

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2009
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NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032
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L 000	Initial Comments A licensure survey was conducted on February 17 through 20, 2009. The following deficiencies were based on observations, record review, and staff and resident interviews. The sample included 24 residents based on a census of 156 residents on the first day of survey and nine (9) supplemental residents.	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 11 newly hired employees, it was determined that the facility staff failed to complete a criminal background check for one (1) new employee. The findings include: According to 47DCMR 4701.2, " Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. " A review of personnel records revealed, Employee #24 was hired on December 29, 2008. On February 20, 2009 at approximately 11:00 AM a copy of Employee #24 ' s background report	L 001		

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TITLE

(X6) DATE

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

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L 001	Continued From page 1 was presented which revealed, " ... Request Date: February 19, 2009 and Returned: February 20, 2009 ... No court records found in the jurisdictions searched." The facility lacked evidence the criminal background check was conducted prior to hire. A face-to-face interview was conducted with Employee #23 on February 20, 2009 at 11:00 AM. He/she acknowledged that the criminal background was not conducted prior to hire.	L 001		
L 008	3202.2 Nursing Facilities Each facility shall develop and maintain personnel policies which shall include methods used to document the presence or absence of communicable disease. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 11 newly hired employees, it was determined that facility staff failed to administer a tuberculosis test for three (3) new employees. The findings include: A review of the " CBL Recruitment Checklist " [no date of initiation] revealed, " ...PPD [purified protein derivative]/Nursing [indicating the a PPD is to be conducted] Employee # 24 was hired on December 29, 2008 Employee # 26 was hired on December 8, 2008 Employee # 25 was hired on January 26, 2009 There was no evidence in the record that the above cited employees received a PPD test prior to the date of hire.	L 008	1. Active and current employees will have TB Test administered and results within 48 hours. 2. An audit of all new hires as of November 3, 2008 was conducted. See Attached I. 3. Human Resources staff will meet weekly to review pending applications to determine if all requirements are met prior to extending an offer of employment and scheduling an orientation date. See attached II. Human Resources new hire checklist will be used during recruitment and hiring process. Process will be monitored by the Human Resources Manager. Report of all new hires for the previous Quarter will be reported at the monthly CQI meeting.	3/18/09 3/09/09

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L 008	Continued From page 2 A face-to-face interview was conducted with Employee #22 on February 19, 2009 at 3:30 PM. He/she acknowledged that the PPD were not administered prior to hire.	L 008		
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 four (4) of 24 sampled residents, it was determined that the charge nurse failed to: provide dignity to one (1) resident during a dressing change, reassess one (1) resident complaining of pain during a dressing change, administer a Fentanyl patch as per physician's	L 051		

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L 051	<p>Continued From page 3</p> <p>orders and ensure that laboratory values were on the clinical record, develop a care plan for the use of a seat belt and inform the responsible party about the use of the seat belt for one (1) resident, and ensure that laboratory values were on the record and update a fall care plan for one (1) resident. Resident #4, 5, 7 and 8.</p> <p>The findings include:</p> <p>1. The charge nurse failed to maintain Resident #4's dignity during a wound dressing change.</p> <p>During an observation of a dressing change to Resident # 4's sacrum, Employee #17 wrote the time of the dressing change on the tape after the wound dressing was taped to the resident's body.</p> <p>The observation of the dressing change was made at approximately 12:30 PM on February 19, 2009.</p> <p>A face-to-face interview was conducted with Employee # 17 immediately after the dressing change on February 19, 2009. He/she acknowledged writing the time on the tape while it was affixed to the resident's body.</p> <p>2. The charge nurse failed to re-assess Resident #5 for complaint of pain during a wound treatment, follow the physician's order to administer Fentanyl patch for chronic pain every 72 hours related to sacral ulcers and ensure that the resident's clinical record was accurately documented.</p> <p>A review of the resident's clinical record revealed the following order first initiated on January 26, 2009 and renewed on the February 2009 Physician Order Form on February 2, 2009</p>	L 051	<p>#1</p> <p>1. Employee #17 received counseling on "Maintaining Residents Rights and Dignity" as well as proper Wound Care. 2-23-09</p> <p>2. Rounds will be conducted on the units by the DON, ADON and Unit Managers to ensure resident dignity is maintained for residents having the potential to be affected. 2-23-09 Ongoing</p> <p>3. The Licensed Staff member will be trained on "Resident Rights and Dignity and Wound Care". 3-31-09</p> <p>4. The Educator will review employee educational profiles monthly to ensure mandatory educational compliance of employees. Findings of the review as well as the results of the rounds by the DON, ADON and the Nurse Managers will be submitted to the CQI committee monthly x3 then quarterly. 3/19/09</p> <p>#2</p> <p>1. Employee #17 was counseled. She/he received training in the following areas: a) pain management, b) aseptic dressing changes. 2/23/09</p> <p>2. Unit Managers will monitor wound care procedures and records during dressing changing every week and document results. 3/13/09</p> <p>3. Licensed staff will be trained on a) pain management, b) Aseptic dressing changes. 3/31/09</p> <p>4. Findings of the weekly monitoring of dressing changes and wound care will be submitted to the CQI Committee monthly x3 then quarterly. 3/19/09</p>	

