Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0005	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2008
NAME OF PROVIDER OR SUPPLIER THE WASHINGTON HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3720 UPTON STREET NW WASHINGTON, DC 20016		

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L 000	Initial Comments An annual licensure survey was conducted on December 1 through 5, 2008. The following deficiencies were cited based on observations, staff and resident interviews and record review. The sample size included 27 residents based on a census of 180 the first day of survey, with eight (8) supplemental residents.	L 000	The Washington Home makes its best effort to operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	
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: I. Based on observations, staff interview and record review for four (4) of 27 sampled residents, it was determined that the charge	L 051	**1. Corrective Action(s)** I. Resident #1 was re-assessed and care plan was updated to address impaired vision. Resident's #7's medication regime was reviewed and the resident did not have any adverse reactions to the 9+ medications. The care plan was modified to address 9 + medications, an interdisciplinary care plan was developed for Resident #16 based on the triggered RAPs and care plan decision process for vision impairment, cognitive loss and Atonic Colon. A review of **(Degowin & Degowin manual)** revealed that management of constipation is the plan of care for a medical diagnosis of Atonic Colon, A care plan was in place to address constipation. Resident #22's medication regime was reviewed and the resident did not have any adverse reactions to the 9+ medications. A care plan was developed to address 9 + medications. II. The care plans for Residents #3, #8, #14, #15, #16 and #24 were reviewed and revised. The care plan updates were specific for potential drug interaction post fall interventions, and following MDS assessments. In addition a comprehensive care plan was developed for Resident #8 relevant to a significant change MDS following hospitalization.	

Health Regulation Administration

Donna V Allen Williamson — TITLE: Administrator — (X6) DATE: 1/30/09

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

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L 051	Continued From page 1 nurse failed to initiate and/or update care plans with appropriate goals and approaches for: two (2) residents with limited visual function, two (2) residents for the potential adverse interaction for the use of nine (9) or more medications, one (1) resident with incontinence, one (1) resident for cognitive loss and atonic colon. Residents #1, 7, 16, and 22. The findings include: 1. The charge nurse failed to initiate a care plan for Resident #1 with interventions for blindness. The annual Minimum Data Set (MDS) dated August 8, 2008 coded the resident in the Section D,"Visual Patterns" as "Highly Impaired Vision". A review of Resident #1's record revealed that the care plan was last updated on November 19, 2008 and there was no care plan developed with appropriate goals and interventions for blindness. A face-to-face interview was conducted with Employee #1 at approximately 3:00 PM on November 3, 2008. He/she acknowledged that the record lacked a care plan for blindness. The record was reviewed on November 3, 2008. 2A. The charge nurse failed to develop a care plan with appropriate goals and approaches for the potential adverse interaction of the use of nine (9) or more medications and failed to develop a care plan with appropriate goals and approaches for incontinence for Resident #7. The review of the clinical record for Resident # 7 revealed a physician's order dated and signed November 5, 2008 that included the following medications: Acetaminophen, Avapro, Calcarb,	L 051	III. A record review for residents #15, #17, and #27 was conducted. Staff was re-educated. Unable to retrospectively correct for Resident #15, and #27. The care plan for Resident #17 was revised as 60-minute monitoring is no longer required. **2. Identification of Deficient Practices & Corrective Actions** An audit of MDS and care plans completed in last 30 days was done with emphasis on the RAPs and care plan decisions including vision, cognitive status, diagnosis, 9+ medications, ASA therapy, and post falls. Care plans were revised if indicated. The nursing management team reviewed the documentation for residents completed within the last 30 days. No other residents were found to be affected by this practice. **3. Systemic Changes** Inservice training for Interdisciplinary team members was completed emphasizing the regulatory requirement and standards of care for revising and updating care plans. All licensed clinical staff were re-educated on the requirement for accuracy in documentation and thorough assessment. **4. Monitoring** A review of care plans and its accuracy is a part of the monthly nurse management audit. This information is presented at the QI committee meeting. The Medical Records staff conduct concurrent and retrospective audits. The content of documentation is reviewed for accuracy. This will be reported at the Quarterly QI Committee.	1/19/09

