

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/19/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09E020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2007
NAME OF PROVIDER OR SUPPLIER JEANNE JUGAN RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 253 SS=D	<p>An annual recertification survey was conducted January 11 through 12, 2007. The following deficiencies were based on record review, observation and interviews with facility staff. The sample included 10 residents based on a census of 39 residents on the first day of survey and three (3) supplemental residents.</p> <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations during the environmental tour, it was determined that facility staff failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable environment as evidenced by: soiled/dusty bed frames, a mechanical lift, floors, carpets, exterior windows, marred doors and dining room chairs, and peeling paint on the windows. These observations were made in the presence of the Directors of Maintenance and Housekeeping and nursing staff.</p> <p>The findings include:</p> <p>1. Horizontal bed frames were dusty and soiled with debris in the following areas:</p> <p>Rooms 1204, 1206, 1401, 1411, 1415 and 1421 in six (6) of 17 observations at 10:55 AM on January 11 and between 9:20 AM and 10:40 AM on January 12, 2007.</p>	F 253	<p>Plan of Correction</p> <p>F253</p> <p>Finding #1</p> <ol style="list-style-type: none"> 1. Housekeeping Staff dusted and sanitized the bed frames in Rooms 1204, 1206, 1401, 1415, and 1421 on 1/12/07. 2. Housekeeping Staff will dust all bed frames as part of their daily cleaning. On sheet changing days they will also clean and sanitize the bed frames of all the beds. This is part of the routine cleaning plan every other week. 3. Contract Housekeeping Manager will monitor this by inspecting a random sample of Resident bed frames twice weekly and will give a report of the results to the Administrator. 4. These reports will be collected and given to the QI nurse to be referred to the QI and QA meetings. 5. Corrective action complete 1/12/07. <p>Finding #2</p> <ol style="list-style-type: none"> 1. The handles and foot pedals of the lifts on Good Shepherd and Sacred Heart units were cleaned on 1/12/07. 2. All lifts will be cleaned every night by night shift nursing staff and checked by the night nurse to assure that they are clean. 3. A schedule for night shift nursing staff has been put into place and will be monitored by the Unit Coordinators on a weekly basis. 	1/12/07	

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

TITLE

(X6) DATE

Cecile Zeringue

Adm.

1/29/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	<p>Continued From page 1</p> <p>2. The foot pedals and handles of the mechanical lift were soiled with debris in the laundry rooms in three (3) of three (3) observations at 11:15 AM on the Good Shepherd unit and two (2) of two (2) observations on the Sacred Heart unit at 10:00 AM on January 12, 2007.</p> <p>3. Floor and carpet surfaces were sticky, soiled and/or marred in the following areas:</p> <p>Rooms 1210, 1411, 1419, 1423 and Café floors in five (5) of 18 observations between 10:55 AM and 4:08 PM on January 11, 2007 and between 9:20 AM and 10:40 AM on January 12, 2007.</p> <p>4. The exterior surfaces of windows were soiled and stained in the following areas:</p> <p>Rooms 1204, 1206, 1214, 1421, Café area, day room and rehabilitation services area in seven (7) of 21 observations between 10:55 AM and 4:08 PM on January 11, 2007 and between 9:20 AM and 10:40 AM on January 12, 2007.</p> <p>5. Entrance and bathroom doors were marred and scarred in the following areas:</p> <p>Good Shepherd Rooms 1204, 1206, 1211, 1214 and 1217 in five (5) of nine (9) observations between 10:40 AM and 4:08 PM on January 11, 2007.</p> <p>Sacred Heart Rooms 1403, 1415 and 1421 in three (3) of eight (8) observations between 9:20 AM and 10:40 AM on January 12, 2007.</p> <p>6. Dining room chairs were marred and scarred on leg and arm surfaces in 18 of 19 observations at 12:40 PM on January 12, 2007.</p>	F 253	<p>4. A report will be given to the QI nurse on a monthly basis. Findings will be reported at QI and QA meetings.</p> <p>5. Corrective action taken 1/12/07.</p> <p>Finding #3</p> <p>1. The carpet in Room 1210 was cleaned. The café floor and the floors in rooms 1411, 1419, and 1423 were washed on 1/12/07.</p> <p>2. The carpet will be vacuumed daily by housekeeping. Spots will be identified and treated. Floors will be swept and mopped daily and as needed.</p> <p>3. All floors will be inspected and monitored by the Contract Housekeeping Manager daily. Any sticky or soiled floors will be brought to the attention of the responsible housekeeper or janitor.</p> <p>4. The Contract Housekeeping Manager will give a monthly audit report as to the cleanliness of the floors and carpets to the QI nurse. Findings will be referred to the QI and QA committee meetings.</p> <p>5. Corrective action taken 1/15/07.</p> <p>Finding #4</p> <p>1. Facility has contracted with a professional window cleaning service to clean windows in Rooms 1204, 1206, 1214, 1421, the café area, day room and rehabilitation services area on 3/20/07.</p> <p>2. Facility will contract professional services to clean all windows annually every spring.</p> <p>3. Housekeeping will be responsible for cleaning windows that may become soiled or stained in-between those services when it is</p>	<p>1/12/07</p> <p>1/15/07</p>