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L 051	<p>Continued From page 4</p> <p>directed:</p> <p>"...(2) Sacral Ulcer- Cleanse with normal sterile saline (NSS), pat dry then apply polysporin powder and Santyl ...QD & PRN (Once daily and as needed) 14 days..."</p> <p>"(3) (L) [Left] buttock ulcer-cleanse with NSS, pat dry ..."</p> <p>"(4) Fentanyl patch (25mcg/hr) I patch ...Q72hours (every 72 hours) for chronic pain related to sacral ulcers"</p> <p>"(5) Tylenol #3 (300-30) ii tabs [Tablets] via GT [Gastrointestinal Tube] QD [Once day] 30 minutes before wound treatment for pain management ..."</p> <p>A. Facility staff failed to re-assess Resident #5 for pain during a wound care treatment.</p> <p>On February 17, 2009 at 1:30 PM, a sacral and buttock wound care treatment observation was conducted for Resident #5.</p> <p>The resident was positioned on his/her right side, exposing both ulcers. Employee #17 cleansed the interior and exterior edges of the sacral ulcer twice with NSS moistened gauze and patted dry the exterior edges and skin, applied santyl ointment, polysporin powder, calcium alginate dressing and secured the dressing with a pre-initialed and dated piece of tape. Each time Employee #17 cleansed the wound, the resident grimaced and held tightly to the bed rail with both hands.</p> <p>After the completion of the treatment on the sacral wound, Employee #17 began treatment on the left buttock ulcer. Employee #17 cleansed twice the interior and exterior of the left buttock ulcer, patted dry the exterior of the ulcer, applied</p>	L 051	<p>A.</p> <p>1. Employee #17 was counseled. She/he received training in the following areas: a) pain management, b) aseptic dressing changes.</p> <p>2. Unit Managers will monitor wound care procedures and records during dressing changing every week and document results.</p> <p>3. Licensed staff will be trained on a) pain management, b) Aseptic dressing changes.</p> <p>4. Findings of the weekly monitoring of dressing changes and wound care will be submitted to the CQI Committee monthly x3 then quarterly.</p>	<p>2/23/09</p> <p>3/13/09</p> <p>3/31/09</p> <p>3/19/09</p>

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L 051	<p>Continued From page 5</p> <p>santyl ointment and polysporin powder on 4 x 4 gauze pads and secured with a pre-initialed and dated piece of tape.</p> <p>At the initiation of the wound care procedure, while repositioning the resident on his/her right side and each time Employee #17 cleansed the wounds, the resident grimaced. Employee #17 responded to the resident, "I am sorry".</p> <p>Employee #17 failed to stop the ulcer treatment and re-assess the resident's complaint of pain.</p> <p>A face-to-face interview was conducted with Employee #2 on February 18, 2009 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. The record was reviewed February 18, 2009.</p> <p>B. Facility staff failed to administer a Fentanyl patch as per physician's order to Resident #5.</p> <p>A review of the resident's February 2009 Medication Administration Record revealed that Resident #5 was last administered a Fentanyl patch on February 4, 2009 at 6:00 AM as evidenced by the initials entered for that date. There was no evidence that the Fentanyl patch was administered on February 7, 10, 13 or 16, 2009, as per the physician's orders (stated above), by the absence of the initials on the aforementioned days.</p> <p>Facility staff failed to administer a Fentanyl patch as per the physician's order to Resident #5.</p> <p>A face-to-face interview was conducted on February 19, 2009 at approximately 11:00 AM with Employee #17. He/she acknowledged that the Fentanyl patch was not administered as per</p>	L 051	<p>B. Resident #5's medication error corrected. Physician notified. Employees counseled.</p> <p>2. Review of the Mars/POS were completed by Unit Manager of resident records. Corrections made as indicated.</p> <p>3. Licensed staff trained on Documentation, with emphasis on monthly checking of order, reading the MAR and Medication Administration.</p> <p>4. Unit Managers will randomly audit resident's MAR/TAR weekly to ensure compliance. Findings of the audit will be submitted to CQI Committee monthly.</p>	<p>2/23/09</p> <p>3/13/09</p> <p>3/31/09</p> <p>3/19/09</p>

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L 051	<p>Continued From page 6</p> <p>the physician's order. The record was reviewed February 19, 2009.</p> <p>C. A review of the resident's clinical record revealed a "Physician's Order Form" (POS) for February 2009 dated and signed on February 2, 2009. The order included treatments and the following three (3) routine medications:</p> <p>"Acetaminophen w/codeine #3 300mg-30mg Tablet" "Fentanyl 25 mcg/hr patch TD72 (WF: Duragesic)" "Tab-A-Vite Tablet (WF:Multi-vitamin)"</p> <p>The resident was hospitalized from January 16 through January 23, 2009. A review of the readmission orders signed January 26, 2009 included an additional 15 medications to the above cited medications.</p> <p>A review of the resident's record revealed a February 2009 Medication Administration Record (MAR) listed the 15 additional medications that appeared on the January 26, 2009 POS. The resident received all 18 medications as prescribed by the physician on the January 26, 2009 readmission orders from January 26 through February 16, 2009.</p> <p>There was no evidence in the physician's progress notes or orders to indicate that the 15 medications on the January 26, 2009 orders were discontinued.</p> <p>The record lacked evidence that Resident #5's February 2009 Physician's Order Form was complete and accurately documented.</p> <p>A face-to-face interview was conducted with</p>	L 051	<p>C.</p> <p>1. The Medical Record reviewed. Unable to correct due to time constraints. Physician contacted to ensure resident plan of care is as ordered.</p> <p>2. Resident medical records will be reviewed for compliance and corrections as indicated.</p> <p>3. a) Medical Record Coordinator will train the Unit Secretary on the Chart maintenance and order. b) Licensed Nurses will be trained in Documentation to include Admissions, Monthly turnover and transcription of telephone orders. c) Unit Managers/Supervisors will review admission and readmissions within 48 hours of admissions.</p> <p>4. Unit Managers will audit admissions/readmissions every month. Findings will be submitted to the CQI Committee meeting monthly.</p>	<p>3/17/09</p> <p>3/31/09</p> <p>3-31-09</p> <p>3-31-09</p> <p>3-13-09</p> <p>On-going</p>

