incontinence audit, dietary fluid restriction audit, nursing care plan audit and any other compliance monitoring outcomes will be presented by the RCC and Dietician at the QA meetings on a quarterly basis. 5. Completion by 12.22.07	

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L 051	Continued From page 5 A face-to-face interview was conducted on November 8, 2007 at 9:55 AM with Employee #8. He/she stated, "...[Resident] has urinary incontinence at times and does not want to wear incontinent pads. When I started working here [at the facility in the beginning of the year] it was a concern. The staff cleans after the resident and within one hour the room smells again. The resident is on Lasix and doesn't want us to assist [him/her]..." A face-to-face interview was conducted on November 8, 2007 at 10:10 AM with Employee #12. He/she stated, "I assist the resident sometimes... Housekeeping assists. They mop the floor and wash down the bed. When I care for the resident I encourage [him/her] to take a shower and change clothes, but [he/she] yells and refuses to care." The most recent quarterly MDS (Minimum Data Set) dated September 6, 2007 for Section H1b (Bladder Continence) coded the resident as continent. A review of the care plan with the identified problem, "Requires assistance with ADL care", was last updated on September 7, 2007 and revealed "Resident is using the bathroom freely" and "Resident is continent". A face-to-face interview was conducted with Employee #8 on November 8, 2007 at 9:58 AM. He/she acknowledged that there was no care plan to address the resident's incontinence. The record was reviewed November 8, 2007.	L 051		
L 052	3211.1 Nursing Facilities	L 052		

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L 052	Continued From page 6 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 independently:	L 052	L 052 1. Resident #8's hand mittens were discontinued on November 8, 2007. The shower schedule has been revised to reflect the actual shower days. The care plan for resident #8 was updated on November 12, 2007 and **resident #8 received a shower.** 2. The RCCs reviewed all resident shower schedules and will continue to monitor for compliance with shower schedule and ensure that ADL flow sheets accurately reflects the bathing modality i.e. shower, bed bath etc. 3. The RCC or Designee will perform daily rounds to monitor personal hygiene and care. The Rehab Director or Designee will conduct an in-service on transferring, body mechanics, and showering residents who may be difficult to maneuver. In addition, the IDT determined that some residents have a history of refusing showers. Social Services and resident family representatives will assist the facility staff with encouraging those residents to shower. **Residents who are non-compliant with showers will be documented and care planned.** 4. Compliance monitoring outcomes related to resident showers will be presented by the RCCs at the QA meetings on a quarterly basis in efforts to maintain effective grooming and personal hygiene of our residents. 5. Completion 12.22.07	

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L 052	Continued From page 7 (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 bv: Based on observation, record review and staff interview for one (1) of 15 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to provide the necessary services to maintain good grooming and personal hygiene for Resident # 8 as evidenced by strong body odor and soiled hand mittens. The findings include: On November 8, 2007 at approximately 7:50 AM, Resident #8 was observed in bed awake. The resident emitted a strong body odor. The resident had soiled hand mittens on both hand and two additional soiled pairs of mittens at the resident's bedside. According to the quarterly Minimum Data Set (MDS) completed October 25, 2007, he/she is bedfast most of the time and totally dependent on staff for all of his/her activities of daily living: ambulation, dressing, personal hygiene, toileting and bathing. (Section G). He/she presents with bowel and bladder incontinence (Section H1). Diseases listed in Section I included: Diabetes Mellitus, Hypertension, Congestive Heart failure and Alzheimer ' s, Dementia other than Alzheimer ' s disease. A review of an Interdisciplinary Care Plan with the last entry dated August 3, 2007 revealed the following " Problem: Resident is totally dependent on nursing for all aspects of care ...	L 052		