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possible and safe. They will clean inside of windows.

4. The exterior surfaces of the windows will be inspected every six months by the Contract Housekeeping Manager and report of soiled windows given to the Administrator for review. Findings will be referred to the QI and QA committee meetings.

5. Corrective action will be completed by 3/20/07.

3/20/07

Finding #5

1. Repair of door surfaces by sanding and staining will be done in Rooms #1204, 1206, 1211, 1214, 1217, 1403, 1415 and 1421 will be done by 3/20/07.

2. All of the Residents' rooms' door surfaces were inspected to see which ones were in need of repair and report given to Administrator.

3. These inspections will be added to the quarterly preventive maintenance program.

4. Results of quarterly maintenance program will be reported to the Administrator and the QI nurse. Findings will be referred to the QI and QA committee meetings.

5. Corrective actions will be completed by 3/20/07.

3/20/07

Finding #6

1. All dining room chairs were inspected on 1/12/07.

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2. All chairs will be replaced by new chairs by 3/30/07.
3. Dining room chairs will be inspected as part of the quarterly maintenance program.
4. Results of report of quarterly inspection of dining room chairs will be given to the Administrator and QI nurse. Findings will be referred to the QI and QA committee meetings.
5. Corrective action will be completed by 3/20/07.

3/20/07

Finding #7

1. Window sills and frames in rooms #1204, 1206, 1419, 1423, and the Café will be painted by an outside contractor by 3/20/07.
2. Maintenance will inspect all Residents' rooms for any window sills or frames that are in need of painting because of peeling paint and will give a report to the Administrator.
3. These inspections will be added to the quarterly preventative maintenance program.
4. Results of reports from quarterly inspections will be reported to the Administrator and the QI nurse. Findings will be referred to the QI and QA committee meetings.
5. Corrective actions will be completed by an outside contractor by 3/20/07.

3/20/07

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F 253	Continued From page 2	F 253			
F 279 SS=D	<p>7. Paint on window sills and frames was peeling in the following areas:</p> <p>Rooms 1204, 1206, Café, 1419, 1421 and 1423 in six (6) of 21 observations between 10:55 AM and 4:08 PM on January 11, 2007 and between 9:20 AM and 10:20 AM on January 12, 2007.</p> <p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and record review for two (2) of 10 sampled residents and two (2) supplemental records, it was determined that facility staff failed to initiate a care plan with</p>	F 279	<p>F279</p> <p>1. Care plans with appropriate approaches and goals for nine or more meds were implemented on 1/11/07 for Residents #1,#8, JH2, and JH3. A care plan for Resident #8 for the use of a safety belt was completed by the charge nurse on 1/12/07 and placed for review and implementation by staff.</p> <p>2. All Residents' POFs were reviewed for use of nine or more meds and care plans initiated or updated with appropriate goals and approaches. Residents' POFs were reviewed for safety belt orders.</p> <p>3. The QI nurse and the MDS coordinator will continue to review care plans and educate charge nurses on initiating and updating care plans for Residents with new orders.</p> <p>4. Monthly audits will be done when MARS are updated and with monthly nursing summaries. Discrepancies will be reported to the QI nurse and the MDS coordinator for review. Findings will be referred to the QI and QA committee meetings.</p> <p>5. Corrective actions completed by 1/12/07</p>	1/12/07	