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L 051	<p>Continued From page 7</p> <p>Employee #1 on February 17, 2009 at approximately 3:00 PM. He/she acknowledged that facility staff failed to ensure that Resident #5's February 2009 Physician Order Form was complete and accurately documented. The record was reviewed February 17, 2009.</p> <p>3. The charge nurse failed to initiate a care plan for the use of seat belt and inform the responsible party of the use of the seat belt for Resident #7.</p> <p>A. The charge nurse failed to develop a care plan for the use of a seat belt.</p> <p>Review of the clinical record for Resident # 7 revealed an initial physician ' s order dated October 15, 2008, most recently reviewed February 4, 2009, which documented the following: " Apply seat belt for seating and hip positioning when in wheelchair. " Further review of the record revealed that no care plan was ever initiated for the resident ' s use of a seat belt.</p> <p>On February 20, 2009 at approximately 11:00 AM, Resident # 7 was observed sitting in a wheel chair with a seat belt in place. The resident was unable to release the seat belt.</p> <p>A face-to-face interview was conducted with Employee # 2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked a care plan for the use of a seat belt and added, "I will add one right away." The record was reviewed on February 18, 2009.</p> <p>B. The charge nurse failed to inform the responsible party about the use of a seat belt.</p> <p>On February 20, 2009 at approximately 11:00</p>	L 051	<p>3. A&B</p> <p>1. Resident #7's Care Plan for seatbelt has been initiated. 2-23-09</p> <p>2. Residents having restrictive devices care plan have been reviewed and corrected as indicated. 2-28-09</p> <p>3. Nursing staff will be educated on the "Policy and Procedure for the Implementation of Restraints" . The Fall/Restraint Committee will review restraint usage during the bi-weekly meeting to ensure compliance. 3-31-09</p> <p>4. The Nurse Manager will audit residents utilizing any type of restrictive device monthly. The finding of the audit will be submitted to the CQI Committee monthly x3 then quarterly. 3-19-09</p>	
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L 051	<p>Continued From page 8</p> <p>AM, Resident #7 was observed sitting in a wheel chair with a seat belt in place. According to the annual MDS dated December 31, 2008 Section B2 (Cognitive Impairment) the resident is coded as being cognitively impaired. The resident was unable to release the seat belt.</p> <p>A review of the resident's clinical record revealed an initial physician's order dated October 15, 2008, most recently reviewed February 4, 2009, which documented the following: "Apply seat belt for seating and hip positioning when in wheelchair." There was no evidence in the record that the use of the seat belt, risks, benefits and alternatives to its use were ever discussed with the resident's responsible party. The responsible party was therefore never afforded the opportunity to make an informed choice regarding the resident's use of the seatbelt.</p> <p>A face-to-face interview was conducted with Employee #2 on February 20, 2009 at approximately 11:30 AM. He/she acknowledged that the record lacked an informed consent and information documenting that the responsible party was ever notified of the resident's use of a seat belt. Employee # 2 added, "The responsible party lives in another state. I will call him/her to inform him/her of the use of the seat belt and will obtain consent for its use at the same time." The record was reviewed on February 17, 2009.</p> <p>4. The charge nurse failed to: ensure that the HGA1C [Glycated Hemoglobin] laboratory value was completed and update the falls care plan after the resident fell multiple times. Resident #8. A. Review of the resident's clinical record revealed Physician's Order Forms signed by the nurse practitioner on December 3, 2008, January</p>	L 051	<p>#4A</p> <ol style="list-style-type: none"> 1. The Diagnostic test was ordered on 2/17/09 and results obtained on 2/18/09 and physician notified. 2/18/09 2. Residents Laboratory Log and POS were compared for compliance corrections made as indicated. 3/16/09 3. Licensed staff trained obtaining "Diagnostic tests and Physician notification of diagnostic testing results and follow-up. 3/31/09 4. Unit Managers will audit the Laboratory log bi-weekly and the findings of the audit will be submitted to the CQI Committee monthly. 3/19/09 Ongoing 	

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L 051	<p>Continued From page 9</p> <p>9 and February 4, 2009 that directed "HGBA1C every 3 months Mar/Jun/Sep/Dec ... "</p> <p>There was no evidence on the record that the December 2008 HGBA1C laboratory test was done.</p> <p>A face-to-face interview was conducted with Employee #2 on February 17, 2009 at approximately 3:00 PM. He/She acknowledged the aforementioned findings. He/she received a fax from the laboratory showing that the blood work was done on January 27, 2009. The test was requested on February 17, 2009 and the results were available on February 18, 2009. The record was reviewed on February 18, 2009.</p> <p>B. The charge nurse failed to update Resident #8's "Fall Prevention Care Plan" after multiple falls with no injury.</p> <p>A review of Resident #8's record revealed that the resident fell on January 26, and 27, 2009.</p> <p>A review of the "Falls Prevention Care Plan" initiated April 4, 2008 revealed the following handwritten entry under "Evaluation" "Resident observed on the floor in room by w/c (wheelchair) x 2. Napping @ time of fall. Observed on knee. No injuries or pain voiced."</p> <p>There was no evidence in the record that additional goals and approaches were initiated after the aforementioned falls with no injuries.</p> <p>A face-to-face interview was conducted with Employee #2 on February 19, 2009 at approximately 1:45 PM. He/she acknowledged that the resident's clinical record lacked evidence that additional goals and approaches were</p>	L 051	<p>#4B</p> <p>1. Resident #8 Care plan has been reviewed/updated for compliance. 2-23-09</p> <p>2. A review has been completed of residents who have sustained a "Fall", corrections have been made as indicated. 2/23/09</p> <p>3. Nursing staff will be educated on the "Policy and Procedure for Fall follow-up". The Fall/Restraint Committee will review Falls that have occurred during the bi-weekly meeting to ensure compliance 3-31-09</p> <p>4. The Nurse Manager will audit residents that have fallen monthly. The finding of the audit will be submitted to the CQI committee monthly x3 then quarterly. 3-19-09</p>	

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L 051	Continued From page 10 initiated after the aforementioned falls. The record was reviewed February 19, 2009.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (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	L 052		

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NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(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	<p>Continued From page 11</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j) Prompt response to an activated call bell or call for help.</p> <p><i>This Statute is not met as evidenced by:</i> Based on observations, staff interviews and record review for four (4) of 24 sampled residents, and one (1) of nine (9) supplemental residents reviewed, it was determined that sufficient nursing time was not given to ensure: isolation technique was maintained during a dressing change for one (1) resident, incontinent care for one (1) resident, an attempted dose reduction for two (2) residents receiving antipsychotic medication, and that one (1) resident was able to self-medicate. Residents #4, 11, 13, 16 and F1.</p> <p>The findings include:</p> <p>1. Sufficient nursing time was not given during one (1) of five (5) dressing changes to maintain isolation technique for Resident #4, who was in Contact Isolation.</p> <p>On February 19, 2009 at approximately 12:45 PM Employee # 17 removed the following items: Three (3) unopened 4 x 4 (Gauze pads) One (1) partially used tube of Bacitracin ointment One (1) partially used small bottle of Normal Saline Solution (120 ml bottle) from the room of a resident who was on Contact</p>	L 052	<p><u># 1</u></p> <p>1. <u>A.</u> Employee #17 was counseled. She/he received training in the following areas: a) pain management, b) aseptic dressing change.</p> <p>2. Because other residents have the potential to be affect, Unit Manager will monitor wound care records and procedure during dressing change every week and document results.</p> <p>3. Licensed staff will be trained on a) pain management and b) aseptic dressing changes.</p> <p>4. The findings of the weekly monitoring of dressings changes and wound care records will be submitted to the CQI Committee monthly x3 then quarterly.</p>	<p>2-23-09</p> <p>3/13/09 Ongoing</p> <p>3/31/09</p> <p>3/19/09 Ongoing</p>