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L 052	Continued From page 8 Goals: Resident will be well groomed, free of odors... Approaches: Provide daily care for resident. " According to the daily shower list revised 2007, the resident was scheduled for a shower on Mondays and Tuesdays. According to the " Resident Care Flow Record " for October and November 2007, the resident received a bed bath daily. There was no evidence that the resident received a shower for October and November 2007. A face-to-face interview was conducted with Employee # 8 on November 8, 2007 at approximately 7:55 AM. He/she acknowledged that the resident had a strong body odor, and soiled hand mittens. Additionally He/she could not explain why the resident had not received a shower in October and November 2007.	L 052		
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless: (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful; (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours,except when a resident's rest would be unnecessary disturbed. (d)The use of the restraint doe not result in a decline in the resident's physical, mental	L 083	L 083 1. Resident #8 was reassessed and it was determined that physical restraints were unnecessary. The interdisciplinary team decided the best intervention was to place an abdominal pad over the G-Tube to prevent the resident from pulling it out of place. Subsequently, the physician order for hand mittens was discontinued and the care plan was updated November 7, 2007.	

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L 083	Continued From page 9 psychological or functional status; and (e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition. This Statute is not met as evidenced by: Based on observations, record review and staff interview, for one (1) of 15 sampled residents, it was determined that facility staff failed to consistently assess the resident for the least restrictive device and attempt restraint reduction for Resident #8. The findings include: A physician's order initially dated May 31, 2007 and renewed October 10, 2007, directed, "Right and left hand mittens for 24 hours for prevention on pulling G.Tube (gastrostomy tube)." Resident #8 was observed in bed with both hands secured in mittens on the following days: November 6, 2007 at approximately 9:30 AM, 11:30 AM, 1:30 PM, and 2:30 PM. November 7, 2007 at approximately 7:10 AM, 9:10 AM, 11: 10 AM, and 1:10 PM . November 8, 2007 at approximately 7:15 AM, 9:15 AM, 11:15 AM, and 1:15 PM. A care plan was initiated on May 31, 2007 and reviewed August 30 and October 18, 2007, which directed, "Resident needs to use hand mitts continuously to prevent pulling [out] G-tube." There was no evidence in the record that the interdisciplinary care team assessed the resident in May 2007 for the least restrictive device or that an on-going attempt for restraint reduction was attempted after the hand mitts were applied.	L 083	L 083 2. All residents with restraints were audited 11-12-07 to ensure the orders were necessary. These residents were assessed for the least restrictive devices and there was an attempt at restraint reduction (see attachment #1). No other resident have been identified to be affected by this practice. All family representatives of resident's with restraints have been notified. 3. The staff will be in-serviced by our RCC's or designee on our facility's restraint reduction policy by 12-22-07. The in-service will review restraint assessments and reduction protocols. A restraint information and consent form (see attachment #2) has been instituted. 4. Results of the restraints audit tool and the findings from At-Risk meetings will also be shared at the Quality Improvement/Performance Committee meeting, quarterly. 5. Completed by 12-22-07	

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L 083	Continued From page 10 There was no evidence in the record that the resident's responsible party was notified that the use of hand mitts was initiated on May 31, 2007 at the time of this review. "Restraint Intervention" sheets were not available at the time of this review. Facility staff located the "Restraint Intervention" sheets after the survey was completed. A sample of the sheets was faxed to the surveyor on November 15, 2007. A review of the "Restraint Intervention" sheets revealed that "Attempted alternative measures" was not consistently checked and no explanation was offered as to the type of alternative restraint attempted if checked. Employee #2 documented on the facsimile message transmittal sheet that there were no "Restraint Intervention" sheets for May or June, 2007. The first sheet initiated was July 2, 2007. A face-to-face interview was conducted on November 7, 2007 at approximately 10:00 AM with Employee # 8. He/she acknowledged that facility staff failed to inform the resident or responsible party of the use of hand mitts, consistently assess the resident for least restrictive device and consistently attempt to reduce the restraint. The record was reviewed November 7, 2007.	L 083	L 099 – 1 & 2 **1. No residents were affected by this practice. All other areas in the kitchen were inspected to ensure no other expired foods are present. Expired foods were removed immediately 11-08-07. The chicken and biscuit were removed immediately.** 2. There were no residents affected by this practice. All areas of the kitchen were checked to ensure that no foods were expired. The (1) case of great shake plus nutrient and one (1) case of great shake supplement nutrient were observed in the walk in refrigerator with expiration dates of September 11, 2007 was immediately removed from the walk in refrigerator. An audit was done immediately to ensure that no other food items were found. 3. Staff in-service was scheduled by food service manger on proper storage and labeling and dating practices, mostly stressing the importance of rotation of food by understanding the (First In First Out Method). Quarterly staff in-services will be conducted to educate new staff and reinforce standard policy practice. 4. Food service supervisors will monitor walk in boxes 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion: 12-22-07	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40.	L 099	L 099- 3 1. No resident was affected by this practice. The exterior surfaces of the compressor body and fan covers in the walk in refrigerator that were soiled with accumulated dust and debris will be cleaned by maintenance.	