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F 279	<p>Continued From page 3</p> <p>appropriate goals and approaches for the use of nine (9) or more medications for four (4) residents and the use of a safety belt for one (1) resident. Residents #1, 8, JH2 and JH3.</p> <p>The findings include:</p> <p>1. Facility staff failed to initiate care plans with goals and and approaches for the use of nine (9) or more medications for four (4) residents.</p> <p>A. The review of the clinical record for Resident # 1 revealed that a physician's order dated December 20, 2006 prescribed Tylenol, Aspirin, Dilantin, Diovan, Ranitidine, Senokot, Seroquel, Toprol and Trazodone.</p> <p>The resident's care plan was dated November 16 , 2006. There was no update or revision to the care plan to include nine (9) or more medications.</p> <p>On January 12, 2007 at approximately 10:00 AM, a face-to-face interview was conducted with the Minimum Data Set Coordinator, who acknowledged the lack of a care plan for nine (9) or more medications. The record was reviewed January 12, 2007.</p> <p>B. The review of the clinical record for Resident # 8 revealed that a physician's order dated December 12, 2006 prescribed Tylenol, Aricept, Colace, Prozac, Lipitor, Claritin, Miacalcin, Multivitamin, Namenda, Naproxen, Norvasc, Os-Cal, Zantac, Vitamin E, and Rhinocort.</p> <p>The resident's care plan was dated October 31, 2006. There was no update or revision to the care plan to include nine (9) or more medications.</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>On January 12, 2007 at approximately 10:00 AM a face-to-face interview was conducted with the Minimum Data Set Coordinator who acknowledged the lack of a care plan for nine (9) or more medications. The record was reviewed on January 12, 2007.</p> <p>C. The review of the clinical record for Resident JH2 revealed a physician's order dated December 14, 2006 prescribed Digitek, Colace, Clopidogrel, Celebrex, Furosemide, Lisinopril, Vitron C, Benzonatate, and Albuterol.</p> <p>The resident's care plan was dated November 21, 2006. There was no update or revision to the care plan to include nine (9) or more medications.</p> <p>On January 12, 2007 at approximately 10:00 AM a face-to face- interview was conducted with the MDS Coordinator who acknowledged the lack of a care plan for nine (9) or more medications. The record was reviewed on January 11, 2007.</p> <p>D. The review of the clinical record for Resident JH3 revealed that a physician's order dated November 22, 2006 prescribed Glipizide, Gabapentin, Calcium Gluconate, Multivitamin, Loratadine, Lisinopril, Norvasc, Omeprazole, Metformin and Sertraline.</p> <p>The resident's care plan was dated November 28, 2007. There was no update or revision to the care plan to include nine (9) or more medications.</p> <p>On January 12, 2007 at approximately 10:00 AM a face-to-face interview was conducted with the MDS Coordinator who acknowledged the lack of a care plan for nine (9) or more medications. The record was reviewed on January 11, 2007.</p>	F 279			

