STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD02-0005		02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(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 052	Continued From page 37 lid down to expose the conjunctival sac, have the patient look up and away, then squeezed the prescribed number of drops into the sac. " During a medication pass conducted with Employee #15 on January 24, 2011 at approximately 10:00 AM, licensed staff was observed instilling an eye drop in the resident's left eye; the eye drop did not make full contact with the conjunctival sac, the opthalmic solution was observed running down resident ' s cheek. The observation was made on January 24, 2011. 2. A review of the clinical record for Resident #17 revealed that facility staff failed to ensure that sufficient nursing time was provided to assess the resident ' s blood pressure prior to the administration of an anti-hypertensive medication. The prescription included parameters of administration. Physician ' s orders dated December 1, 2010 directed the administration of Diovan 160mg one (1) tablet daily for blood pressure, hold for systolic blood pressure less than 110 or heart rate less than 60. A review of the Medication Administration Record [MAR] for January 2011 revealed licensed staff administered Diovan on January 1, 2011 at 9AM. The record lacked evidence of an assessment of the resident ' s blood pressure on January 1, 2011. There was no evidence that licensed staff made a determination regarding the appropriateness of administration of Diovan in the absence of a blood pressure assessment. The findings were reviewed and confirmed with Employee #3 during a face-to-face interview on	L 052	4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011

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L 052	Continued From page 38 January 31, 2011 at approximately 11:00 AM. 3. An observation of medication administration revealed facility staff failed to administer Resident #18's eye drop in accordance with professional standards. Physician ' s orders dated January 11, 2100 directed the administration of Timoptic Ocumeter 0.5% instill one (1) drop to each eye every morning for glaucoma. According to the " 2006 Lippincott ' s Nursing Procedure Manual, page 283 under " Medication Administration, to instill eye drops...pull the lower lid down to expose the conjunctival sac, have the patient look up and away, then squeezed the prescribed numb of drops into the sac. " During a medication pass conducted with Employee #15 on January 24, 2011 at approximately 9:15 AM, licensed staff was observed instilling an eye drop in each eye of Resident #18; the eye drops did not make full contact with the conjunctival sac and the opthalmic solution was observed running down resident's cheek. The observation was made on January 24, 2011. C. Based on observations, record review and staff and resident interviews for four (4) of 27 sampled residents and one(1) of 12 supplemental residents, it was determined that facility staff failed to enusre that sufficient nursing time was provided to: administer thickened liquid additive according to	L 052		

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L 052	Continued From page 39 Manufacturer ' s specifications for one (1) resident; assess blood pressure prior to the administration of an anti-hypertensive medication for one (1) resident; obtain a bedside commode per physician's order for one (1) resident; administer Vitamin D in accordance with physician ' s orders for one (1) resident, and administer pain medication in accordance with physician's orders for one (1) resident. Residents #12 #17, #18, #25 and # F2. The findings include: 1. Facility failed to ensure sufficient nursing time to administer thicken liquid additive according to manufactures specifications for Resident #12. During a medication pass observation conducted on January 25, 2011 at 8:45 AM with Employee #32, he/she poured an unmeasured amount of white powder (thicken liquid) into a 4 ounce cup of apple juice, precede to administer the medications and offered the thicken liquid following the medication administration. Review of the Physician ' s Order Form for January 2011 dated and signed by the physician on January 2, 2011 directed the following for Resident #2 ' s diet: " Pureed diet with nectar thick liquids ... " Review of the container directed to use one (1) tablespoon of thicken liquid in 4 ounces of apple juice for nectar thick. A face-to-face interview was conducted on January 25, 2011 at 12:15 PM with Employee #32. He/she indicated that the powder was not measure and it is by trial and error to get the right consistency for the resident to swallow. A face-to-face interview was also conducted on January 25, 2011 at 12:25 PM with Employee #33. He/she indicated that the instructions on the container are followed to obtain a thicken	L 052	L052(C) 1. Resident#12-Nurse education conducted regarding following instructions for accurate measurement of powered thickener added to liquids during medication administration. The resident did not sustain any negative outcomes from this incident. 2. A follow up random medication administration observation of nurse adding a powdered thickener to liquids was completed. Random medication administration observation rounds, including observing a nurse measuring powered thickener (when appropriate) will be conducted at least once per month of nurses giving medications to all residents, at least once per month by nurse managers on their respective units. Random medication administration observations were conducted during the week of April 11, 2011 (including where appropriate residents receiving thickened liquids during the medication administration): no other residents had negative effect.	

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L 052	Continued From page 40 liquid, nectar consistency, add one (1) tablespoon of thicken liquid to 4 ounces of apple juice. After review of the above Employee #32 acknowledged the findings of the above observation was made on January 25, 2011. 2. A review of the clinical record for Resident #17 revealed that the facility failed to ensure that sufficient nursing time was given to assess the resident ' s blood pressure prior to the administration of an anti-hypertensive medication. The prescription included parameters of administration. Physician ' s orders dated December 1, 2010 directed the administration of Diovan 160mg one (1) tablet daily for blood pressure, hold for systolic blood pressure less than 110 or heart rate less than 60. A review of the Medication Administration Record [MAR] for January 2011 revealed licensed staff administered Diovan on January 1, 2011 at 9AM. The record lacked evidence of an assessment of the resident ' s blood pressure on January 1, 2011. There was no evidence that licensed staff made a determination regarding the appropriateness of administration of Diovan in the absence of a blood pressure assessment. The findings were reviewed and confirmed with Employee #3 during a face-to-face interview on January 31, 2011 at approximately 11:00 AM. 3.Facility staff failed to ensure sufficient nursing time was given to follow a physician ' s order for a bedside commode for Resident #18. A review of Resident #18 ' s record revealed the	L 052	3. Powdered thickening agents (multi-dose cans) will no longer be used to administer thickened liquids to residents during medication administration. Pre-thickened water and juices or a pre-mixed powdered packet will be provided on each medication cart. A memorandum will be sent to all nurses to inform them to no longer use powered thickener (multi-dose cans) for medication administration: signed signature sheet will give evidence that the nurses understand (have been educated) to not use multi-dose powdered thickeners. 4. Once per month Nurse Managers or their designee will conduct a random medication administration observation with one nurse on each shift. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the monthly Quality Improvement Committee. 5. Compliance Date	4/8/2011

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L 052	Continued From page 41 following physician order dated January 11, 2011 that directed, " Place commode at bedside (toileting). " During the orientation tour of the facility on January 24, 2011 and January 27 and 31, 2011, no bed side commode was observed at Resident #18 ' s bedside. A face-to-face interview was conducted with Resident #18 on January 31, 2011 at approximately 1:00 PM, he/she stated, " I get up and go to the bathroom, I have to take my time. " A face-to-face interview was conducted with Employee #6 on January 31, 2011 at 3:30 PM. He/she acknowledged that resident did not have a bedside commode at bedside. The record was reviewed on January 31, 2011. 4. A review of the clinical record for Resident #25 revealed facility staff failed to ensure suffcient nursing time was provided to administer Vitamin D in accordance with physician ' s orders. According to a physician ' s summary dated December 10, 2010, Resident #25 was admitted to the facility ' s sub-acute unit for rehabilitation status post fall with functional decline. Diagnoses included Gait Disorder, Peripheral Neuropathy, spinal arthritis, acute renal failure and hypertension. The clinical record revealed the following physician orders for the month of December 2010: December 9, 2010 Vitamin D3 50,000 units buy mouth monthly for supplement	L 052		

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L 052	Continued From page 42 December 14, 2010 Vitamin D 50,000 units, one (1) capsule by mouth biweekly for Vitamin D deficiency December 17, 2010 Discontinue monthly Vitamin D orders A review of laboratory data revealed the resident ' s Vitamin D level, preformed December 10, 2010, was 23.9 [normal 32-100]. A review of the Medication Administration Record [MAR] for the month of December 2010 revealed Vitamin D3, 50,000 units was administered on December 12, 2011. The physician ' s order of December 14, 2010 for the weekly administration of Vitamin D was transcribed onto the MAR and a dosage was administered on December 16, 2010. " Discontinued 12/17/10 " was documented on the MAR for the monthly and weekly orders of Vitamin D. There were no doses of Vitamin D administered subsequent to December 16, 2010. A face-to-face interview was conducted with Employee #40 on February 1, 2011 at approximately 11:00 AM. S/he stated that both orders of the Vitamin D were erroneously discontinued, however, the resident progressed well in rehabilitation and had no adverse effect from the omitted doses. The record was reviewed February 1, 2011. 5. Facility staff failed to ensure that sufficient nursing time was given to provide Resident #F2's medications as per the physician ' s order. The Physician ' s Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Lidocaine HCL 5% Ointment, apply to legs from knee down twice daily for pain,	L 052		