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L 099	Continued From page 11 This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared, stored and served in a safe and sanitary manner as evidenced by: expired nutritional supplements and undated and/or unlabeled food stored in the pantry refrigerator, a soiled compressor body and fan covers, deep fryers and dish machine tray and a large mixer with an oil leak. The observations were made in the presence of Employee #4, 5, 6, 7 and 9 on November 7, 2007 between 8:45 AM and 11:00 AM. The findings include: 1. One (1) case of great shake plus nutrient and one (1) case of great shake supplement nutrient were observed in the walk in refrigerator with expiration dates of September 11, 2007 in two (2) of two (2) cases of nutritional supplement observed. 2. One (1) undated and unlabeled zip lock bag containing chicken and a biscuit and one (1) undated hot pocket were observed in one (1) of two (2) pantries on the nursing units. 3. The exterior surfaces of the compressor body and fan covers in the walk in refrigerator were soiled with accumulated dust and debris in one (1) of one (1) compressor fan observed. 4. The exterior panels, inner panels, valves and burner surfaces of deep fryers were soiled with food deposits and grease in two (2) of two (2) deep fryers observed. 5. A mechanical mixer located adjacent to cooking hoods in the main kitchen was observed	L 099	2. No other residents were found affected by this practice. An audit was done immediately to ensure that no other fans or vents were soiled. An in-service has been scheduled by the food service manager to address the cleanliness of the compressor body and fan cover. 3. Maintenance will be requested to clean compressor body and fan covers monthly to ensure that the practice does not recur. 4. The Food Service supervisor will monitor compressor body and fans covers in walk in boxes 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion 12-22-07 + Ongoing L 099 - 4 1. No resident was affected by this practice. The exterior panels, inner panels, valves and burner surfaces of deep fryers that were soiled with food deposits and grease were cleaned immediately. 2. No other resident were identified to be affected by this practice. An audit was done immediately to ensure that all deep fryers weren't soiled with food deposits and grease. 3. The systemic changes put in place will be reinforcing to staff the importance of following cleaning schedule. In addition, quarterly staff in-services will be conducted to educate new staff and reinforce standard policy practice. 4. The Food Service supervisor will monitor cooking equipment 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings.	