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F 279	Continued From page 5 2. Facility staff failed to care plan for the use of a safety belt for Resident #8. During the review of the clinical record for Resident #8 a physician's order (original) dated September 23, 2005 and the current orders dated December 12, 2006 directed, "Alarm safety belt with quick release." The resident's care plan was dated October 31, 2006 and did not include the safety belt alarm. On January 12, 2007 at approximately 9:30 AM a face-to-face interview was conducted with the charge nurse who acknowledged the lack of a care plan for a safety belt. The record was reviewed on January 12, 2007.	F 279			
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on observation, staff interview and record review for three (3) of 10 sampled residents, it was determined that facility staff failed to notify the physician when a medication was not available for one (1) resident, obtain a chest x-ray when ordered by the physician for one (1) resident and clarify a medication order for (1) resident. Residents #5, 7 and JH1.	F 309	F309 1. Resident #1 received medication upon arrival from pharmacy. Lab monitoring will continue. Resident #7 had her chest x-ray done at the understood annual time from her last chest x-ray which coincides with her annual physical exam. Need for "month" clarification of this order was done with staff. Resident JH1 received correct insulin coverage. The importance of prompt clarification of this order was reviewed with staff. 2. All MARS were reviewed for clarity and timely execution. Pharmacy was notified again of ongoing problem with medication delivery. 3. Nursing staff was in-serviced on 1/24/07 re: need for clarification of order, timely execution of same, as well as, assuring that these items are verified at the time of the monthly MAR/POF review. Services of the current pharmacy will be terminated due to "failure to deliver goods and services as per contract" effective 2/21/07.		

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F 309	<p>Continued From page 6</p> <p>The findings include:</p> <p>1. Facility staff failed to notify the physician when a medication was not available for Resident #5.</p> <p>A review of Resident #5's record revealed a physician's order dated November 28, 2006, "Epoetin (Procrit) inject 40,000 units subcutaneously every month for anemia of chronic disease. Hold if Hematocrit is above 33 %."</p> <p>According to a laboratory report dated December 27, 2006, Resident #5's Hematocrit was 28.7%.</p> <p>A review of the December 2006 Medication Administration Record (MAR) and the nurses' notes from December 27 through December 31, 2006, revealed that the Epoetin was not administered.</p> <p>A face-to-face interview was conducted with the charge nurse on January 11, 2007 at 3:18 PM. He/she stated, "The medication was not available. We called many times to the pharmacy to get the medication. The pharmacy didn't send it until the beginning of January (2007). I guess we should have called the physician and told [him/her] that we couldn't get the medication right away."</p> <p>According to the January 2007 MAR the resident received the Epoetin on January 3, 2007. There was no evidence in the record that the physician was notified that the medication was not available. The record was reviewed January 11, 2007.</p> <p>2. Facility staff failed to obtain a chest x-ray at the time it was ordered by the physician for Resident</p>	F 309	<p>4. The QI nurse will receive monthly reports of discrepancies and will report to the QI Committee. The MDS coordinator will review on a quarterly basis the physicians orders and MARs to assure execution and completion of same.</p> <p>5. Corrective action completed 1/24/07</p>		1/24/07

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F 309	<p>Continued From page 7 #7.</p> <p>A review of Resident #7's record revealed a physician's order dated July 27, 2006, "Annual chest x-ray." The chest x-ray was completed November 21, 2006.</p> <p>A face-to-face interview was conducted with the Director of Nursing on January 12, 2006 at 7:30 AM. He/she acknowledged that the chest x-ray was completed approximately four (4) months after the physician's order.</p> <p>According to the " X-ray Examination Report- No tuberculosis nor other acute disease ... " The record was reviewed January 12, 2007.</p> <p>3. Facility staff failed to clarify an insulin order for Resident JH1.</p> <p>A review of Resident JH1's record revealed a telephone order that directed the administration of insulin according to the resident's blood sugar level as tested by Accucheck.</p> <p>According to the telephone order dated December 20, 2006 and signed by the physician, (no date indicated) " Accucheck bid (twice per day). Cover: 300 or greater, 8 units. 250-299, 6 units, 200-249, 4 units, 150-199, 2 units. "</p> <p>No insulin type was identified and there was no evidence in the record that facility staff contacted the physician to clarify the type of insulin to use in the above cited order.</p> <p>A review of the Medication Administration Record (MAR) for December 2006 revealed that " Regular" was written on the above transcribed</p>	F 309			