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L 052	Continued From page 43 pt (patient) may refuse. " A review of the Medication Administration Record for January 2011 revealed that on January 9 and 20, 2011 nurses initials were circled indicating that Lidocaine was not given. A review of the reverse side of the MAR for January 2011 revealed that facility staff documented " not available from pharmacy " as the reason that Lidocaine was not administered. A face-to-face interview was conducted with Resident #F2 on January 31, 2011 at 9:40 AM. He/she stated, " I was told that my medication [resident was point to his/her legs] ran out. " The record lacked evidence that Resident #F2 received Lidocaine as per the physician ' s order. A face-to-face interview was conducted on February 1, 2011 at 12:50 PM with Employee #7. He/she acknowledged that the medication was not given as it was not available from pharmacy. The record was reviewed on February 1, 2011. D. Based on observation and interview of an isolated resident review in one (1) of 27 sampled residents, it was determined that facility staff failed to ensure that sufficient nursing time was given to provide incontinence care for Resident #6. The findings include: During a wound treatment observation on January 26, 2011 at approximately 8:45 AM, Employee #20 deferred the wound treatment secondary to determining Resident #6 was in need of incontinence care.	L 052	L052 (D) 1. Resident #6 - Night staff was counseled regarding failure to complete timely incontinence care. 2. Nursing staff re-educated regarding conducting at least every two hour incontinence care rounds for assigned residents.The resident was not negatively impacted. Random night shift rounds were conducted by House Supervisors from April 8th through April 15th: no other residents were found to be negatively impacted.	

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L 052	Continued From page 44 Employee #40 proceeded with the incontinence care. The incontinent brief that was removed from the resident was " soggy " and saturated with urine. The dressing that served to cover the resident ' s sacral wound slid off with the removal of the brief due to wetness. An interview with Employee #40, subsequent to the delivery of incontinence care revealed that it was not likely that the resident received incontinent care consistent with the facility ' s practice. He/she stated that incontinence care should be provided at least every 2 hours or sooner if needed. Employees #20 and #40 agreed that it was not likely that the resident had been changed during the [night] shift. Facility staff failed to ensure that sufficent nursing time was given to provide incontinence care for Resident #6. E. Based on observation, record review and staff interview for one (1) of 27 sampled residents and one (1) of 12 supplemental residents, it was determined that facility staff failed to ensure that sufficent nursing time was given to implement measures to prevent accidents by failing to apply safety devices for one(1) resident ' s with a history of falls and medication was left unattended in one (1) observation. Residents #10 and K3. The findings include: 1. During a medication pass on January 24, 2011 at 10:00 AM for Resident #10, Employee #15 was observed leaving Resident #10 ' s room to obtain gloves and a box of tissues from another	L 052	3. a. Increase in unit rounds by Nurse Managers during off nursing shifts. All nurse managers are to conduct at least one off nursing shift rounds on their respective units, by the 25th of each month and forward a documented report to the director of nursing. Nursing staff re-educated regarding conducting at least every two hour incontinence care rounds for assigned residents. b. Review of call light report determining length of time from call placed to answer received from staff. 4. Call light response report reviewed weekly by QI and findings reported to Nurse Managers for correction of identified variances. Nurse Managers will counsel staff individually, as appropriate. QI will report outcomes to the Quality Improvement Committee quarterly. 5. Compliance Date L052 (E) 1. Resident #10—nurse re-educated regarding principles of medication administration.	4/8/2011

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L 052	Continued From page 45 room for his/her eye drop administration. Employee #15 left the resident ' s medicine unattended on top of medicine cart. The observation was made January 24, 2011. 2. Facility staff failed to ensure that sufficient nursing time was given to the application of a safety device for a resident with a history of falls for Resident K3. Physician ' s orders for January 2011 directed " Vigilon monitor alarm at all times when up in chair. " An observation of Resident #K3 on January 25, 2011 at approximately 4:00 PM revealed he/she was being transported to the dining area of the unit while seated in a wheelchair. An audible alert device [Vigilon monitor] was observed attached to the wheelchair with a portion of the device dangling from the chair. After approximately 15 minutes of observation, an interview was conducted with Employee #42 at approximately 4:15 PM. S/he identified the device attached to the wheelchair of Resident #K3 as a " Vigilon Monitor, " a safety device for fall prevention. S/he stated that the resident had a history of falls and that the monitor was to be attached when the resident was in up in the wheelchair. The alarm was assessed as detached [dangling portion] and the employee proceeded to properly attached it to the resident, " we are supposed to check this every evening to make sure it is connected properly. " The record was reviewed on January 25, 2011. F. Based on observation, record review and interview for one (1) of 27 sampled residents and	L 052	2. Follow up medication administration completed with nurse. All nurses during unit meetings were re-educated on the 5-rights of medication administration: the guideline to not leave medications unattended was a part of the discussion in order to ensure safe medication administration to all residents. Beginning April 8, 2011 random medication administration observations were conducted with all nurses. During the observations, no deficiencies were seen with any other residents. 3. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. The Nurse Managers have received training through our pharmacy as to how to conduct Medication Administration observations. Follow up medication administration completed with nurse. All nurses during unit meetings were re-educated on the 5-rights of medication administration: the guideline to not leave medications unattended was a part of the discussion in order to ensure safe medication administration to all residents. 4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the monthly Quality Improvement Committee. 5. Compliance Date	4/8/2011

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L 052	Continued From page 46 two (2) of 12 supplemental residents, it was determined that facility staff failed to ensure that sufficient nursing time was given to promote residents' dignity as evidenced by one (1) resident who was exposed during medication pass, one (1) resident who sat idle as others dined in his/her presence and failure to provide sufficient mealtime supervision for one (1) resident. Residents #10, # K1 and K2. The findings include: 1. During a medication pass on January 24, 2011, it was determined that facility staff failed to give sufficient nursing time to ensure Resident #10' s dignity was maintained by failing to provide sufficient covering to his/her chest. During a medication pass on January 24, 2011 at approximately 9:30 AM, Resident #10 was observed sitting in the bed after consuming his/her breakfast. In response to the query, " can we come in? " the resident verbalized discontent with his/her chest being exposed. He/she stated that [he/she] wasted coffee and he/she likes to " show respect ...I am from the old school. I like to be presentable. " A face-to-face interview was conducted with Employee #6 on January 24, 2011 at approximately 10:30 AM. He/she stated that Employee #15 should have acknowledged Resident ' s #10 ' s comments and asked if he/she needed assistance with providing cover for his/her bare chest. 2. During a dining observation of the breakfast meal on January 25, 2011, it was determined that facility staff failed to ensure sufficient nursing time was given to promote Resident K1 ' s dignity by allowing the resident to sit idle while others dined.	L 052	1. Resident K3—staff member re-educated to check fall prevention alarm for placement during transport of resident. No negative impact to resident. 2. Re-education of staff—facility policy to complete nightly checks of functionality of fall prevention alarms and whenever a resident is transported: especially during transport for continued safety of any resident. 3. House Supervisor during shift rounds to observe functionality of fall prevention alarms. House Supervisors (and Nurse Managers) re-educated to include this duty as part of unit rounds. 4. Audit of functionality of fall prevention alarms to occur weekly by Restorative Nurse, who will report outcomes to the Quality Improvement Committee monthly. 5. Compliance Date L052 (F) 1. Resident #10 - One on one education done with staff member to acknowledge resident before entering room by knocking on door and waiting for an answer from resident giving the staff member permission to enter the room.	4/8/2011