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L 051	Continued From page 2 Colace, Multiple Vitamin (MVI), Prednisone, Prilosec, Vitamin D Softgel, Vitron C and Percocet. A review of the care plan that was last updated on October 23, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving use of nine (9) or more medications. A face-to-face interview was conducted with Employee # 4 on December 3, 2008 at approximately 4:00 PM. He/She acknowledged that the record lacked a care plan for the use of nine (9) or more medications, and stated, "No. I don't see it [the care plan]; I will put one on [the chart] right away." The record was reviewed on December 2, 2008. 2B. The charge nurse failed to develop a care plan with appropriate goals and approaches for incontinence for Resident # 7 who was coded for incontinence on the last quarterly Minimum Data Set (MDS), which was completed on September 17, 2008. The resident was also observed wearing Incontinent Pads on December 2 and 3, 2008. A review of the care plan that was last updated on October 23, 2008 failed to reveal a care plan with appropriate goals and approaches for incontinence. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on December 3, 2008. He/She acknowledged that the Incontinence Care Plan was not on the record and stated, "No. I don't see it [the care plan]; I will put one on [the chart] right away." The record	L 051		

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L 051	Continued From page 3 was reviewed on December 3, 2008. 3. The charge nurse failed to initiate care plans with appropriate goals and approaches for Resident #16 for cognitive loss, visual function and Atonic Colon. A review of Resident #16's record revealed a significant change Minimum Data Set assessment completed May 22, 2008. The resident was coded in: Section B (Cognitive Patterns), with long and short term memory loss and Section D (Visual Patterns) with highly impaired vision. Section "V" A. "Resident Assessment Protocol Summary" of the same MDS, included the following problem areas triggered by the above cited coding: cognitive loss and visual function. Under the Section V, A (b), "Care Planning Decision - check if addressed in care plan," cognitive loss and visual function were checked. A review of the resident's record revealed that no care plans had been initiated for cognitive loss and visual function. Additionally, a physician's order dated June 11, 2008 and renewed monthly, most recently October 30, 2008, directed, "Soap suds enema twice daily every other day for Atonic Colon." There was no evidence that a care plan for "Atonic Colon" was initiated. A care plan was present for "Constipation" which included the prescribed medications for bowel stimulation hand written under the "Goals" area of the care plan, but included no interventions regarding an Atonic Colon.	L 051		

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L 051	Continued From page 4 A face-to-face interview was conducted with Employee #1 on December 3, 2008 at 2:30 PM. He/she acknowledged that care plans were not initiated for the above cited areas. The record was reviewed December 3, 2008. 4. The charge nurse failed to develop a care plan with appropriate goals and approaches for the potential adverse interactions for the use of nine (9) or more medications for Resident #22. The review of the clinical record for Resident #22 revealed a physician's order dated and signed November 15, 2008 that included the following medications: Aspirin, Calcitrol, Captopril, Norvasc, Tums, Xanax, Toprol, Nexium, Zocor, Vitamin D, Oxycodone and Tylenol # 3. A review of the care plan that was last updated on December 1, 2008 revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #5 on December 5, 2008 at approximately 10:00 AM. He/She acknowledged that the record lacked a care plan for the use of nine (9) or more medications. The record was reviewed on December 5, 2008. II. Based on observations, staff interviews and record review for six (6) of 27 sampled residents, it was determined that the charge nurse failed to review and revise care plans with appropriate goals and approaches for: one (1) resident for the potential adverse interaction for the use of nine (9) or more medications, three (3) residents after a Minimum Data Set (MDS) assessment,	L 051		

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L 051	Continued From page 5 one (1) resident on aspirin therapy and one (1) resident after multiple falls. Residents #3, 8, 14, 15, 16 and 24. The findings include: 1. The charge nurse failed to revise Resident #3's care plan after two (2) fall incidents. A review of the resident's clinical record revealed, "Assessment tools for falls" that included the followings: "June 2, 2008 ... Staff observed resident sitting on the floor next to [his/her] bed, [he/she] was asking for help to get back into his wheel chair. No apparent injuries." "July 2, 2008 observed resident sitting on the floor in dinning area. No injuries." "August 23, 2008 Resident was observed on the floor mat in [his/her] room in response to vigilon monitor, clothing wet with urine. Assisted into bed, clothing changed." A review of the resident's care plans lacked evidence that facility staff revised the care plans with new goals and approaches after the resident's fall incidents of June 2, and August 23, 2008. A face-to-face interview was conducted with Employee #3 on December 5, 2008 at approximately 8:50 AM. He/she acknowledged that the resident's care plans were not updated with new goals and approaches after the aforementioned skin bruising and discolorations incidences. The record was reviewed December 5, 2008. 2. The charge nurse failed to review and revise	L 051		