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F 309	Continued From page 8 order to indicate the type of insulin. The January 2007 MAR revealed that the resident received insulin coverage 19 times and no type of insulin was identified. A face-to-face interview was conducted with the charge nurse on January 12, 2007 at 10:30 AM. When queried about the type of insulin used for the coverage, he/she stated, "We use regular insulin." The surveyor asked if the type of insulin was written on the January 2007 MAR. The charge nurse acknowledged that there was no type of insulin indicated on the January 2007 MAR.	F 309			
F 363 SS=D	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by : Based on observations during the dietary tour, it was determined that the dietician failed to sign menus and spread sheets. The findings include: The dietician failed to sign the menus and spread sheets, indicating that he/she had reviewed the nutritional values of the meals and substitute menu items in one (1) of one (1) observation at approximately 2:40 PM on January 11, 2007.	F 363	F 363 483.35(c) 1. To ensure that menus meet the nutritional need of Residents in accordance with the recommended dietary allowances of the Food and nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance and to be followed the dietician will review the nutritional values of the meals and substitute menu items and her/his signature will be placed on menu and spread sheets. 2. The dietician will be asked to sign all menus and spreadsheets 3. After menus have been prepared for the week the dietician will review and sign. 4. After menus are prepared the dietary manager will give the weeks menu to the dietician for review and signature. After review and making of any necessary changes, they will be returned to dietary manager who will be sure they have been signed and then only can they be posted and followed. 5. Corrective action was taken 1/12/07.		1/12/07

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09E020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2007
NAME OF PROVIDER OR SUPPLIER JEANNE JUGAN RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4200 HAREWOOD ROAD NE WASHINGTON, DC 20017		
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F 371 SS=E	<p>483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE</p> <p>The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>This REQUIREMENT is not met as evidenced by : Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: ungloved staff handling dishes, silverware only washed twice and racked for reuse with the eating side up, flat racks stored on the floor, serving scoops without an identified portion size, and a soiled deep fryer, cooking hood cables, and ice/water chutes of the ice machine. These observations were made in the presence of the Director of Food Services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Dietary staff was observed in the dish area handling chinaware without gloves or washing their hands in three (3) of three (3) observations at 1:30 PM on January 11, 2007. 2. Silverware was racked and ready for reuse with the eating surfaces up and washed twice instead of three (3) times in four (4) of four (4) observations at 1:35 PM on January 11, 2007. 3. Flat racks for washing silverware were stored on the floor between washes in four (4) of four (4) observations at 1:45 PM on January 11, 2007. 	F 371	<p>F 371 483.35 (i)(2)</p> <p><i>Finding 1.</i></p> <ol style="list-style-type: none"> 1. Dietary staff will wash hands and wear gloves when handling chinaware to ensure that foods are served in a safe and sanitary manner. 2. Gloves are provided to dishwashing personnel and instructions are given regarding their usage for dishwashing. An in-service was conducted by the food service director for dishwashing and pantry personnel on, " Proper Dishwashing Procedures." The importance of hand washing and the wearing of gloves when handling chinaware was stressed. This in- service was conducted on 1/17/07. 3. Special signs are posted in dishwashing and pantry area to remind personnel of this requirement. 4. The food service director & the staff dietitian, will daily monitor through observation compliance to this requirement and report its findings at the QA meeting. 5. Corrective action took place 1/12/07. <p><i>Finding 2.</i></p> <ol style="list-style-type: none"> 1. Dietary staff will rack the silverware with eating ends up and wash them twice through the dishwasher and then wash them a third time with handles up to ensure that foods are served in a safe and sanitary manner. 2. An in-service was conducted by the food service director for dishwashing and pantry personnel on Proper Dishwashing Procedures. The requirement of washing silverware through the machine twice with 	1/12/07	

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eating end up and once with handles up was emphasized. Although we pre-wash the silverware before racking, it is still required to put them through the dishwasher three times, the last time with handles up. This in-service was conducted on 1/11/07.