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L 052	<p>Continued From page 12</p> <p>Isolation Precautions.</p> <p>The employee removed the aforementioned items from the resident ' s room and placed them on a Medication Cart. Employee # 17 removed the items from the medication cart and placed them into a drawer in the Medication Room.</p> <p>A face-to-face interview was conducted with Employee # 17 at approximately 1:00 PM on February 19, 2009. The employee acknowledged the observation but did not offer an explanation.</p> <p>2. Sufficient nursing time was not given to Resident #11 for incontinent care.</p> <p>According to the resident ' s clinical record, the quarterly Minimum Data Set (MDS) completed on December 4, 2008, Resident #11 was coded a four (4) on both bowel and bladder assessment and a four/two (4/2) on toilet use and personal hygiene, indicating that the resident was incontinent of bowel and bladder function and that he/she was totally dependent on one (1) person staff assistance for toileting and personal hygiene.</p> <p>On February 19, 2009 at approximately 10:30 AM, Employee #20 was observed in the day room adjacent to the nursing station administering morning medication to Resident #11. The resident remained in the day room after the medication administration.</p> <p>Employee #19 was observed in the day room at about 12:15 PM assisting with lunch. At approximately 12:45 PM, Employee #19 was observed feeding the resident.</p> <p>At approximately 2:30 PM, Employee #19 was</p>	L 052	<p>#2.</p> <p>1. Employee #20 was counseled on " Incontinence Care, Resident Rights, Dignity and Elder Abuse and Neglect".</p> <p>2. Unit Managers will be making rounds to ensure incontinence care is conducted as stated in the Policy and Procedure.</p> <p>3. A review of <u>Charge Nurse Responsibilities</u> is being conducted with the Licensed Nurses by the Unit Managers with emphasis on monitoring CNA's as well as training in Resident Rights/Dignity and Elder Abuse and Neglect for all nursing staff.</p> <p>4. The Unit Manager will conduct random rounds weekly to ensure Incontinence care is done in a timely manner and documented. Findings will be submitted to the CQI Committee monthly x3 then quarterly.</p>	<p>2-20-09</p> <p>Ongoing</p> <p>3-31-09</p> <p>3-19-09</p>

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L 052	<p>Continued From page 13</p> <p>observed wheeling the resident to his/her room and transferred the resident from the wheel chair to his/her bed. At approximately 3:10 PM, Employee #11 was observed leaving the resident's bedside with a wet incontinent pad with strong urine odor.</p> <p>On December 16, 2008 the resident was assessed by facility staff on the "Continence Assessment" as being incontinent of bladder control and totally dependent for toileting.</p> <p>According to the facility's policy #1010, "Assessing Residents Elimination Patterns" and dated 9/29/03, "Incontinent. Residents in this group have no control over their elimination. They will be placed on a two-hour change schedule with the objective of keeping them dry and preventing skin breakdown."</p> <p>Facility staff failed to provide incontinent care for Resident #11 for approximately seven (7) hours.</p> <p>A face-to face interview was conducted with Employee #19 on February 19, 2009 at approximately 3:25 PM. Employee #19 acknowledged that the resident was last given incontinent care at approximately 7:00 AM by the night shift. The record was reviewed February 19, 2009.</p> <p>3. Sufficient nursing time was not given to ensure that an attempted dose reduction was initiated for Resident #13 who was receiving Ativan 0.5 mg PO (by mouth) BID (twice daily).</p> <p>A review of Resident #13's record revealed the following medications were prescribed by the physician. On March 11, 2008 "Discontinue Clonazepam. Ativan 1 [one] mg [milligram] IM</p>	L 052		

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L 052	<p>Continued From page 14</p> <p>[Intramuscularly] every 8[eight] hours times one week for agitation. If resident agrees to switch to oral give 0.5mg PO BID until seen by (name) psychiatrist." On March 12, 2008 another order instructed, "Change Ativan 1mg IM to 0.5mg PO bid until seen by [psychiatrist]."</p> <p>On March 11, 2008 the psychiatrist documented the following on a "Report of Consultation" under the heading of "Report." "Patient has been acting out despite on Aricept and Clonazepam.[He/She] has also been refusing meds [medications]. No acute medical issues reported." Under the heading of "Recommendations " the psychiatrist wrote the following: "1. D/C Clonazepam. 2. Ativan 1mg IM every 8 [eight] hours X [times] one week for agitation - if patient agrees to switch to oral give Ativan 0.5mg PO BID until seen by writer. 3. Hold #2 if falls, sedation or B/P [blood pressure] below 90/60. "</p> <p>Further review of the record failed to reveal any other documentation from the psychiatrist.</p> <p>A face-to-face interview was conducted with Employee #3 at approximately 11:30 AM on February 19, 2009. He/she acknowledged that there was no attempt at dose reduction for the Lorazepam since March 11, 2008. The employee also acknowledged that there was no documentation from the psychiatrist since March 11, 2008. The record was reviewed on February 18, 2008.</p> <p>4. Sufficient nursing time was not given to ensure that an attempted dose reduction was initiated for Resident #16, who was receiving Haldol daily.</p> <p>A review of Resident #16's record revealed that he/she was initially prescribed the following by the</p>	L 052	<p><u>#3</u></p> <p>1. A review of Resident #16's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #16 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p> <p><u>#4</u></p> <p>1. A review of Resident #13's medication has been completed by the psychiatrist and changes made as indicated. The MDS for Resident #13 has been corrected. 4/07/09</p> <p>2. An audit of residents receiving psychotropic medications will be completed by the Social Worker and discussion held with the psychiatrist to determine need for dose Reduction. 4/07/09</p> <p>3. Quarterly review of residents on antipsychotic medication will be completed by Social Worker. On-going</p> <p>4. A report will be provided to the CQI Committee quarterly by the Social Worker. On-going</p>	