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L 052	Continued From page 47 Resident K1 sat idly at the dining table in the main dining room on the unit while other resident ' s dined in his/her presence. When Resident K1 received assistance to consume his/her breakfast, the other residents who accompanied him/her at the table had completed their meals. Approximately 25 minutes elapsed between the time the others were served and the time Resident K1 was offered feeding assistance. The findings were reviewed with Employee #3 on January 31, 2011 at approximately 2:00 PM. 3. During a dining observation of the breakfast meal on January 25, 2011, it was determined that facility staff failed to promote Resident K2 ' s dignity by failing to provide sufficient mealtime supervision. Resident K2 ' s breakfast tray was set up by facility staff at the table in the main dining area on the unit. The resident exhibited limited dexterity of the hands and appeared to have difficulty managing the fork that was provided [no spoon was observed]. The resident was observed eating cereal covered with yogurt with his/her fingers. According to an occupational therapy progress note dated January 14, 2011, Resident #K2 had decreased motor control for wrist flexion and extension with limited range of motion. His/her level of function for feeding included set up with minimal assist. Mealtime supervision/assistance was not provided for Resident K2. The resident was assisted with clean-up following the completion	L 052	2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: knocking before entering resident room, wait for permission to enter before actually entering resident room. Staff will be observed randomly to ascertain if they are maintaining resident dignity, as daily unit rounds are made by Nurse Managers and House Supervisors beginning April 8 through April22, 2011. On-the-spot education will be conducted as needed if staff is not observed maintaining resident dignity. 3. An annual mandatory staff education class, topic: Maintaining Resident Dignity and Respect will be offered to all facility staff by the Education Department. 4. Nursing management team will make daily rounds on nursing unit. On-the-spot education for individuals found in violation of maintaining resident dignity will be given (disciplinary action will be given where needed and if appropriate. 5. Compliance Date 1. Resident #K1- One on one education done with staff member reminding them when serving meals to resident K1, ensure resident K1 meal is placed on the table at the same time the other table mates receive their meals. 2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: meal service to residents. Random meal observations were conducted by the Nurse Managers April 8 through April 12th: no other residents were affected.	4/8/2011

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L 052	Continued From page 48 of breakfast. G. Based on observation, record review and interview for one (1) of 12 residents reviewed, it was determined that facility staff failed to ensure that sufficient nursing time was given to assist the resident in the fulfillment of exercising choices for Resident #11. The findings include: During the orientation tour of the facility on January 24, 2011 at approximately 9:20 AM, Resident #11 was observed sitting on the side of the bed consuming breakfast. In response to the query, " how are you? " the resident verbalized discontent with the meal and rising schedule. He/she stated that [he/she] had always been an " early riser " and expressed a desire to get started with his/her day at an earlier hour, " this is too late for breakfast. " He/she stated that this had been expressed to staff prior to this dialogue. A review of the clinical record revealed the resident was admitted to the subacute unit of the facility on December 23, 2010 and transferred within the facility to a long term care unit on January 19, 2011. According to the admission Minimum Data Set (MDS) dated January 4, 2011, Resident #11 was coded as cognitively intact, required limited assistance for activities of daily living and consumed meals independently with set up help only. The record lacked evidence that staff proactively assisted the resident in fulfilling choices related to his/her	L 052	3. Systemic: During orientation of newly hired nursing staff the Education Department will present the topic—Maintaining Resident Dignity & Respect: a portion of the session will include serving a resident meals (ensuring all residents that are table mates will receive their meals on the table at the same time). The same topic is to be presented as a mandatory staff education class annually for all nursing staff. On-going random meal observations will be conducted by Nurse Managers and House Supervisors to observe staff in the practice of maintaining dignity while serving meals (specifically observing that idle diners are not present at dining tables). Variances will be corrected on- the- spot and on-the-spot education given to staff. 4. The Quality Improvement Nurse, Unit Nurse Managers and House Nursing Supervisors will conduct random meal observations to ensure staff education is successful. Negative trends will warrant on-the-spot individual staff counseling. 5. Compliance Date 1. Resident #K2—re-education of staff member regarding maintaining resident dignity during meals: ensuring resident receives the appropriate utensils to complete their meal.	4/8/2011

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NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016		

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L 052	Continued From page 49 daily arising/dining schedule. A face-to-face interview was conducted with Employee #3 on January 28, 2011 at approximately 9:40 AM. . He/she stated that the facility offered an option of an early breakfast tray for those who chose to eat early, however, acknowledged that the option had not been explored with Resident #11. H. Based on medication administration observation of four (4) of 27 sampled residents, it was determined that the facility failed to ensure that sufficient nursing time was given to maintain a medication error rate of less than five (5) percent by not administering medications according to physician ' s order for four (4) residents. There were four (4) medication errors in 44 opportunities resulting in a medication error rate of 9.09%. Residents #8, 10, 18, and 22. The findings include: 1. On January 26, 2011 at approximately 9:30AM Employee #36 administered one (1) Probiotic tablet to Resident #8. A review of the physician ' s orders revealed the following order: " Probiotic 1 [one] tab [tablet] po [by mouth] daily x [times] 14 days. The medication was ordered on January 12, 2011. A review of the Medication Administration Record [MAR] revealed that January 25th was the 14th day and the last scheduled day for the administration of the medication.. A box was designated for the nurse to sign after administering the medication. The word STOP was written on the MAR for January 26, 2011.	L 052	2. Re-education of nursing staff (by April 8, 2011) by the Education Department regarding preserving resident dignity: meal service to residents. Random meal observations were conducted by the Nurse Managers April 8 through April 12th: no other residents were affected. 3. Systemic: During orientation of newly hired nursing staff the Education Department will present the topic—Maintaining Resident Dignity & Respect: a portion of the session will include serving a resident a meal. The same topic is to be presented as a mandatory staff education class annually for all (residents have the appropriate utensils for meal completion) nursing staff. 4. The Quality Improvement Nurse, Unit Nurse Managers and House Nursing Supervisors will conduct random meal observations to ensure staff education is successful. Negative trends will warrant on-the-spot individual staff counseling. 5. Compliance Date L052 (G) 1. Resident #11—was given explanation of early tray option and placed on list to receive an early tray. Discussion documented.	4/8/2011

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L 052	Continued From page 50 A face-to-face interview was conducted with Employee #37 immediately after the medication administration. He/she acknowledged administering the medication and stated, I thought today was the last day for that medication. " 2. During the medication pass observation on January 24, 2011 at approximately 9:35 AM, Employee #15 was observed administering Resident #10 ' s medications, one of which included Cosopt Ocumeter Plus, instill one (1) drop in left eye every 12 hours for glaucoma. He/she informed the resident that he/she was going to administer his/her eye drops. Employee #15 instilled one drop in the resident's right eye. A review of Resident #10 ' s record revealed physician ' s orders dated January 7, 2011 which directed, " Cosopt Ocumeter Plus..instill (one) 1 drop in left eye every 12 hours for glaucoma. The findings were reviewed and confirmed by Employee #15 during a face-to-face interview on January 24, 2011 at 9:50 AM. The record was reviewed January 24, 2011. 3. During the medication pass observation on January 24, 2011 at approximately 9:15 AM, the nurse was observed administering Resident #18's medications, one of which included Timoptic Ocumeter, instill one (1) drop to each eye every morning for glaucoma. He/she informed the resident that he/she was going to administer his/her eye drops. Employee #15 instilled two drops into the resident's left eye. A review of Resident #18 ' s record revealed	L 052	2. At time of admission and quarterly there-after, residents are to be queried regarding their preference for an early tray option.Nutritionists & licensed nurses will receive (by April 8, 2011) education to remind them to query newly admitted residents for the early tray option. The IDT will receive education to remind them to query resident about this choice during quarterly care plan conferences. 10% of new admission charts were audited and no other residents had concerns regarding request for an early tray. 3. At time of admission a documented explanation of the early tray meal option will be a part of the admission packet. Verbal explanation will be given to resident as part of the nurse assessment interview (where applicable) with second follow up during the admission nutritionist interview. 4. As per facility policy, (or per resident request) during the nutritionist's quarterly resident review, the nutritionist will review resident options of meal choices—including the option of early meal tray. 5. Compliance Date <u>L052 (H)</u> 1. Resident # 8 - Nurse re-educated concerning 5-Rights of Medication Administration. No negative outcome to resident.	4/8/2011