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L 099	Continued From page 12 to have an oil drip around a bolt near the metal shaft which was directly over the bowl when the mixer was in operation in one (1) of one (1) mixer observed. 6. Food was allowed to collect on the clean side of the dishwasher tray as dishes were washed after the breakfast meal in one (1) of one (1) dish washer observed. Employees #4, 5, 6, 7 and 9 acknowledged the above findings at the time of the observations.	L 099	5. Completed 12-22-07 + Ongoing L 099 – 5 1. No resident was affected by this practice. The observed mechanical mixer located adjacent to cooking hoods was taken out of operation for repair. 2. No other residents were affected by this practice. An audit was done on the other mechanical mixer to ensure there is no leakage. 3. Maintenance will be requested to provide preventative maintenance on the mixers as needed once mixer is repaired. 4. The Food Service supervisor will monitor mechanical mixers and report all deficient findings to Maintenance and Quality Improvement / Performance Committee meetings on a monthly basis. 5. Completed by 12.22.07	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility staff failed to maintain a hazard free environment as evidenced by an unsecured box of laundry detergent in a resident's room. The environmental tour was conducted on November 6, 2007 between 10:30 AM and 11:35 AM in the presence of Employees #4, 5, 6 and 7. The findings include: A box of dish detergent was observed unsecured on a table in a resident's room, #335. Employee #4, 5, 6 and 7 acknowledged the above finding at the time of the observations.	L 214	L 099 – 6 1. No residents were affected. 2. Food was removed from the clean side of the dishwasher tray immediately. 3. An in-service has been scheduled, which will center on proper dish washing techniques. 4. The Food Service Supervisor will monitor the dish-washing practices. The results of the in-service will be reported to QA on a monthly basis. 5. Completion date 12-22-07	

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L 227	Continued From page 13	L 227	L 214	
L 227	3235.2 Nursing Facilities Each electrical cord, appliance, and equipment shall be maintained in a safe operating condition, and each frayed wire and cracked or damaged switch and plug shall be replaced. This Statute is not met as evidenced by: Based on observations during the dietary survey, it was determined that electrical outlets near the tray line were damaged. The finding include: During the tour of the dietary department, it was determined that one (1) electrical outlet installed in the floor near the tray line were damaged and not secured to the floor. One (1) outlet lacked power as evidenced by failure of a cold box to operate when the cord was plugged into the outlet socket in one (1) of three (3) outlets observed at 12:30 PM on November 6, 2007	L 227	1. The unsecured box of detergent in resident's room #335 was immediately taken out of the room when it was discovered. This resident was re-educated on the proper placement of detergent on November 6, 2007. The Resident verbalized understanding. 2. **The Charge Nurse, Housekeeping, and Maintenance conducted daily room rounds in all rooms- in order to maintain a hazard free environment.** 3. The facility staff will be in-serviced by RCCs or Designee on the facility's practice of maintaining a hazard free environment and the need environmental room rounds. 4. Compliance monitoring outcomes related to maintaining a hazard free environment will be presented by the Maintenance Manager at the QA meetings on a quarterly basis. 5. Completion by 12-22-07 + Ongoing	
L 245	3238.1 Nursing Facilities Each piece of heating and air conditioning equipment and its installation shall comply with the 1996 BOCA International Mechanical Code (Heating, Air Conditioning and Refrigeration), and all applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations during the dietary survey, it was determined that electrical outlets near the tray line were damaged; and during the environmental survey, it was determined that Heating Ventilation and Air Conditioning (HVAC) systems were not operating in two (2) residents' rooms. The findings include:	L 245	Answer L 227 & L 245 1. The electrical outlets will be repaired in dietary. The HVAC unit in room 332 was installed on 11/06/07 and the HVAC unit in room 338 was repaired and working on **11/06/07.** 2. Environmental rounds will be conducted in each unit and repairs will be issued a work order. The fan coils (HVAC units) are presently on a quarterly PM cycle. See attachments. 3. Environmental rounds will include housekeeping, maintenance and the department head or manager.	