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L 052	<p>Continued From page 15</p> <p>psychiatrist, "Haldol 1 mg by mouth daily for psychosis" on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, "Med Review done today." There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, "Haldol 0.5 mg by mouth daily." There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed "Haldol 0.5 mg by mouth every day for psychosis." The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The attending physician saw the resident on June 29, July 30, August 16, September 19, October 31, November 30 and December 27, 2008 and February 17, 2009. There was no evidence in the physician's notes that the use of Haldol was reviewed or a dose reduction attempted or documentation to indicate that a dose reduction was clinically contraindicated.</p> <p>The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in the day room. The resident was alert and responsive to name when called.</p>	L 052		

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L 052	Continued From page 16 A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009. 5. Sufficient nursing time was not given to Resident F1 to ensure the resident was able to self-administer a medication. According to Resident F1's February 2009 Physician's Order Sheet signed by the physician on February 2, 2009 directed, "Advair Diskus 100-50 MCG, inhale one puff by mouth twice daily for COPD [chronic obstructive pulmonary disease]." On February 17, 2009 approximately 9:30AM, during the medication pass for Resident F1, Employee #21 allowed the resident to self administer Advair Diskus medication. The resident was observed holding the medication to his/her lips, inhaling deeply and sucking the medication into his/her mouth and held the medication for several seconds while Employee # 21 was at the hand washing sink [the resident was observed taking the Advair correctly]. According to the facility's policy " 2.2 Self Administering Medications, Effective dated August 1, 2002 " Each customer is given the opportunity to self-administer his/her medications if the interdisciplinary team, upon evaluation of a customer ' s ability to safely self-administer medications, has determined that this practice is safe. There was no evidence in the record that the Interdisciplinary Care Team (IDT) determined that Resident F1 was safe for self administration of	L 052	#5 1. The Physician was contacted and an order obtained for the Resident F1 to self-medicate the "Advair Diskus 100-50 MCG inhalant". 2. Residents that have the potential to be affected will be assessed for the ability to self-medicate and initiated as indicated. 3. Nurse Managers will educate licensed staff on the policy regarding self-medication to ensure proper assessment of residents with the potential to self-medicate. 4. Residents will be reviewed during quarterly for the ability to self-medicate. This assessment will be reviewed at the Quality IDT Conference. The findings of the Quarterly IDT Conference will be submitted to the CQI Committee quarterly.	2-23-09 3-31-09 3/31/09 3-19-09

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L 052	Continued From page 17 medications. There was no physician's order to self administer medications. The record lacked evidence that a routine assessment was conducted by the IDT to assess the resident's ability to self medicate. A face-to-face interview was conducted on February 17, 2009 at 9:00 AM with Employee # 21. He/she stated, "Resident F1 wants to give [his/her] own medications." The record was reviewed February 17, 2009.	L 052		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on an observation of one (1) of five (5) dressing changes the facility staff failed to maintain isolation technique to prevent the spread of infection for one resident on Contact Isolation. Resident # 4. The findings include: On February 19, 2009 at approximately 12:45 PM Employee # 17 removed the following items: Three (3) unopened 4 x 4 (Gauze pads). One (1) partially used tube of Bacitracin ointment. One (1) partially used small bottle of Normal Saline Solution (120 ml bottle). from the room of a resident who was on Contact Isolation Precautions. The employee removed the aforementioned items from the resident ' s	L 091	1. Opened, undated medications were discarded. 2. Refrigerators and Medication rooms were checked by the Unit Managers and corrections were made as needed. 3. The DON/ADON will educate the Unit Managers and Clinical Supervisors of the "Medication: Expired/Undated Audit Sheet." An audit of refrigerators and Medication rooms will be completed by Unit Managers and supervisors weekly. 4. Findings of the "Medication: Expired/ Undated" audit tool will be submitted to CQI Committee monthly	3/15/09 3/15/09 3/15/09 3/19/09 Ongoing

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L 091	Continued From page 18 room and placed them on a Medication Cart. Employee #17 removed the items from the medication cart and placed them into a drawer in the Medication Room. A face-to-face interview was conducted with Employee # 17 at approximately 1:00 PM on February 19, 2009. The employee acknowledged the observation but did not offer an explanation.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations during the tour of the main kitchen on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidence by: lack of a trash receptacle by the hand wash sink by the tray line, components under the deep fryer soiled with accumulated grease, the condenser in the walk-in refrigerator dripping water, the door to the walk-in refrigerator failed to close tightly, caulking stained on the sink in the salad prep area, garbage disposal broken by salad prep area, food and paper waste disposed of in the same trash receptacle, and food in the 1st and 2nd floor pantries unlabeled and undated. Employee #7 acknowledged these findings at the time of the observations. The findings include:	L 099		

4. In-service was conducted for Utility staff on how to clean the deep fat fryer. Morning and evening checklist will be implemented to ensure all components of the fryer are clean. 3/10/09

5. Results will be monitored and reported monthly to the CQI Committee. On-going

#3

1. Maintenance Department was informed of the problem with the condenser leaking water onto the food during the February 20, 2009 survey and corrections have been made. 3/18/09

2. N/A

3. Staff will be in-services on how to use the door to prevent condensation. 3/30/09

4. Process will be monitored by the Food Services Supervisor and reported to the monthly CQI meeting. On-going

#4

1. Gasket was replaced on the walk-in refrigerator. 3/17/09

2. N/A

3. Refrigerator will be checked by the Director of Food Services for proper functioning. Maintenance staff will make monthly rounds to monitor refrigerator. 3/10/09

4. Findings will be reported in the monthly CQI meeting. On-going

L-Tag 099 continued page 20b

#5

1. Caulking above sink will be completed on 3/20/09
3/20/09.
2. Other sinks have been audited and
correction will be made as needed. 3/30/09
3. Kitchen areas have been placed on
preventive maintenance schedule. Staff
have been educated on this schedule. 3/11/09
4. A report of findings will be reported to the
CQI Committee quarterly. On-going