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L 051	Continued From page 6 Resident #8's care plan after a significant change MDS assessment. A significant change MDS assessment was completed on November 3, 2008, after Resident #8 had returned from a hospitalization for a right hip fracture. The resident's care plans were last reviewed and revised by facility staff after the quarterly MDS dated August 14, 2008. A face-to-face interview with Employee #4 was conducted on December 4, 2008 at 11:30 AM. He/she acknowledged that the care plans were not reviewed and/or revised after the significant change MDS completed November 3, 2008. The record was reviewed December 4, 2008. 3. The charge nurse failed to review and update multiple care plans for Resident #14 for, Activities of Daily Living (ADL), Cognitive Loss/Dementia, Falls, Hypertension (HTN), Incontinence, Mood State, Pressure Ulcers, Psychoactive Drug use and Use of nine (9) or more medications after completion of the quarterly Minimum Data Set (MDS) on November 10, 2008. The review of the clinical record revealed documentation in an annual MDS (Minimum Data Set) dated March 11, 2008 listing Dementia, Depression and Hypertension (HTN) under Section I1, Failure To Thrive (FTT) under Section I3 and needing two (2) persons to assist him/her with all ADLs. A review of the care plans revealed that all of the aforementioned care plan were last reviewed and updated on August 8, 2008.	L 051		

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L 051	Continued From page 7 A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on December 4, 2008. He/she acknowledged that the aforementioned care plans were not updated since August 8, 2008. The record was reviewed on December 3, 2008. 4. The charge nurse failed to review and update the care plan with new goals and approaches for a resident on aspirin therapy after observed incidences of skin bruising and discoloration. Resident #15. A review of Resident #15's clinical record revealed the following nurse's notes. June 1, 2008 at 8:00 AM, " Discoloration observed by caregiver during ADLs [Activities of Daily Living] care to left dorsal lateral hand, skin intact ...unable to tell writer what happened to him/her. MD [Medical doctor] and POA [Power of Attorney] aware, no new order given ..." June 30, 2008 at 9:30 PM CNA assigned to resident noticed a couple of red skin discoloration on the resident's left hip (lateral area) when changing his/her diaper. No Swelling noted and no pain when area is touched. Supervisor called to evaluate the resident ...Awaiting MD to return phone call ..." July 1, 2008 at 8:10 AM, " ...Small red area on left hip skin intact, no swelling observed ..." October 4, 2008 at 8:30 AM, "...Skin discoloration (bruise) noted to right area, measured 15cm x 6cm. Skin intact and dry to touch. No bleeding noted ...Nursing supervisor notified ..." October 4, 2008 at 3:00 PM, "...Redness on right	L 051		

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L 051	Continued From page 8 hand remains same ..." October 6, 2008 at 7:15 PM, "Reddened area on right arm remains ..." October 20, 2008 at 2:00 PM, "...Noted blood, clear red with a bad odor on resident's diaper ...Upon assessment, resident was laying flat in bed and observed a gush of red blood with clots coming from vaginal area of the resident ...MD and Nurse Practitioner notified immediately ...Aspirin discontinued. A review of the resident's record revealed a care plan entry on June 18, 2008 with goals and approaches for skin bruising and hemorrhage secondary to aspirin therapy and an anticoagulation care plan initiated on August 28, 2008 and evaluated October 20, 2008 after the bleeding incident. The resident's clinical records lacked evidence that facility staff reviewed and updated the resident's care plans after each of the aforementioned skin bruising and discoloration incidences and provided new goals and approaches after each incident. A face-to-face interview was conducted with Employee #3 on December 5, 2008 at approximately 9:00 AM. He/she acknowledged that the clinical record lacked evidence that Resident #15 who is on aspirin therapy care plans' were reviewed and revised with new goals and approaches after each observed incidences of skin bruising and discoloration. The record was reviewed December 5, 2008. 5. The charge nurse failed to review and revise Resident #16's care plan after a quarterly MDS assessment.	L 051		