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L 052	Continued From page 51 physician ' s orders dated January 11, 2011 directed, " Timoptic Ocumeter ophthalmic 0.5% drops ...instill one (1) drop to each eye every morning for glaucoma. The findings were reviewed and confirmed by Employee #25 during a face-to-face interview on January 24, 2011 at 9:30 AM. The record was reviewed January 24, 2011. 4. Facility staff failed to ensure that sufficient nursing time was given to follow the physician's order to administer Insulin before breakfast to Resident #22. On January 26, 2011 at approximately 10:00AM Resident #22 became agitated during the medication pass observation. The nurse was unable to give him/her the Insulin and placed the syringe with Insulin in a drawer in the medication cart. Employee#22 was observed administering the prescribed Insulin at approximately 10:30AM, after the resident had eaten his/her breakfast and contrary to the physician's order which directed that the Insulin should be administered before breakfast. A review of the clinical record revealed a physician's order initiated May 17, 2010 which directed, "Novolog100 units/ml vial 3units sub-q before breakfast for Diabetes Mellitus." A review of the resident's January 2011 Medication Administration Record revealed the following: " Novolog 3units sub-q before breakfast and Novolog 100 units/ml inject sub-q per sliding scale: check blood sugar before meals and at bedtime." A face-to-face interview was conducted with	L 052	2. Follow up medication administration observation completed with nurse. During the medication administration observation completed with the nurse, no other residents receiving probiotics had any negative effects. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering medications. The 5-Rights of Medication Administration were reviewed during the same unit meetings. 3. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers received an education session presented by the pharmacy, on how to conduct Medication Administration Observations. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering medications. 4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report outcome trends and corrections to the QI Committee quarterly. 5. Compliance Date	4/8/2011

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L 052	Continued From page 52 Employee #22 on January 26, 2011 at approximately 11:30 AM. He/she acknowledged the findings. The medication order was reviewed on January 26, 2011. I. Based on record review and staff interview for one (1) of 12 supplemental residents, it was determined that the facility failed to ensure that sufficient nursing time was given to administer prescribed pain medication. Resident #F2. The findings include: The Physician ' s Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Lidocaine HCL 5% Ointment, apply to legs from knee down twice daily for pain, pt (patient) may refuse. " A review of the Medication Administration Record for January 2011 revealed that on January 9 and 20, 2011 nurses initials were circled indicating that Lidocaine was not given. A review of the reverse side of the MAR for January 2011 revealed that facility staff documented " not available from pharmacy " as the reason that Lidocaine was not administered. A face-to-face interview was conducted with Resident #F2 on January 31, 2011 at 9:40 AM. He/she stated, " I was told that my medication [resident was point to his/her legs] ran out. " There was no evidence that the facility ensured that Lidocaine was received from the pharmacy in a timely manner to be administered to the resident in accordance with the physician's order.	L 052	1. Resident #10—eye drops given in wrong eye Nurse re-educated concerning Five-Rights of Medication administration. Resident did not sustain any negative outcomes from the occurrence. 2. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering eye drops. During the medication administration observation completed with the nurse, no other residents receiving eye drops had any negative effects. The 5-Rights of Medication Administration were reviewed during the same unit meetings. 3. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering eye drops. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers received an education session presented by the pharmacy, on how to conduct Medication Administration Observations. 4. Completed Medication Administration audit forms will be forwarded to the Education Department.	

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L 052	Continued From page 53 A face-to-face interview was conducted on February 1, 2011 at 12:50 PM with Employee #7. He/she acknowledged that the medication was not given as it was not available from pharmacy. The record was reviewed on February 1, 2011. J. Based on a review of the Omni cell inventory records and staff interview, it was determined that the facility failed to ensure that controlled drugs were reconciled each shift, daily. The findings include: The Omni Cell inventory records from December 14, 2010 through January 29, 2011 revealed that on December 15, 16, 17, 18, 20, 22, 24, 25, 27, 29, and 31, 2010; January 3, 6, 9, 10, 13, 14, 15, 17, 19, 22, 23, 25, and 27, 2011 facility staff failed to reconcile the schedule II medications stored in the Omni Cell. A face-to-face interview was conducted on February 1, 2011 at approximately 5:00 PM with Employees #2, 3, 4, 5, 6 , and 7. They stated that the practice is to reconcile the schedule II medications every shift on a daily bases. Additionally, the staff acknowledged that the schedule II medications stored in the Omni Cell were not reconciled on a daily and shift-to-shift basis.	L 052	The Education Department will report negative trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date 1. Resident # 18 - Nurse re-educated concerning 5-Rights of Medication administration. 2. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering eye drops. During the medication administration observation completed with the nurse, no other residents receiving eye drops had any negative effects. The 5-Rights of Medication Administration were reviewed during the same unit meetings. 3. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers received an education session presented by the pharmacy, on how to conduct Medication Administration Observations. 4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report negative trends and corrections to the monthly Quality Improvement Committee. 5. Compliance Date	4/8/2011 4/8/2011
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.	L 091		

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L 091	Continued From page 54 This Statute is not met as evidenced by: A. Based on observations, record review and interview for four (4) of 27 sampled residents and two (2) of 12 supplemental residents, it was determined that the Infection Control Committee failed to ensure that proper infection control policies and procedures were followed during wound care treatments for four (4) residents, during assistance with dining, food preparation for one (1) and/or medication pass for one (1) resident. Residents #6, 7, 10, 15, K1, and M1. The findings include: 1. A wound care treatment observation for Resident #6 was conducted on January 26, 2011 at 9:30 AM. During the observation, it was determined that licensed staff failed to utilize proper hand hygiene practices consistent with CDC [Center for Disease Control] guidelines and facility policy. Hand wash techniques observed, revealed staff washed with soap and water for a period of three (3) seconds in one instance and eight (8) seconds or less when washing hands during the course of the procedure. Additionally, staff failed to sanitize hands prior to donning new gloves intermittently during the course of the procedure. Staff failed to sanitize hands prior to donning new gloves between the cleansing the wound and the application of treatment to the wound site. The resident ' s pillow dropped onto the floor and was replaced onto the bed. The pillow linen that contacted the floor surface was not removed. 2. Infection Control Committee failed to ensure that infection control policies and procedures were followed to decrease the spread of infection during a wound treatment for Resident #7. A wound treatment observation was made on	L 091	1. Resident #22 - Nurse re-educated concerning 5-Rights of Medication Administration. Resident did not sustain any negative outcomes from occurrence. 2. Follow up medication administration observation completed with nurse. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering insulin. During the medication administration observation completed with the nurse, no other residents receiving insulin had any negative effects. The 5-Rights of Medication Administration were reviewed during the same unit meetings. 3. By April 8, 2011 Nurse Managers or their designee will conduct a random medication administration observation with one nurse. Once per month Nurse Managers or their designee will conduct a random medication administration with one nurse on each shift. Nurse Managers received an education session presented by the pharmacy, on how to conduct Medication Administration Observations. All nurses, during unit meetings were instructed to review the procedure in the Lippincott manual, for administering insulin. 4. Completed Medication Administration audit forms will be forwarded to the Education Department. The Education Department will report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011

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L 091	Continued From page 55 January 31, 2011 at 11:00 AM with Employee #20, Employee #21 was assisting. The treatment order was to " cleanse right heel ulcer with soap and water rinse off with saline, pat dry apply skin prep to periwound, bacitracin to wound bed, secure with gauze and kling daily. " The original date was December 14, 2010. After Employee #20 created the sterile field, an ointment tube fell to the floor, Employee #21 picked up the tube and replaced it on top of the corner of sterile field. During the observation Employee #21 exited the room to retrieve an item, after placing the item down he/she placed on a pair of gloves without washing his or her hands. A face-to face interview was conducted on February 1, 2011 at 1:00 PM with Employees #20 and #21, after review of the observations both acknowledged the findings. 3. The Infection Control Committee failed to ensure that infection control policies and procedures were followed to decrease the spread of infection prior to administration of eye drops for Resident #10. During a medication pass observation on January 24, 2011 at approximately 9:30 AM , Employee #15 obtained a box of tissues and gloves from another resident ' s room prior to administration of Resident #10's eye drops. 4. Infection Control Committee failed to ensure that infection control policies and procedures were followed to clean the over bed table after wound care procedure for Resident #15. During a treatment observation conducted on January 31, 2011 at 10:55 AM of Resident #15 ' s Stage three (3) left lower leg wound, it was observed that the nurse failed to clean the over bed table upon completion of the dressing	L 091	L052 (I) 1. Lidocaine was ordered and received for Resident #F2. 2. A report was obtained from Omnicare Pharmacy reviewing all residents on lidocaine 5% ointment to ensure delay in therapy did not occur. Nurse managers, supervisors and pharmacist will review pharmacy fax cut-off times, refill cut-off times and requests for STAT deliveries with nursing staff to ensure the facility receives orders to the pharmacy in a timely fashion for scheduled deliveries. Fax and refill cut-off times will be posted on each unit. Nurse managers and supervisors will also review the process if cut-off times are missed, e.g., request STAT delivery. Nursing staff will be instructed to notify nurse managers or supervisors if medication does not arrive with the anticipated delivery. 3. Nurse managers, supervisors and pharmacist will review electronic refill listing with nursing staff. The nurse managers, house supervisors and pharmacist will be instructed to use our consulting pharmacy, Omnicare real time, on-line tool, Issue Resolution Protocol, to document and report delay in delivery of medication and track consulting pharmacy Omnicare's response to reported delays in delivery. An information sheet was provided to all of the unit managers to share with the nursing staff on the respective units in a highly visible, conspicuous location. The information sheet contained the pharmacy telephone and fax numbers,	