#8

1. Undated and unlabeled food and condiments
were removed from refrigerated. 3/13/09
2. Administrator memorandum directed that
refrigerators be cleaned daily by night staff. 3/14/09
3. To be monitored by the Nurse Coordinator
or Nurse Manager. Ongoing
4. Findings to be reported at the Quarterly
CQI meeting. Ongoing

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L 099	Continued From page 20 Cheese sandwich, pot pie and ½ filled container of ice cream.	L 099		
L 118	<p>3222.3 Nursing Facilities</p> <p>A three (3) day supply of non-perishable staples shall be maintained on the premises. This Statute is not met as evidenced by: Based on observations and staff interview during the tour of the main kitchen, it was determined that facility staff failed to maintain a three (3) day supply of non-perishable staples for emergency use. This observation was made in the presence of Employee #7 on February 17, 2009 from 8:45 AM through 10:30 AM. Employee #7 acknowledged these findings at the time of the observations.</p> <p>The findings include:</p> <p>Employee #7 presented a three (3) day " Cold Food " menu that was developed for use by the facility for emergencies. The following non-perishable items were included on the menu:</p> <p>Day One: cottage cheese and fruit plate for lunch and turkey and cheese sandwiches for dinner.</p> <p>Day Two: Cold Cut sandwich for dinner.</p> <p>Additionally, items on the menu and not stocked at the facility included potato chips, soda and dry milk.</p> <p>A face-to-face interview was conducted at the time of the observations. Employee #7 stated, "If the electricity goes out, we have about 4 to 6 hours before the cold food gets too warm to use. I guess that would mean the cottage cheese, turkey and cold cuts couldn't be used if the</p>	L 118	<p>1. Emergency food items have been increased to meet regulations.</p> <p>2. Emergency menus have been changed to reflect the foods needed in case of power outage.</p> <p>3. The emergency food shelf will be monitored for rotation and needed items by the Food Services Supervisor.</p> <p>4. The results will be reported to the CQI CQI Committee meetings.</p>	<p>3/17/09</p> <p>3/17/09</p> <p>3/17/09</p> <p>Ongoing</p>

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L 118	Continued From page 21 electricity goes out at midnight. We don't have alternative food planned for those items."	L 118		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 24 sampled residents, it was determined that the pharmacist failed to recommend a dose reduction for Resident #16, who was receiving a psychotropic medication. The findings include:	L 128		

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NAME OF PROVIDER OR SUPPLIER CAROLYN BOONE LEWIS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(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 128	<p>Continued From page 22</p> <p>A review of Resident #16 ' s record revealed that he/she was initially prescribed the following by the psychiatrist, " Haldol 1 mg by mouth daily for psychosis " on December 19, 2006.</p> <p>On January 23, 2007 and August 21, 2007, the psychiatrist wrote, " Med Review done today. " There was no evidence in the record that the psychiatrist saw the resident after August 21, 2007. An order signed by the attending physician dated November 20, 2007 directed, " Haldol 0.5 mg by mouth daily. " There was no evidence in the record that the use of Haldol was assessed by the psychiatrist or the attending physician after the November 20, 2007 order.</p> <p>The resident was hospitalized from June 20 through until June 25, 2008. Re-admission orders signed by the attending physician on June 29, 2008 directed " Haldol 0.5 mg by mouth every day for psychosis. " The order was renewed monthly, most recently February 2, 2009.</p> <p>According to the annual Minimum Data Set assessment completed August 24, 2008, the resident was not coded in Section E (Mood and Behavior Patterns) for any behavior problems and in Section I, (Disease Diagnoses) for psychosis.</p> <p>The pharmacist reviewed the resident ' s drug regimen on February 2, March 26, April 25, May 22, June 23, July 18, August 27, September 29, October 24, November 26, December 17, 2008 and January 29 and February 21, 2009. There was no evidence that the pharmacist recommended a dose reduction for Haldol.</p> <p>The resident was observed sitting calmly in a wheelchair on February 19, 2009 at 11:00 AM in</p>	L 128	<ol style="list-style-type: none"> 1. On 3/13/09 the pharmacist reviewed the resident's medication regime and recommendation were made. 2. The pharmacist will review other residents on psychotropic medication and recommendation made as needed. 3. The pharmacist will audit psychotropic medications monthly. 4. A report will be provided to the CQI Committee quarterly of results of those audits. 	<p>3/13/09</p> <p>4/30/09</p> <p>3/11/09</p> <p>On-going</p>	

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L 128	Continued From page 23 the day room. The resident was alert and responsive to name when called. A face-to-face interview was conducted with Employee #3 on February 19, 2009 at 11:30 AM. He/she acknowledged the above findings. The record was reviewed February 19, 2009.	L 128		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to remove expired medications that were present in the medication refrigerators. The findings include: Facility staff failed to remove expired medications from the current stock. These findings were observed on February 17, 2009 in the presence of Employees #10, 14 and 15. Employees #10, 14 and 15 acknowledged these findings at the time of the observations. 1. The following items were observed in two (2) of three (3) medication refrigerators as expired: February 17, 2009 at 1:00 PM One (1) of 10 vials of PPD opened November 3, 2008 and January 17, 2009 and expired December 4, 2008. 2nd floor February 17, 2009 at 12:25 PM Two (2) of three (3) vials of Novolin 70/30 insulin opened January 14, 2009 and expired February 14, 2009.	L 161	1. Opened, undated medications were discarded. 2. Refrigerators and Medication rooms were checked by the Unit Managers and corrections were made as needed. 3. The DON/ADON will educate the Unit Managers and Clinical Supervisors of the "Medication: Expired/Undated Audit Sheet." An audit of refrigerators and Medication rooms will be completed by Unit Managers and supervisors weekly. 4. Findings of the "Medication: Expired/Undated" audit tool will be submitted to CQI Committee monthly	3/15/09 3/15/09 3/15/09 3/19/09 Ongoing