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L 051	Continued From page 9 A quarterly MDS assessment was completed on November 3, 2008. The resident's care plans were last reviewed and revised by facility staff after the quarterly MDS dated August 5, 2008. A face-to-face interview with Employee #1 was conducted on December 3, 2008 at 3:30 PM. He/she acknowledged that the care plans were not reviewed after the quarterly MDS completed November 3, 2008. The record was reviewed December 3, 2008. 6. The charge nurse failed to review and revise Resident #24's care plan after a quarterly MDS assessment. A quarterly MDS assessment was completed on October 24, 2008. The resident's care plans were last reviewed and revised by facility staff after a significant change MDS dated August 5, 2008. A face-to-face interview with Employee #1 was conducted on December 3, 2008 at 1:30 PM. He/she acknowledged that the care plans were not reviewed after the quarterly MDS completed October 24, 2008. The record was reviewed December 3, 2008. III. Based on staff interview and record review for three (3) of 27 sampled residents, it was determined that the charge nurse failed to document: the correct psychotropic medication on the care plan for one (1) resident; the residents whereabouts as per the plan of care for one (1) resident and failed to document a	L 051		

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L 051	Continued From page 10 complete/adequate assessment of one (1) resident observed with an observed with ecchymotic right eye. Residents #15, 17 and 27. The findings include: 1. The charge nurse failed to accurately document Resident #15's psychotropic medication on the care plan. A review of Resident #15's clinical a record revealed Physician' s Order Forms from January to November 2008, " Mirtazapine 15mg tablet (Remeron) 1 tablet by mouth at bedtime for depression. " According to the resident's psychotropic drug use care plans dated June 18, August 28, and November 2008, facility ' s staff consistently documented that the resident was on Zoloft for depression. A face-to-face interview was conducted with Employee #3 on December 5, 2008 at 9:00 AM. He/she acknowledged that he/she failed to accurately document the correct medication on the resident ' s care plan for psychotropic drug use. The record was reviewed December 5, 2008. 2. The charge nurse failed to document Resident #17's whereabouts as per the care plan. A review of the "Elopement" care plan last updated November 10, 2008 revealed, "Approaches/Interventions ...3. Check for resident's whereabouts every 60 minutes. 6. Document behaviors that escalate the need to elope and use redirection to prevent elopement. "	L 051		

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L 051	Continued From page 11 A face-to-face interview was conducted on December 4, 2008 at 10:45 AM with Employee # 4. He/she acknowledged that there was no documentation related to the every 60 minute checks and no documentation of behaviors. The record was reviewed on December 4, 2008. 3. The charge nurse failed to document a complete/adequate assessment of Resident #27 who was observed with an ecchymotic right eye. A review of the "Quality of Life Review Form" dated August 20, 2008 [no time indicated] revealed, "Notice resident with ecchymotic area to his/her right orbit; unknown as to occurrence, resident had two explanations as to [unable to read] January and October; outer area is slight green and yellow, upper lid and above eye brow red. Medical service and residents [family member] notified. " The nursing note lacked a time of the written entry, vital signs at the time of the observation, level of alertness and orientation and a pain assessment. A face-to-face interview was conducted on December 3, 2008 at approximately 5:30 PM with Employee #3. They acknowledged that the note was absent of the time of the written entry, vital signs at the time of the observation, level of alertness and orientation and a pain assessment. The record was reviewed on December 3, 2008.	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:	L 052		

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L 052	Continued From page 12 (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j) Prompt response to an activated call bell or call	L 052	**1. Corrective Action(s)** I. Resident # 7 was reassessed. Appropriate environmental Fall Precautions were put in place per the clinical management team and doctor's order. The care plan was updated and the resident's care needs were communicated to staff. II. Resident FJ1 sustained no harm as a result of this error in medication administration in June of 2008. Unable to retrospectively correct. The staff member was re-educated immediately following notification of incident. **2. Identification of Deficient Practices & Corrective Actions** I. All residents on Fall Precaution with environmental monitors were re-evaluated and no other residents were found to be affected. II. A review of residents receiving extended/ controlled release drugs was completed. No other resident were affected by this practice. **3. Systemic Changes** A meeting was held with the nursing management staff to review the implementation of fall precaution as it pertains to the physicians orders. A staff inservice was conducted on Drug Administration to include "DO NOT CRUSH" prescriptions. A reference list was also provided in each Medication Administration Record.	