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L 091	Continued From page 56 change procedure. The nurse used the over bed table for his/her wound care supplies. After the dressing change was completed Employee #22 removed the table barrier and wound care supplies and failed to clean the over bed-table. A face-to-face interview was conducted on January 31, 2011 at approximately 11:10 AM with Employees #22. He/she acknowledged that the over bed table should have been sanitized after the wound treatment. The treatment was observed on January 31, 2011 at 10:55 AM. 5. An observation of the breakfast meal on January 25, 2011 revealed that the Infection Control Committee failed to consistently utilize proper hand hygiene practices during dining. Employee #39 transported a chair across the room in order to assist Resident #K1 with meal consumption then proceeded to assist the resident with dining utilizing bare hands to butter bread and manipulate food. He/she failed to wash/sanitize hands immediately prior to manipulating the resident ' s food with bare hands. 6. Infection Control Committee failed to ensure that infection control policies and procedures were followed to clean the over bed table after wound care procedure for Resident #M1. During a treatment observation conducted on January 31, 2011 at 12:30AM of Resident #M1's left buttock wound care, it was observed that the nurse failed to clean the over bed table after the wound care procedure. The nurse used the over bed table for his/her	L 091	Phone hours of operation, contact information for various pharmacy personnel, pharmacy cut-off times for new orders and refills as well as delivery times. Pharmacy cut-off times are also reviewed during clinical orientation. 4. Negative outcomes will be reported to quarterly Quality Improvement committee. 5. Compliance Date L052 (J) 1. Missing audits cannot be created retrospectively. 2. Re-education of House nursing supervisors was conducted to complete audits consistently. House Nursing Supervisors to complete audit consistently each night and forward to the Director of Nursing. No residents were adversely affected. 3. House Nursing supervisors to complete audit consistently each night, and forward to Director of Nursing . Re-education of House Nursing Superviosrs was conducted to complete audits consistently. 4. Director of Nursing will report outcome to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011 4/8/2011

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L 091	Continued From page 57 wound care supplies. After the dressing change was completed Employee #23 removed the table barrier and wound care supplies and failed to clean the over bed-table. A face-to-face interview was conducted on January 31, 2011 at approximately 12:45 AM with Employees #23. He/she acknowledged that the over bed table should have been sanitized after the wound treatment. The treatment was observed on January 31, 2011 at 12:30 AM. B. Based on observations made during the environmental tour of the facility from January 26 thru January 28, 2011, it was determined that the Infection Control Committee failed to ensure that infection control policies and procedures were followed to provide a safe, sanitary and comfortable environment as indicated by insufficient air gap to drain on three (3) of five (5) ice machines. The findings include: Drain lines from ice machines located in the pantries of units 1A, 3A and 3B did not provide sufficient air gap to drains. These observations were made in the presence of Employees # 8 and #37 who acknowledged these findings during the survey.	L 091	L091 1. Staff re-educated about hand hygiene during unit meetings. 2. During orientation and annually the Education Department will conduct Hand Hygiene in-service classes. During random daily unit rounds conducted by Nurse Managers staff were observed following hand hygiene procedures: where staff were found not to follow procedures, on-the-spot reminders (education) were given to staff. No residents were adversely affected due to improper hand hygiene of staff. 3. By April 8, 2011 the Education Department will conduct role play hand hygiene in-service classes across all shifts. 4. The Education Department will report attendance at in-service classes quarterly to the Quality Improvement Committee. 5. Compliance Date L091 (B) 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B were corrected by maintenance staff to the required distance between the line and the drain 01/28/11. 2. All drain lines were observed for proper drain line to drain distance. No other areas of concern were noticed.	4/8/2011
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		

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L 099	Continued From page 58	L 099		

L 099 — Continued From page 58

This Statute is not met as evidenced by:
A. Based on observations that were made during a tour of the dietary services on January 24 thru January 28, 2011, it was determined that the facility failed to prepare and serve food and drink clean, wholesome, free from spoilage and safe for human consumption under sanitary conditions as evidenced by expired food items such as 44 of 44 of 4 four (4)-ounce cartons of skim milk in the tray line refrigerator, one (1) of one (1) pan of rice dinner, one (1) of one (1) pan of ground pork and one (1) of one (1) pan of ground pork in the walk-in refrigerator and nine (9) of 60 loaves of white bread on the bread storage shelf, soiled articles such as two (2) of two (2) convection ovens, four (4) of five (5) pizza pans, one (1) of eight (8) large pans and one (1) of one (1) ice cream freezer, 39 of 39 sheet pans that were stored wet and on top of each other, low water temperatures in two (2) of two (2) hand washing sinks, two (2) of ten (10) hot food items that were less than 140 degrees Fahrenheit (F) and one (1) of one (1) cold food item that were above 40 degrees F, a dusty fire extinguishing system, two (2) of six (6) fruit salad plates that were not dated, two (2) of two (2) loose door handles and one (1) of two (2) worn gasket in one (1) of one air curtain refrigerator and pre-recorded refrigerator temperatures on three (3) of ten (10) temperature logs reviewed.

The findings include:

1. Food items were stored beyond their expiration date in several observations:
A) Forty-four (44) four (4)- ounce cartons of skim milk were expired as of January 17 in the tray line refrigerator.
B) A pan of rice dinner and a pan of meat loaf (expired January 23, 2011) and a pan of ground

Provider's Plan of Correction (L 099):

3. The maintenance technicians were trained on the correct distance required between the drain lines and drains. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians.
4. Drain lines will be monitored daily by engineer/maintenance and reported to supervisory staff.
5. Compliance Date — 4/8/2011

<u>L099 (A&B)</u>
1. Milk cartons, pans of rice dinner, meat loaf, and ground pork past expiration dates were discarded and dietary staff was re-educated on correct dating of food items.
2. A review of all food dates identified no other items past the expiration date.
3. Food storage expiration dates are reviewed by dietary management daily and foods past expiration date are discarded. Pre-printed food date stickers were purchased and implemented, to clearly identify day of week the item is placed in storage and day of week the item expires.
4. Dietary management audits food item dates daily and corrective action is taken immediately. Outcome, identified variances, and trends are reported to QI Committee monthly.
5. Compliance Date — 4/8/2011

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING B. WING	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

(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 099	Continued From page 59 pork (expired January 22, 2011) were observed in the walk-in refrigerator. C) Nine (9) of 60 loaves of white bread dated January 19, 2011 were observed on the bread storage shelf. 2. Two (2) convection ovens, four (4) pizza pans, one (1) large pan and the ice cream freezer were soiled. In addition, 39 sheet pans were stored wet and on top of each other. 3. Policies and procedures (P and P ' s) for hand washing were not properly followed. Both P and P ' s require hot water temperatures in the kitchen to equal or exceed 100 degrees F and the highest measured water temperature was 80 degrees F. 4. Hot food temperature for two (2) items was less than 140 degrees F and milk was tested at 44 degrees F. 5. The Ansul fire extinguishing system was soiled with dust particles. 6. Two(2) fruit plate salads stored in the tray line refrigerator were not dated. 7. Both door handles were loose and a door gasket was worn and damaged on the air curtain refrigerator. 8. Refrigerator temperatures were pre-recorded on three (3) of ten (10) temperature logs reviewed on January 24, 2011. These observations were made in the presence of Employee # 38 who acknowledged these findings during the survey. B. Based on observation and interview, it was determined that the facility failed to prepare and serve food and drink clean, wholesome, free from spoilage and safe for human consumption under sanitary conditions as evidenced by expired food items that were stored beyond the manufacturer ' s expiration date.	L 099	1. Loaves of bread with Sell By date of 01/19/11 were verified in writing by vendor as within date for safe serving. 2. A review of all bread identified no additional loaves with Sell By date of 01/19/11. 3. Dietary staff was re-in-serviced on using pre-printed food date stickers to ensure correct rotation of loaves. 4. Dietary management will monitor rotation bread daily and report outcome, corrections, and trends to QI Committee monthly. F371 - 2 1. Soiled items were immediately cleaned and cleaned sheet pans were stacked to dry vertically. 2. An inspection of the kitchen identified no other soiled ware or equipment. 3. Dietary staff was re-in-service on correct sanitation practices for maintaining cleanliness of equipment/ware and correct storage method for washed sheet pans. A sanitation and equipment inspection form was developed and implemented. Dietary staff makes daily kitchen rounds to ensure cleanliness of all equipment and correct storage. 4.Dietary management will inspect cleanliness of equipment/ware and storage of sheet pans daily. Outcomes, corrective actions, and trends will be reported to QI Committee monthly. 5. Compliance Date 1.Hand sanitizers were immediately installed at each hand washing sink. 2.Dietary staff was re-in-serviced on correct hand hygiene. Water temperatures were corrected to within prescribed range. 3.Dietary management and Plant Operations will monitor temperature of water in hand washing sink to ensure hot water temperature meets regulation.	4/8/2011