3. Special signs are posted in the dishwashing area to remind all personnel of this requirement.

4. The food service director & the staff dietitian, will daily monitor compliance to this requirement and report its findings at the QA meeting.

5. Corrective action took place immediately on 1/11/07.

1/11/07

Finding 3.

1. Dietary staff will not place dish racks on floor at any time to ensure that foods are served in a safe and sanitary manner.

2. Dish racks are used for soiled silverware and dishes and sent through the dishwasher to be sanitized, they are not to be placed on the floor at any time. An in-service was conducted by the food service director for dishwashing and pantry personnel on, "Proper Dishwashing Procedures." The requirement of not placing dish racks on the floor was emphasized. This in-service was conducted on 1/11/07. A special dish rack dolly has been purchased to hold the racks off the floor. Dish carts were used on a temporary basis in order that this issue could

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be corrected immediately when brought to our attention.

3. Special signs are posted in the dishwashing area to remind all personnel of this requirement.

4. The food service director & the staff dietitian, will daily monitor through observation, compliance to this requirement and report its findings at the QA meeting.

5. Corrective action took place immediately on 1/11/07.

1/11/07

Finding 4.

1. Marked serving scoops with portion size are now used to serve entrees in the dining room to ensure proper portion control to Residents.

2. All non marked serving spoons have been removed from the serving area to prevent them from being used. To replace these spoons marked scoops have been purchased and are presently being used.

3. Menu and spreadsheet are in serving area so correct scoop size will be used according to portion size prescribed on spread sheet.

4. The food service director & the staff dietitian, will daily monitor through meal observation, compliance to this requirement and report its findings at the QA meeting.

5. Corrective action took place on 1/23/07.

1/23/07

Finding 5.

1. The inner panel door of the deep fryer had not been cleaned for 2 weeks according to our charted cleaning schedule. Our cleaning schedule will be re-evaluated and changed to have this area cleaned more frequently.

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2. The utility person who cleans the grease from the deep fryer has been instructed to clean this area each time he strains or changes the grease.
3. A revised cleaning schedule for this area of equipment has been put into place.
4. The food service director & the staff dietitian, will monitor weekly the following of the revised cleaning schedule for this area of the deep fryer. They will report the results at the QA meeting.
5. The area of the deep fryer was cleaned immediately on 1/11/07.

1/11/07

Finding 6.

1. Cable sensor wires cleaned 1/11/07.
2. All cable wires will be cleaned on a regular basis to ensure fire safety.
3. Cable wires will be inspected weekly.
4. Cable wire inspection will be added to weekly preventive maintenance program and results will be reported at the QI & QA meeting.
5. Corrective action taken 1/11/07.

1/11/07

Finding 7.

1. The ice and water machine is cleaned and sanitized once a day according to the cleaning schedule. This is done at the end of the morning shift about 2:30pm. The use of a de-liming solution would be helpful to remove the mineral deposits that form in the chutes.
2. All pantry aids who daily clean and sanitize this equipment have been given instructions on 1/13/07 to use a de-liming solution when carrying out this task.

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3. A reminder to pantry aides will be placed in their work area to continue to daily clean and sanitize but also to de-lime the chutes in the ice and water machine.

4. The food service director & the staff dietitian, will monitor weekly the cleaning of this ice and water machine and will report to the QA meeting its results.