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	HFD02-0005		12/05/2008

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L 052	Continued From page 13 for help. This Statute is not met as evidenced by: Based on observations, record review and staff interview it was determined that sufficient nursing time was not given to each resident to ensure that the residents environment was free from accident hazards as evidenced by: OxyContin was not administered in accordance with the manufactures recommendations for one (1) resident and failed to follow the physician's complete order for Fall Precautions for one (1) resident. Residents' #7 and FJ1. The findings include: 1. The nursing staff failed to follow the physician's complete order for Fall Precautions for Resident #7. A review of the clinical record revealed the following Physician ' s order, " Add to POS [Physician ' s Order Sheet] Current Fall Precautions, (1) Low Bed, (2) Floor Mats, (3) Sensor Pad to bed and (4) Sensor Pad to chair. " The order was signed by the physician on July 31, 2008. On December 4, 2008 at approximately 11:30 AM Resident #7 was observed sitting on his/her bed (a low bed). A Floor Mat was folded over and leaning up against a closed window on the resident's left side in the room. A wheel chair was noted away from the resident's bed. A Sensor Pad was noted on the wheel chair. Employee #4 was present in the room and failed to locate a Sensor Pad on the resident's bed at that time. A face-to-face interview was conducted with	L 052	**4. Monitoring** The environment is assessed following an occurrence and presented at the Environment of Care Safety Committee meeting. This information is also presented at the Quarterly QI Committee meeting. The Staff Educator or designee will ensure that a Med Pass Competency is completed at orientation and, at least annually. This information will be reported at the QI Committee meeting bi-annually.	1/19/09

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	HFD02-0005	A. BUILDING B. WING	12/05/2008

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L 052	Continued From page 14 Employee #4 immediately after the observation. He/She acknowledged that the Sensor Pad was not on the bed as ordered by the physician. The record was reviewed on December 3, 2008. 2. The nursing staff failed to administer OxyContin in accordance with the manufactures recommendations for Resident FJ1. A review of the drug monograph located on Epocrates, the Black Box Warnings stipulates, "...Controlled-Release Formulation...swallow tablets whole, do not break/crush/chew as rapid release and absorption of potentially fatal oxycodone dose may occur." A face-to-face interview was conducted on December 2, 2008 at 2:00 PM with Resident FJ1. He/she stated, "... Back in June of this year [2008] a nurse crushed my oxycodone 120 mg and it was extended released tablets ..." The nurses' notes revealed the following: June 2, 2008 at 8:15 PM revealed, "Resident was accidentally given oxycodone 120 mg crushed instead of whole. Nurse supervisor of made aware and nurse practitioner made aware as well, gave no new orders but just to check V.S. [vital signs] every hour. Responsible party made aware of situation. VS 125/72 blood pressure [B/P], 20 respirations [R], 98.6 degrees Fahrenheit [F], 78 pulse [P], Pulse Ox 98%. Will continue to monitor." June 2, 2008 at 10:30 PM, "Resident remains stable. Continue to check VS. VS 130/80 [B/P], 20 [R], 98.1 [F], 82 [P], Pulse Ox 97%. Will continue to monitor." June 2, 2008 at 11:30 PM, "Resident remains	L 052		