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L 161	Continued From page 24 One (1) of three (3) vials of Novolog insulin opened January 14, 2009 and expired February 14, 2009. Two (2) of eight (8) vials of Lantus insulin opened January 14, 2009 and expired February 14, 2009.	L 161		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations during the initial tour, it was determined that facility staff failed to date medications when opened. The findings include: Facility staff failed to date vials when opened. These findings were observed on February 17, 2009 in the presence of Employees #10, 14 and 15. Employees #10, 14 and 15 acknowledged these findings at the time of the observations. 1. The following items were observed in two (2) of three (3) medication refrigerators as undated when opened: February 17, 2009 at 1:00 PM 1st Floor: One (1) of two (2) 10 ml vials of Ativan undated when opened. 2nd floor February 17, 2009 at 12:25 PM One (1) of two (2) vials of Tuberculin Purified Protein Derivative (PPD) undated when opened. One (1) of three (3) vial of Novolin 70/30 insulin	L 168	1. Opened, undated medications were discarded. 2. Refrigerators and Medication rooms were checked by the Unit Managers and corrections were made as needed. 3. The DON/ADON will educate the Unit Managers and Clinical Supervisors of the "Medication: Expired/Undated Audit Sheet." An audit of refrigerators and Medication rooms will be completed by Unit Managers and supervisors weekly. 4. Findings of the "Medication: Expired/Undated" audit tool will be submitted to CQI Committee monthly	3/15/09 3/15/09 3/15/09 3/19/09 Ongoing

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L 168	Continued From page 25 undated when opened. One (1) of three (3) vials of Novolog insulin undated when opened. One (1) of eight (8) vials of Lantus insulin undated when opened.	L 168		
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 environmental tour and tour of the main kitchen, it was determined that facility staff failed to ensure that the environment remained free from accidents and hazards as evidence by: broken/damaged light fixtures, crack in the glass window in a resident's room, medications left at the bedside, razors stored on top of a cart in the shower room, and a broken pureed mixer in the main kitchen. The environmental tour was conducted on February 17, 2009 from 12:30 through 4:00 PM and February 18, 2009 from 8:30 AM through 10:30 AM. These observations were made in the presence of Employees #8, 9, 1, 2, and 3. The findings were acknowledged at the time of the observations. The tour of the main kitchen was conducted on February 17, 2009 from 8:45 AM through 10:30 AM in the presence of Employee #7. The findings were acknowledged at the time of the observations.	L 214	#1 1. All Broken/damaged light fixtures were replaced. 2. Maintenance staff will make monthly rounds to check light fixtures for safety. 3. Maintenance staff will be in-serviced by the Director of Maintenance on safety issues in shower rooms. 4. Findings will be reported at the Quarterly CQI meeting. #2 1. New window panel was installed. 2. Maintenance staff will check rooms and windows for safety on monthly rounds. 3. Maintenance Director will monitor during monthly rounds. 4. Findings will be reported at the Quarterly CQI meeting.	3/11/09 Ongoing 3/11/09 Ongoing 3/2/09 Ongoing Ongoing Ongoing

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L 214	Continued From page 26 The findings include: 1. Broken/damaged light fixtures were observed in rooms 140, 210 and the 3rd floor shower room in three (3) of 42 rooms observed. 2. A crack in the glass window was observed in room 244 in one (1) of 24 rooms observed. 3. Medications were observed in the following resident 's rooms: Room 122: open bottle of Dakin ' s Solution, 10 Curafil wound gel dressings, tube of Vitamin A&D ointment, three (3) tubes of Santyl ointment. Room 142: open bottle of Normal Sterile Saline and Calmoseptin ointment in two (2) of 42 rooms observed. 4. Four (4) straight edge disposable razors were stored on top of a yellow isolation cart stored in the 2nd floor shower room in one (1) of 42 rooms observed. 5. The base of a food processor, in the main kitchen, used to puree food was observed with duct tape around the middle of the base of the machine. When the duct tape was removed, the base separated into two pieces in one (1) of one (1) food processor observed	L 214	#3 1. Medication, dressings and creams were removed from bedside. 2. Resident rooms were check for unauthorized dressings, ointments, creams and removed where indicated. 3. Unit Manager reviewed with Nursing Staff the appropriate items to be kept at bedside. 4. Random rounds will be conducted biweekly by the Safety Committee to ensure resident areas are in compliance. Findings of the rounds will be submitted to the CQI Committee monthly x3 then quarterly.	2/27/09 2-27-09 2/27/09 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 environmental	L 410	#4 1. Straight edge disposable razors stored on top of yellow isolation cart were removed. 2. Nursing staff in-serviced on storing supplies and equipment in shower rooms. 3. To be monitored by the Nurse Manager and Safety Committee. 4. Findings and corrections will be reported monthly to the Quarterly CQI meeting.	2/18/09 3/04/09 3/16/09 On-going

#5

1. New food processor has been purchased with delivery week of March 16, 2009. 3/16/09
2. Safety inspection has been conducted on other Dietary equipment by the Director of Food Services. 3/16/09
3. Monitor maintenance of equipment with Food Safety Audit by Director of Food Services monthly. 3/16/09
4. Findings and corrections will be reported monthly to the CQI meeting. On-going

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L 410	<p>Continued From page 27</p> <p>tour conducted on February 17, 2009 from 12:30 through 4:00 PM and February 18, 2009 from 8:30 AM through 10:30 AM, it was determined that facility staff failed to maintain housekeeping and maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by: soiled window sills in 14 of 42 rooms , corners in 17 of 42 rooms , floors in 10 of 42 rooms , bathroom vents in five (5) of 42 rooms , privacy curtains in six (6) of 42 rooms , inside of bathroom light fixtures in three (3) of 42 rooms , Heating Ventilation and Cooling (HVAC) in nine (9) of 42 rooms; items stored in two (2) of three (3) shower rooms, damaged walls and cove base in 13 of 42 rooms observed, and marred/scarred furniture in six (6) of 42 rooms .</p> <p>These observations were made in the presence of Employees #1, 2,3 ,8, and 9. The findings were acknowledged at the time of the observations.</p> <p>The findings include:</p> <p>The following items were observed soiled:</p> <p>1. Window sills: Rooms 108, 109, 111, 112, 115, 131, 142, 143, 146, 210, 218, 234, 237 and 320 in 14 of 42 rooms observed.</p> <p>2. Corners: Rooms 108, 109, 111, 115, 122, 131, 137, 143, 146, 210, 241, 309, 320, 335, 338, 341 and 343 in 17 of 42 rooms observed.</p> <p>3. Floors: Rooms 115, 127, 210, 218, 227, 237, 328, 335, 341 and 334 in 10 of 42 rooms observed.</p> <p>4. Bathroom vents: Rooms 108, 115, 213, 218 and 237 in five (5) of 42 rooms observed.</p>	L 410	<p>#1 Window sills:</p> <p>1. Window sills observed with accumulated dust were cleaned and brought into Compliance. 2/21/09</p> <p>2. All windows were assessed for routine cleaning. 3/18/09</p> <p>3. Daily inspection will be done by the supervisor to ensure compliance. 3/16/09</p> <p>4. Staff In-serviced in Cleaning Rooms. (See attached document.) 3/12/09</p> <p>5. Monitor report will be given at the monthly CQI meeting. On-going</p>	