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L 099	Continued From page 60 The findings include: An observation of the storage closet on unit 1-A on February 1, 2011 at 10:30 AM revealed the following food items were stored beyond expiration dates: 14 of 14 bottles of Jevity enteral feeding solution and three (3) of six (6) cans of Beneprotien nutritional supplement. The observations were made in the presence of Employee #3.	L 099	4. Water temperature log will be reviewed by Dietary management daily and variances with corrective actins reported to QI Committee monthly. 5. Compliance Date 1.Hot food and milk out of prescribed temperature range were discarded. 2. All other tray line foods were within prescribed temperature ranges. 3.Staff was re-in-serviced on maintaining foods at correct temperatures by testing foods on tray line and at point served, and documenting temperature measurements. Master Temperature Logs were implemented that clearly identify dates temperatures are measured. Test trays temperatures based on Test Tray Temperature Logs are monitored monthly by Dietary management 4.Dietary management will audit temperature ranges and report variances, corrective actions, and trends to QI Committee monthly. 5. Compliance Date	4/8/2011
L 145	3226.5 Nursing Facilities The medication for self-administration shall be securely stored and accessible only to the appropriate resident and staff. This Statute is not met as evidenced by: Based on observations, record review and interview for two (2) of 27 sampled residents and one (1) of 12 supplementals residents, it was determined that the facility failed to ensure that medication was securely stored for residents that self-administered medications. Residents #1, #18 and #F1. The findings include: 1. The facility staff failed to ensure that medications were secured for Resident #1 who was observed with medications stored on the bedside table. An observation of Resident #1 on January 25, 2011 revealed several medications were stored in manufacturer ' s containers on the bedside table proximal to the resident ' s bed. Facility staff acknowledged that the resident self-administered " natural " medications in accordance with physician ' s orders.	L 145	1.The Ansul fire extinguishing system was cleaned. 2. Inspection of the kitchen identified no other soiled equipment. 3.A sanitation and equipment inspection form was implemented that includes inspection of the Ansul System monthly. The Ansul System will remain on the established annual preventive maintenance cleaning schedule. 4.Dietary management will report outcome, variances, corrective actions, and trends of sanitation and equipment inspection to QI Committee monthly. 5. Compliance Date 1. The fruit plates past expiration date were discarded.	4/8 2011 4/8/2011

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L 145	Continued From page 61 There was no evidence that the facility offered provisions to store the medications safely and in a manner to protect against access by vulnerable or unauthorized individuals. The findings were reviewed and acknowledged during a face-to-face interview with Employee #3 on January 31, 2011 at 3:30 PM. 2. The facility failed to ensure that medication was securely stored for Resident #18 that self-administered his/her eye ointment. An observation of Resident #18 on January 24, 2011 revealed an eye ointment was stored in resident ' s bedside table. There was no evidence that the facility offered provisions to store the medication safely and in a manner to protect against access by unauthorized individuals. The finding was reviewed and acknowledged during a face-to-face interview with Employee #6 on January 24, 2011 at 1:30 PM. The clinical record was reviewed on January 24, 2011 3. The facility failed to ensure that medication was securely stored for Resident #F1 who was observed to have medication at his/her bedside. On January 26, 2011 at 3:00 PM a tour of Resident F1 ' s room was conducted. A can of Cetacaine spray was observed on the night stand (on left side of the bed). At that time Employee #16 was present and acknowledged that the	L 145	2.Inspection identified no other expired fruit plates. 3.Dietary staff was re-in-serviced on correct dating of food items, using pre-printed labels identifying day of week item is placed in storage and day the item expires. Food storage dates are audited/reviewed daily by Dietary management. 4Dietary management will report results of food item date audits, with corrective actions and identification of trends, to QI Committee monthly. 5. Compliance Date 1. Air curtain refrigerator door handles were repaired and the door gasket was replaced. 2.An inspection of the kitchen identified no other equipment in need repair. 3.The sanitation and equipment inspection form was implemented that includes the air curtain refrigerator. Daily rounds by Dietary management is done to identify condition of kitchen equipment. 4.Dietary management reports outcome, corrective actions, and trends identified by sanitation and equipment inspections to QI Committee monthly. 5. Compliance Date 1.Refrigerator temperatures were checked immediately and temperatures recorded.. 2.Dietary staff was re-in-serviced on appropriate documentation of all kitchen quality control measurements. 3.Dietary management will review temperature logs daily for accurate, real-time documentation of temperatures.	4/8/2011 4/8/2011

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L 145	Continued From page 62 medication was on the resident's night stand. Employee #16 stated, " [He/she] self administers the spray to [his/her] throat. " Additionally, Resident #F1 wrote the following on his/her communication board, " I spray it in my mouth. " The Physician's Order Form dated January 2011 and signed by the physician on January 10, 2011 directed, " Cetacaine Spray 2 sprays every 3 hours as needed for pain-may keep at bedside to use as needed. " There was no evidence that the facility offered provisions to store the medications safely and in a manner to protect against access by vulnerable or unauthorized individuals. The findings were reviewed and acknowledged during a face-to-face interview with Employee #16 on January 26, 2011 at 3:00 PM	L 145	4.Dietary management will report outcome of daily temperature log documentation to QI Committee monthly. 5. Date of Compliance L145 1. Residents #1, #18 and #FI received assessments to ensure they were safe to administer medications. The facility purchased and gave residents a lock boxes with a pad lock and key (nurse also given a second key for box) in order that residents can safely secure the medications they self-administer. 2. The Nurse Managers conducted a sweep of all other residents on their units to ascertain if there were other residents self administering medications: no other residents were found. The Self-Administration of Medication policy has been amended to include a safety assessment of each resident desiring to administer their medications. The assessment will be done for an initial review, quarterly at the time of review of the interdisciplinary care plan and when a significant change occurs to the resident. 3. Upon admission to the facility the resident will be queried to determine if they want to self-administer their medications. If an affirmative answer is given, the Self-Administration of Medications policy will be implemented.	4/8/2011
L 152	3227.3 Nursing Facilities Proper storage temperature shall be maintained for each medication according to the manufacturer's direction. This Statute is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure that medications were stored under proper temperature controls in an isolated observation. The findings include: Observations of the medication storage refrigerator on unit 1-A revealed a temperature of	L 152		

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L 152	Continued From page 63 21 degrees Fahrenheit (F) on February 1, 2011 at approximately 10:30 AM. A subsequent observation approximately two (2) hours later yielded a temperature of 32 degrees (F). The observations were made in the presence of Employee #3 and the temperature was obtained via the facility ' s refrigerator thermometer. The medications that were stored in the refrigerator included various brands of Insulin and Travatan ophthalmic solution. According to the facility ' s pharmaceutical provider, Omnicare Inc., " Recommended Minimum Medication Storage Parameters (based on manufacturer package inserts) " refrigerated insulin vials were to be stored at temperatures between 36°F to 46°F and Travatan stored between 36° to 77°F. The refrigerator temperatures were below the recommend parameters for the medications stored. The findings were confirmed with Employee #3 at the time of observation.	L 152	Nursing staff were educated regarding the Self-Administration of Medication Policy and the amendments made to the Self-Administration of Medications Policy. 4. Nurse Managers will conduct an audit of the implementation of the Self-Administration policy quarterly and report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011
			L152 1. The thermometer used to take the refrigerator temperature was removed. 2. One thermometer will be used consistently to measure refrigerator temperatures on all nursing units. Night staff re-educated to take & log unit refrigerator temperatures nightly. 3. Night House supervisors will audit temperature logs daily. Nurse Managers will report outcome trends and corrections to the Quality Improvement Committee quarterly. 4. Director of Nursing will report outcome to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to remove expired medications from use. The findings include: 1. Facility staff failed to remove expired Acetaminophen tablets from one (1) of two (2) medication carts. During a check of the medication carts on January 31, 2011 at 1:50 PM it was identified	L 161		