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L 245	Continued From page 14 1. During the tour of the dietary department, one (1) electrical outlet installed in the floor near the tray line was damaged and not secured to the floor and one (1) outlet lacked power as evidenced by failure of a cold box to operate when the cord was plugged into the outlet socket in two (2) of three (3) outlets observed at 12:30 PM on November 6, 2007. 2. The environmental tour on 3 West was conducted on November 6, 2007 between 10:30 AM and 11:35 AM in the presence of Employees #4, 5, 6 and 7. During an environmental tour, two (2) of 13 HVAC units failed to operate in resident rooms, 332 and 338. A face-to-face interview was conducted on November 6, 2007 at 11: 25 AM with Resident F2 in room 338. He/she stated, "I told the staff that the system does not work. I was told that it [the HVAC system] needed a piece. It's cold at night. It [the HVAC system] has not worked since I have been here [in the facility]. I got here in May of this year. The staff will give me another blanket at night when I ask for one." A face-to-face interview was conducted on November 6, 2007 at 11: 28 AM with Resident F3 in room 332. He/she stated, "They [the staff] know that it ' s not working [HVAC] it has not worked since I have been here [in the facility]. I got here in April [2007]. My spouse brought me another blanket to put on my bed because it's cold at night." A face-to-face interview was conducted on November 6, 2007 at 11:30 AM with Employee #6. He/she acknowledged that both HVAC units	L 245	4. Results from rounds will be reported to the EOC committee and to the Performance Improvement Committee on a **quarterly basis**. 5. Repairs to outlets to be completed by 11/30/07. L 410 - 1 1. No resident was affected by this practice. The floor surfaces that were soiled with accumulated debris in the rear of convection ovens and deep fryers in four (4) of four (4) convection ovens observed were cleaned immediately 2. No other residents identified were affected by this practice. An audit was done on the kitchen floor to ensure no other areas were soiled or had debris build up. 3. Staff will complete an in-service on cleaning the convection ovens and will be required, to sweep and mop area behind convection ovens daily 4. The Food Service supervisors will monitor the area behind convection ovens 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completed 12-5-07 L 410 -2 1. No resident was affected by this practice. The inner surfaces of floor drains under food preparation area in the main kitchen that were soiled and accumulated with food debris in the main kitchen and dish washer area on three (3) of three (3) drains observed were cleaned immediately 2. No other resident was affected by this practice. The Food Service supervisor did an audit on all drains in the kitchen, to ensure they were all clean.	

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L 245	Continued From page 15 were not operating. The two (2) HVAC units were replaced on November 6, 2007 at approximately 3:30 PM.	L 245	3. The staff is required to clean drains daily, as an integral part of Food Services cleaning schedule. **A Staff in-service has been scheduled.** 4. Food Service supervisors will monitor drains throughout the kitchen 3 times a day and track the findings and report all deficient findings to monthly Quality Improvement / Performance Committee meetings. 5. Completion by: 12-22-07 + Ongoing	
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 during the dietary and environmental tour, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a clean, sanitary and safe manner as evidenced by: soiled floor surfaces in the rear of the convection ovens, deep fryers, drains under the dietary work stations and elevator track; damaged dresser drawers and floor tile; cleaning equipment stored on the floor, urine odors detected in resident rooms and missing end caps on hand rails. The dietary and environmental tour observations were made in the presence of Employees # 4, 5, 6, 7 and 9 on November 7, 2007 between 8:00 AM and 11:00 AM and November 8, 2007 at 7:15 AM. The findings include: 1. Floor surfaces were soiled with accumulated debris in the rear of convection ovens and deep fryers in four (4) of four (4) convection ovens observed. 2. The inner surfaces of floor drains under food preparation areas in the main kitchen were soiled with accumulated food and debris in the main kitchen and dishwasher area in three (3) of three	L 410	L 410 – 3 & 5 ***1. No residents were affected by this practice. Elevator tracks were cleaned immediately November 7, 2007.*** *Elevator tracks were cleaned immediately and floor tiles were repaired immediately on November 7, 2007.* 2. No other residents were affected by this practice. The housekeeping supervisor will monitor the elevator tracks to ensure tracks remain free of dirt and other debris. 3. Environmental rounds will include the monitoring of elevator tracks and cleaning of the tracks on a regular weekly schedule. **An in-service on elevator track cleaning will be scheduled.** 4. Our plan to monitor performance and ensure solutions are sustained includes reporting results from rounds to the EOC and Performance Improvement/ Performance Committee on a quarterly basis. 5. Completion by 12-22-07 + Ongoing L 410 – 4 1. No resident was affected by this practice. The residents were made aware that their dressers were damaged and/or required repair, 11-8-07. Families will be removing damaged furniture from the facility.	