#2 Corners in the rooms:

1. Room corners identified will be cleaned. 3/27/09
2. Assessment of all rooms was done and will be cleaned on a scheduled basis. 3/20/09
3. Housekeeping staff was in-serviced in "How to Clean Resident's Room Properly". (See attached outline.) 3/11/09
4. Process will be monitored by the Housekeeping Supervisor to ensure compliance. 3/16/09
5. Results and effectiveness of plan will be reported at the monthly CQI meeting. On-going

#3 Soiled Floors:

1. Floors identified will be stripped and cleaned. 4/11/09
2. All rooms were assessed for cleanliness. Rooms identified as out of compliance will be stripped and floors refinished. 4/11/09
3. Staff was in-serviced in "How to Strip and Refinish Floors". (See attachment.) 3/11/09
4. Housekeeping supervisor will monitor for compliance. (See attachment) 4/11/09
5. Results of the monitoring process will be reported at the monthly CQI meeting. On-going

#4 Bathroom Vents:

1. Bathroom vents observed were cleaned immediately. 2/17/09
2. Bathroom vents were assessed for cleanliness and corrective actions made as needed. Vents were placed on schedule for routine cleaning. 2/20/09
3. Staff was in-serviced on "How to Clean Resident's Rooms". (See attachment) Process to be monitored by the Housekeeping supervisor. 3/11/09
4. Results of the process will be reported at the monthly CQI meeting. On-going

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L 410	Continued From page 28 5. Privacy curtains: Rooms 109, 111, 140, 334, 335 and 343 in six (6) of 42 rooms observed. 6. Inside of bathroom light fixtures: Rooms 326, 338 and 343 in three (3) of 42 rooms observed. 7. HVAC filters: Rooms 111, 137, 146, 227, 326, 334, 335, 337 and 338 in nine (9) of 42 rooms observed. 8. Items stored in shower rooms: 1st floor -2 yellow isolation carts, five (5) IV poles; 2nd floor -1 yellow isolation cart and one (1) wheelchair weight scale. The following items were damaged/soiled: 9. Walls: Rooms 112, 135, 140, 142, 213, 218, 225, 311, 313, 316, 326, 334 and 343 in 13 of 42 rooms observed. 10. Cove base: Rooms 108, 109, 111, 112, 127, 129, 131, 135, 137, 213, 216, 218, 220, 246, 309, 326 and 328 in 17 of 42 rooms observed. The following items were observed marred/scarred: 11. Furniture: Rooms 112, 2nd floor dining room five (5) of seven (7) arm chairs, 326, 328, 335 and 338 in six (6) of 42 rooms observed.	L 410	#5 Privacy Curtains 1. Privacy curtains were cleaned immediately. 2/21/09 2. Privacy curtains of other rooms were inspected and corrections made as needed. 3/16/09 3. Daily inspections will be performed by Housekeeping Supervisor to ensure compliance. A monthly schedule has been implemented to wash or replace privacy curtains. 3/16/09 4. Housekeeping supervisor will audit rooms weekly and report findings monthly to CQI meeting. On-going #6 Light Fixtures 1. Broken light fixtures identified were replaced. 3/11/09 2. Other light fixtures were inspected and replacements made as needed. 3/20/09 3. Maintenance staff will make monthly rounds to ensure all lights are working properly. Maintenance staff will be in-services on resident safety by Director of Maintenance. 3/20/09 4. Findings of monthly rounds will be reported monthly to the CQI Committee. On-going	

L-Tag 410 continued pg. 29a

#7 HVAC - Filters

1. All filters were cleaned or replaced. 3/13/09
2. Other HVAC filters were inspected and cleaned and replaced as needed. 3/23/09
3. Maintenance staff will perform monthly rounds to ensure all filters are in proper working condition. Maintenance staff will be in-serviced by Director of Maintenance on schedule of cleaning the HVAC filters. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI meeting. On-going

#8 Items in Shower Rooms

1. Items have been removed from the shower rooms. 2/20/09
2. Other showers have been inspected and corrections made as needed. 2/23/09
3. Nursing personnel were instructed on not storing items in unauthorized places. The Safety Committee team will make biweekly rounds and document their findings to ensure compliance. 3/16/09
4. Findings of the rounds will be submitted to the CQI Committee monthly. Ongoing 3/19/09

#9 Walls

1. Repair and painting of all walls will be completed. 3/20/09
2. Other rooms will be inspected for damaged walls and repairs will be made as needed. 3/31/09
3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on Painting of the facility. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI meeting. On-going

#10 Cove base

1. Cove base in rooms identified were repaired or replaced. 3/12/09
2. Other rooms were inspected for damaged cove base and repairs made as needed. 2/23/09
3. Maintenance staff will perform monthly rounds to ensure all areas are in compliance. Maintenance staff will be in-serviced by the Director of Maintenance on repairing or replacing of base covers in the facility. 3/20/09
4. Findings of monthly rounds will be reported monthly to the CQI meeting. On-going

#11 Marred/Scarred Furniture

1. Furniture/chairs removed from rooms identified and will be painted or replaced with new furniture. 5/16/09
2. Other rooms were inspected for damaged/scarred furniture and will be painted or replaced as appropriate. 5/5/09
3. Condition of furniture in dayrooms and resident rooms will be monitored by the CQI committee and maintenance staff monthly. On-going
4. Findings will be reported at the quarterly CQI meeting for appropriate action. On-going