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L 161	Continued From page 64 that 18 of 33 regular strength Acetaminophen 325 mg tablets belonging to Resident #S1 had expired December 2010. The expired medications were in the same container as the unexpired medications. A face-to-face interview was conducted on January 31, 2011 at 2:00 PM with Employee #4 and #32. After review of the above findings neither had an explanation as to how the medications ended up in same the box. A telephone interview was conducted with Employee #34 from pharmacy services. After review of the above findings he/she indicated that boxes are packed 1 lot number at a time and in large quantities and that expired and unexpired medications are not packed in the same box. The facility failed to remove expired Acetaminophen tables from the medication cart. The observation was made on January 31, 2011. 2. The facility failed to ensure that expired Pneumococcal Vaccine was removed from medication refrigerator. An observation of the medication refrigerator on unit 3-A on January 25, 2011 at 9:16 AM revealed an immunization vial stored beyond its expiration date: one (1) of one vial of pneumococcal vaccine unopened. Expiration date: December 3, 2010. The observation was made in the presence of Employee #6.	L 161	L161 1. All expired medications were removed from both nursing units.No residents had negative outcomes from this occurrence. 2. Resident S1—nurse re-educated to use standard principles of medication administration (examine medications for expiration date before giving). Nurse Managers to conduct weekly inspection of medication refrigerator for expired drugs to ensure safety for all residents. No residents were adversely affected. 3. Infection Control Nurse to conduct a monthly environmental infection control round (to include medication carts & medication refrigerator). 4. Infection Control Nurse will report outcome trends and corrections to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011
L 183	3229.5 Nursisng Facilities The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incorporated in each resident's medical record,	L 183		

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L 183	Continued From page 65 reviewed quarterly, and revised as necessary. This Statute is not met as evidenced by: A. Based on observation, record review and staff interview for three (3) of 27 sampled residents, it was determined that the Social Worker failed to perform quarterly assessments for two (2) residents; facility staff failed to notify the state agency of an unusual incident for one (1) resident. Residents #1, #4 and #17. The findings include: According to 22 DCMR (District of Columbia Municipal Regulations) 3229.5, "The social assessment and evaluation, plan of care and progress notes, including changes in the resident's social condition, shall be incopporated in each resident's medical record, reviewed quarterly, and revised as necessary." 1. The Social Worker failed to document in Resident #1 ' s record every 90 days. A review of Resident #1 ' s clinical record revealed the most recent social services assessment was documented October 10, 2010. There were no social work entries subsequent to this date. The record lacked evidence of a quarterly social work assessment for January 2011. The record was reviewed January 25, 2011. 2. The Social Worker failed to document in Resident #4 ' s record every 90 days. A review of Resident #4 ' s clinical record revealed the following quarterly assessments: January 19, 2010, June 29, 2010, September 21, 2010, and December 10, 2010.	L 183	L183 1. The quarterly assessment for Resident #1 has been completed and entered into the chart. The quarterly assessment for Resident # 4 could not be corrected as there was a lapse in time between the hiring of the current social worker and the resignation of the previous social worker; thus, subsequent documentations have been entered. 2. The social services staff completes quarterly assessments per the MDS schedule. The Director of Social Services will review charts weekly to ensure timely documentation. Any chart found to be deficient will be corrected immediately. There were no negative outcomes to any resident. 3. The social services staff completes quarterly assessments per the MDS schedule. The Director of Social Services will review & discuss with(educate) the Social Work staff the process timely documentation, according to standards & policy, in the resident medical record. 4. Outcomes will be reported to the Quality Improvement Committee quarterly. 5. Compliance Date 1. An unusual incident report was completed 2/2/2011 for the 911 transfer of Resident #17. 2. All unusual incidents will be documented and reported according to 22 DCMR 3232.4.	4/8/2011

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L 183	Continued From page 66 The record lacked evidence of a quarterly social work assessment for April 2010. A face-to-face interview was conducted with Employees #6 and #13 on January 25, 2011 at approximately 2:00 PM. Both acknowledged that the clinical record did not have a quarterly assessment for April 2010. The record was reviewed January 25, 2011. 3. Facility failed to notify the state agency of an unusual incident. According to 22 DCMR (District of Columbia Municipal Regulations) 3232.4: Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. A review of nurse ' s notes dated January 2, 2011 at 11:00 AM revealed Resident #17 was assessed as unresponsive and hypotensive, transferred to the nearest emergency department via 911 and hospitalized for approximately 19 days. There was no evidence that the facility documented and unusual incident report and notified the state agency regarding the incident. A face-to-face interview was conducted with Employee #3 on January 31, 2011 at approximately 11:00 AM. He/she stated an incident summary was completed on January 25, 2011 following this surveyor ' s request to review the report during the orientation tour of the unit.	L 183	The Director of Nursing or their designee will daily review the 24 hour and Acute Care Report. Any usual incident should warrant a incident report attached to the reports. If an incident report is lacking, The Director of Nursing will ensure an incident report is completed and promptly forwarded to the Department of Health. Variances of documentation not recorded in the medical record will be promptly corrected. Nursing staff failing to follow the procedure for documentation of an unusual occurrence will result in d isciplinary counseling up to and including suspension and or termination. 3. All staff will review the regulation, 22 DCMR 3232.4 on the reporting time frame for an unusual incident and comply. 4. Daily monitoring of facility incident reports will be completed by Nursing Home Administration, Nursing Administration or designee. Unusual incidents will be reported to the licensing agency. Negative outcomes will be reported to Quality Improvement. 5. Compliance Date	4/8/2011 4/8/2011 4/8/2011

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L 183	Continued From page 67 B. Based on observations made during the environmental tour of the facility from January 26 through January 28, 2011, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as indicated by insufficient air gap to drain on three (3) of five (5) ice machines. The findings include: According to 22 DCMR (District of Columbia Municipal Regulations) 3236.2 There shall be no cross-connection between the potable safe water supply and each water supply that is non-potable, or any source of pollution through which a safe supply might become contaminated. 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B did not provide sufficient air gap to drains. These observations were made in the presence of employee # 8 and #37 who acknowledged these findings during the survey.	L 183	L183(B) 1. Drain lines from ice machines located in the pantries of units 1A, 3A and 3B were corrected by maintenance staff to the required distance between the line and the drain 2. All drain lines were observed for proper drain line to drain distance. No other areas of concern were noticed. 3. The maintenance technicians were trained on the correct distance required between the drain lines and drains. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians. 4. Drain lines will be monitored daily by engineer/maintenance and reported to supervisory staff and QI Committee. 5. Compliance Date	4/8/2011
L 212	3233.5 Nursing Facilities Each facility shall use its best efforts to resolve each grievance as soon as practicable, and shall report to the resident and the Resident's Representative on the status of the resolution of the grievance at least thirty (30) days. This Statute is not met as evidenced by: Based on document review and staff interview it was determined that facility failed to ensure that grievances were resolved in a prompt manner for one(1) of 27 sampled residents and one (1) of 12 supplemental residents. Residents #24 and #F2.	L 212		

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NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016		