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L 410	Continued From page 16 (3) floor drains observed. 3. One (1) of three (3) elevator tracks was observed soiled in the 3 West hallway. 4. Dresser drawers in two (2) of 13 rooms were observed damaged in the following areas: Room 324 was missing a front to the first drawer and room 303 the dresser drawer was missing knobs. 5. Floor tile in one (1) of 13 rooms, in room 324, was observed cracked near the resident's bathroom. 6. Cleaning equipment such as dust mops were stored on floor surfaces in one (1) of two (2) janitorial closets. 7. Strong urine odors in two (2) of 13 rooms were detected in rooms 315 and 317. A face-to-face interview was conducted on November 8, 2007 at 7:55 AM with Employee #8. He/she acknowledged that rooms 315 and 317 had a strong odor at 7:45 Am on November 8, 2007. 8. Two (2) of 16 handrail end caps were observed to be missing on unit 3 East on November 6, 2007 at 11:45 AM. Employee #4, 5, 6, 7 and 9 acknowledged the above environmental and kitchen findings at the time of the observations.	L 410	2. No other residents were affected by the practice. During rounds, personal furniture and equipment will be inspected and a report will be given to the units RCC or Charge Nurse to advise the resident and their families, of the condition of personal belongings. **Facility-owned damaged furniture was removed immediately 11-08-07** 3. The RCC, Housekeeping and or Maintenance supervisors will do rounding and note furniture not in compliance. Staff will be informed at staff meeting to note and make appropriate person aware of the compliance issue. 4. Our plan to monitor performance and ensure solutions are sustained includes reporting results from rounds to the EOC and Performance Improvement/Performance Committee on a **quarterly basis.** 5. Completion by 12-22-07 L 410 - 6 1. No residents were affected by this practice. Cleaning equipment such as dust mops were stored on floor surfaces in janitorial closets Hangers will be installed in the janitor closets for mops. **The room was cleansed to remove the odor.** 2. No other residents have been affected by this practice. All SNF janitor closets were inspected by staff immediately 11-08-07. **All SNF resident rooms were inspected for odors on the same day. No other resident's room was found to have an odor.** 3. Monitoring of the janitors closets for items on floor and urine odor will be conducted by the Housekeeping supervisor and Housekeeping staff. **Environmental rounds will include janitor's closets and urine odors daily.**	
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	L 426		

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L 426	Continued From page 17 debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain a pest free environment. This observation was made in the presence of Employees #6 and 7 on November 6, 2007 at 9:30 AM. The findings include: Multiple flying insects were observed in room 317. Employees #6 and 7 acknowledged the above findings at the time of the observation.	L 426	4. Our plan is to monitor performance and ensure solutions are sustained. Includes reporting results from rounds to the EOC and Performance Improvement/Performance Committee **on a quarterly basis.** 5. Completion date 12-22-07 L 426 1. A care plan and behavioral monitoring flow sheet for resident F1 was instituted on November 8, 2007. The new care plan addresses appropriate goals and approaches. 2. All residents with behavioral issues were identified. These residents will be reviewed in our weekly At-Risk Meetings. The resident behavioral monitoring flow sheet was initiated on November 8, 2007. 3. The facility staff will be in-serviced by Social Service Department Head or Designee. The in-service will reinforce the behavioral monitoring flow sheet. Additionally, the in-service will teach facility staff to identify, report, manage and document behaviors, and update care plans to reflect the appropriate goals and approaches. 4. Results from the behavioral monitoring flow sheet and compliance monitoring outcomes will be **discussed by RCC** at the QA meetings on a quarterly basis as well as our weekly At-Risk Meetings. 5. Completion by 12/22/07	