5. Corrective action took place on 1/12/07.

1/12/07

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F 371	Continued From page 10 4. Serving scoops used to serve entrees in the dining room were unmarked to indicate the portion size in four (4) of four (4) observations at 8:40 AM on January 12, 2007. 5. The inner panels of the deep fryers, electrical wires and gas supply lines were soiled with grease in two (2) of two (2) observations at 8:45 AM on January 11, 2007. 6. Cable sensor wires under cooking hoods were soiled with dust and grease in four (4) of four (4) observations between 8:40 AM and 8:50 AM on January 11, 2007. 7. The ice and water machine was observed with mineral deposits and debris on the chutes in the dining room pantry at 12:55 PM on January 12, 2007 in one (1) of one (1) observation.	F 371			
F 411 SS=D	483.55(a) DENTAL SERVICES - SNF The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by :	F 411	F411 1. Resident #6 was seen by the dentist on 1/16/07 for routine prophylaxis. 2. Residents' dental records were reviewed for timely dental visits. Staff was instructed to document reasons for failure to see dentist as scheduled on 1/12/07 and 1/13/07. 3. Residents' dental visits will be monitored as part of the MAR and summary audit. The QI nurse will be notified of any Resident needing appointments. 4. The MDS coordinator will audit the charts quarterly and inform the QI nurse of discrepancies. The QI nurse will assure that all Residents are scheduled at least annually and as needed. 5. Corrective action completed 1/16/07		1/16/07

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F 411	Continued From page 11 Based on observation, staff interview and record review for one (1) of 10 sampled residents, it was determined that facility staff failed to provide routine dental services for Resident #6. The findings include: A review of Resident #6's record revealed that there was no current dental screen in the record. A face-to-face interview was conducted with the Director of Nursing on January 12, 2007 at 7:15 AM. After reviewing the resident's record, he/she stated, " The last dental screening I found was 2004. I think that [Resident #6] refused last year. I know that we should have written a note documenting the refusal of care." There was no evidence in the record that Resident #6 had dental concerns, weight loss or chewing/eating problems. The record was reviewed January 12, 2007.	F 411			
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by :	F 441	F441 1. The shower curtain that was soiled with a soapy film in the Sacred Heart shower room was removed and washed in the washing machine on 1/12/07. 2. All shower curtains were inspected for any soiling and washed. 3. Contract Housekeeping Manager will inspect all of the Residents' shower curtains on a weekly basis. Every shower curtain will be washed weekly and replaced annually according to schedule. 4. Results of inspection will be referred to the QI and QA committee meetings to ensure infection control measures are being followed. 5. Corrective actions completed 1/12/07.		1/12/07

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F 441	Continued From page 12 Based on observations during the environmental tour, it was determined that the bottom of a shower curtain was soiled. This observation was made in the presence of the Directors of Maintenance, Housekeeping and Nursing Staff. The findings include: The bottom of a shower curtain was observed to be soiled with a soapy film in the Sacred Heart shower room in one (1) of three (3) observations at 9:30 AM on January 12, 2007.	F 441			
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by : Based on record review and staff interview, it was determined that the pharmacist failed to conduct one (1) in-service regarding the indications, contraindications and possible side effects of commonly used medications. The findings include: A review of the pharmacy in-services revealed that the pharmacist conducted in-services entitled "Urinary Incontinence & Drug Therapy" on March 15, 2006 and "Pharmacological Management of Pain" on August 29, 2006. According to 22DCMR 3224.3, "The pharmacist	F 492	F492 1. The pharmacy consultant was notified on 1/22/07 and made aware that the pharmacist had failed to conduct a required in-service regarding the indications, contraindications, and possible side effects of commonly used medications. In-service done 1/26/07. 2. All District and Federal required in - services were reviewed and scheduled at specific times throughout the year to assure that the in-services would be done. Pharmacy will be notified as to when those in-services are scheduled. 3. A monthly review will be done by the in- service director as to what in-services were completed and if any need to be rescheduled. She will continue to keep a record of all in- services and the staff attendance. 4. Any required in-services that need to be re-scheduled or were not done on schedule will be brought to the attention of the QI nurse to assure that they are put on the calendar on a timely basis. 5. Corrective action completed 1/26/07		1/26/07

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F 492	<p>Continued From page 13</p> <p>must 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."</p> <p>A face-to-face interview was conducted with the Director of Nursing on January 12, 2007 at 9:45 AM. He/she acknowledged that the pharmacist did not conduct an in-service that included indications, contraindications and possible side effects of commonly used medications.</p>			F 492			