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L 212	Continued From page 68 The findings include: 1. The spouse for Resident #24 filed a grievance on February 28, 2010 regarding delay of care. Review of this grievance and the facility's response indicated that the grievance was resolved on June 29, 2010. The facility ' s " Family Resident Communication Tool Log " revealed, " June 28, 2010 ...delay of care concern ... Follow-up: Unit Manager found no evidence to substantiate allegations made in the concern and met with [spouse of Resident #24]. Grievance was resolved." A review of the " Resident/Family Concern Form " dated June 28, 2010 revealed, " Describe action taken to address concern: At this time my finding is [Resident #24] is keeping the staff preoccupied with him. The needs of all residents have to be met. I have requested the nurse call bell report for the record and will forward. All of [spouse of Resident #24] concern forms have been answered by me since my arrival.. this is the fourth one, 5/27/10, 6/7/10, 6/21/10 and today 6/28/10. " Facility staff failed to resolve a grievance in a timely manner voiced by Resident #24 on February 28, 2010. A face-to-face interview was conducted with Employees #1, Employee #2 and Employee #3 on February 1, 2011. Employee #3 indicated that a request was made to IT [Informational Technology] for the call bell log. However, it was not followed through, because no one knew how to obtain the log. " Employee #1 indicated they now " have a systematic approach to work on grievances. " 2. Facility staff failed to completely resolve Resident #F2 ' s grievances for food preferences.	L 212	L212 1. Identified grievances involving Resident #24 and Resident F2 have been resolved. Call bells are answered within the parameters for Resident #24. Resident F2 received whole wheat toast as stated as a food preference. 2. All concerns/grievance documented on the Communication Tool from residents, family members or visitors will be responded to and a resolution attempt will be completed in a timely manner. Call bell reports are reviewed on a weekly basis for all units and all resident diet orders are confirmed with the dietician and/or nursing staff. 3. The Communication Tool policy and procedure will be re-distributed to the Home staff to re-educate steps to timely resolve a concern/ grievance. All concerns/grievances on the Communication Tool are forwarded to Nursing Home Administration, logged in an electronic database and reviewed for response and resolution. 4. The Communication Tool log will be monitored monthly by Nursing Home Administration and our Quality Improvement Manager for timely response, outstanding resolution and trends. 5. Compliance Date	2/2/2011 3/31/2011 4/8/2011 4/8/2011 4/8/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0005	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/02/2011
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L 212	Continued From page 69 The Diet Communication Form dated and signed by the dietitian on December 15, 2010 revealed, " New Admit; WW (whole wheat) Bread (circled); Additional information-no pork or pork products. The " Resident/Family Communication Tool Log " -Concern from Resident #F2 dated December 26, 2010 revealed, " I informed the dietitian that I did not eat pork, white bread and I did not drink coffee. It took a while before the kitchen, dietitian an myself were on the same page. Time and time again I receive coffee and I still am receiving pork." The Food Services Manager addressed the menu problem and counseled staff member and Resolved the concern on December 29, 2010. A review of the Census List, which lists current diets likes and dislikes for all residents in the facility, dated January 31, 2011 list Resident #F2 ' s Diet Note as " No Pork Products" . There was no evidence that the white bread and coffee was included on the "Census List" as a dislike. A review of the Nutritional Screening and Assessment form dated December 14, 2010 and the progress notes last updated January 25, 2011 lacked evidence that whole wheat bread was included as a food preference for Resident #F2. A face-to-face interview was conducted with Resident #F2 on January 31, 2011 at 9:40 AM. He/she stated, " They [the facility] are still putting pork on my plate and white bread. " A face-to-face interview was conducted with the dietitian on January 31, 2011 at 11:15 AM. After	L 212		

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L 212	Continued From page 70 discussion with the dietitian about the resident ' s concern, he/she acknowledged that the white bread and coffee was not added to the "Census List" as a dislike and whole wheat bread was not added to the "Census List" as a food preference. A face-to-face interview was conducted on February 1, 2011 with Resident #F2. He/she stated, " I received white toast on my breakfast tray this morning. " There was no evidence the facility staff completely resolved Resident #F2 ' s grievances for food preferences.	L 212		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: A. Based on observations made during the environmental tour of the facility from January 26	L 306	L306 (A) 1. Loose call bell covers in rooms #153 and #338 were tightened or replaced by the maintenance technicians. Call bell pull cords that were too short and needed to be extended in the resident bathroom on unit 2A and the tub room on unit 3B drain were removed and longer cords were put in place by the maintenance technicians 2. Call bell covers and cords throughout the facility were inspected for proper functioning. No other areas of concern were noticed. 3. The maintenance technicians were retrained on observing and replacing loose call bell covers. Maintenance technicians were retrained on reporting and, where necessary, verifying with supervisors whether call bell cord lengths are appropriate. These conditions are observed monthly during maintenance rounds conducted by the maintenance technicians. 4. Conditions of call bells will be monitored daily by engineer/maintenance and reported to supervisory staff. 5. Compliance Date	01/28/11. 4/8/2011

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L 306	Continued From page 71 through January 28, 2011, it was determined that the facility failed to maintain resident call system as evidenced by call bells that were not properly cared for in four (4) of 52 rooms. The findings include: Call bell covers were loose in rooms #153 and #338 and call bell pull cords were too short and needed to be extended in the resident ' s bathroom on unit 2A and the tub room on unit 3B. These observations were made in the presence of Employee # 37 who acknowledged these findings during the survey. B. Based on observations made during the environmental tour of the facility from January 26 through January 28, 2011, it was determined that the facility failed to maintain resident call system as evidenced by the failure of the call bell system to operate as intended in four (4) of 48 resident ' s rooms. The findings include: Call bells in rooms #204, #233, # 254 and #356 failed to operate as required and, when activated, did not consistently alert the nursing staff. These observations were made in the presence of Employee # 37 who acknowledged these findings during the survey.	L 306	L306 (B) 1. Call bells in rooms #204, 233, 254 and 356 that failed to operate as required and, when activated, did not consistently alert the nursing staff were replaced by maintenance technicians. 2. Call bells throughout the facility were observed for functionality. No other areas of concern were noticed. No residents were negatively affected. 3. The maintenance technicians were retrained on replacing, installing and testing call bells. These conditions are observed daily by nurse staff and monthly by maintenance technicians during maintenance rounds. 4. Conditions of call bells will be monitored daily by engineer/maintenance and reported to supervisory staff. 5. Compliance Date	01/28/11 4/8/2011
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,	L 410		

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L 410	Continued From page 72 sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: A. Based on observations made during an environmental tour of the facility from January 26 to January 28, 2011, it was determined that the facility failed to provide a safe and clean environmenti as evidenced by a torn carpet on one (1) of five (5) unit, a broken tile in one (1) of 48 resident ' s bathrooms,and a urine like smell in two (2) of 48 resident ' s rooms. The findings include: 1. The carpet in front of rooms #255 and #256 was torn and has numerous lumps which present a tripping hazard. 2. There was a broken tile in the bathroom of room #306 that also presented a tripping hazard. 3. A malodorous smell was evident in rooms #346 and #357. These observations were made in the presence of Employees # 8 and #37 who acknowledged these findings during the survey B. Based on observations made during an environmental tour of the facility on January 26, 2011through January 28, 2011, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by culttered storage room on three (3) of five (5) units. The findings include: Storage rooms observed on units 1A, 2A, and	L 410	L410 (A) 1. Capital proposal submittal for replacement of worn/damaged carpet in resident units. Frayed edges were re-cut to minimize tripping hazards. 2. All carpeting was observed for frays, buckles, etc. Repairs were scheduled as indicated. 3. The plant operations staff was retrained on observing deteriorating carpet conditions, especially in residential areas. Carpet conditions are observed monthly during life safety rounds conducted by plant operations 4. Carpeting conditions will be monitored daily by plant operations and reported to supervisory staff. 5. Compliance Date 1. The broken tile in the bathroom of room #306 was replaced. 2. Floor tile throughout the facility were observed for conditions of service. No other areas of concern were noticed. 3. The plant operations staff was retrained on observing floor tile and other potential tripping hazards. Safety conditions are observed monthly during life safety rounds conducted by plant operations. 4. Bathroom tile conditions will be monitored daily by plant operations and reported to supervisory staff. 5. Compliance Date	4/8/2011 4/8/2011 01/28/11. 4/8/2011

Health Regulation & Licensing Administration

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L 410	Continued From page 73 2B, in three (3) of five (5) storage rooms observed. These observations were made in the presence of Employees #8 and 37 who acknowledged these findings during the survey.	L 410	L410(B) 1. Storage rooms on units 1A, 2A, 2B were cleared of excessive clutter. 2. Unit Secretaries on all nursing units by April 8, 2011 will conduct a unit 'spring cleaning' to de-clutter all unit storage areas 3. Unit Secretaries will conduct weekly de-clutter sweeps of unit storage rooms. 4. All Nursing Unit Managers will conduct monthly unit rounds to inspect all storage areas for clutter. Outcomes will be reported to the Quality Improvement Committee quarterly. 5. Compliance Date	4/8/2011