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L 052	Continued From page 15 alert and verbally responsive. No signs of drowsiness, discomfort or pain, remains stable. [Responsible party and family] by the bed side. VS 130/75 [B/P], 20 [R], 98.8 [F], 83 [P], Pulse Ox 99%. Will continue to monitor." The nursing notes lacked evidence that vitals sign were consistently checked every hour as per the June 2, 2008 at 8:15 PM nursing note. According to the June 2008 "Physician's Order Form" signed May 29, 2008, directed, "Oxycodone ER 40 mg tab SR 12H, 1 tab by mouth every 12 hours for pain with 80 mg to equal 120 mg. Oxycodone ER 80 mg tab SR 12H, 1 tab by mouth every 12 hours for pain with 40 mg to equal 120 mg." A face-to-face interview was conducted on December 3, 2008 at 4:00 PM with Employee # 30. He/she acknowledged that the resident was given 120 mg of crushed oxycodone which is against the manufactures recommendations. The record was reviewed on December 3, 2008.	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 observation, staff interview and record review during the environmental and dietary tours, it was determined that facility staff failed to maintain a sanitary environment as evidenced by: personal care items left in shower rooms, trash	L 091	1. **Corrective Action(s)** Personal care items were removed from shower rooms, step-on trash cans were ordered for the kitchen prior to the survey and have now arrived and are in place. The employee was immediately re-educated on the use of utensils when serving food.	

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L 091	Continued From page 16 cans by the hand wash sinks in the main kitchen requiring lids to be lifted and an employee serving food without serving utensils. The environmental tour was conducted on December 1, 2008 from 9:30 AM through 3:30 PM and December 2, 2008 from 9:00 AM through 10:30 AM, in the presence of Employees #10, 11, 12 and 13. The dietary tour was conducted on December 1, 2008 from 7:00 AM through 9:30 AM, in the presence of Employee #14. The findings include: 1. During the environmental tour, personal care items of body wash, shampoo and body lotion were observed in the common shower area on Units 1A, 2A and 3A in five (5) of nine (9) common shower areas observed. Employees #10, 11, 12 and 13 acknowledged these findings at the time of the observations. 2. The trash cans by the three (3) hand washing sinks in the main kitchen required that the lids be lifted to dispose of paper towels. Employee #14 acknowledged these findings at the time of the observations. 3. Serving on the breakfast tray line was observed on December 1, 2008 at 7:15 AM. Employee #18 picked up waffles and bacon, placed them on a plate, rested hands on the counter, turned around, picked up a serving spoon, filled bowls with oatmeal, placed hands on the counter then picked up waffles and bacon with same gloved hands and placed them on the	L 091	**2. Identification of Deficient Practices & Corrective Actions** A sanitation audit of the kitchen was conducted including observation of staff while on tray line. No other deficient Practices were identified. **3. Systemic Changes** Staff was re-educated on the removal of personal care items after use when exiting shower rooms. Step-on trash cans were ordered for the kitchen. The employee was counseled regarding serving food without utensils. **4. Monitoring** Daily environmental rounds by the nursing management staff is conducted. A sanitation audit is conducted by Food Services supervisors including serving of foods. All findings are reported at the Quarterly QI Committee meeting.	1/19/09

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L 091	Continued From page 17 plate five (5) times. The employee was then handed a serving utensil for the waffles and bacon. Employee #19 acknowledged these findings at the time of the observations.	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 observation and staff interview during the tour of the main kitchen, it was determined that the facility failed to store and serve food under sanitary conditions as evidenced by: undated foods in dry storage, decaying tomatoes in the walk-in refrigerator, and use of incorrect serving scoops for the breakfast meal. These observations were made on December 1, 2008 from 7:00 AM through 9:30 AM, in the presence of Employee #14. The findings include: 1. The following foods were not dated in the dry storage area: Six (6)-107 ounce cans of pineapple chunks. Six (6)-107 ounce cans of pineapple slices. Four (4)-50 ounce cans of chicken soup. Six (6) - 105 ounce cans of spaghetti sauce. 10-40 ounce boxes of Cream of Wheat. 11-28 ounce boxes of Cream of Rice. 2. 15 of 21 tomatoes were observed decaying in the walk-in refrigerator.	L 099	**1. Corrective Action(s)** All items in the dry storage areas are now dated. These stock items are reordered weekly. The kitchen staff practiced (FIFO), Fist in-First out stock rotation. Produce is checked daily, and sorted for disposal. The tomatoes identified in the survey were separated to be discarded. Ingredients used for menu are also checked by certified food handlers prior to preparing the residents' food. The menu for Oatmeal required 6oz. serving, however, an error in the production spreadsheet was identified and corrected. No resident's nutritional status was compromised. **2. Identification of Deficient Practices & Corrective Actions** The dry storage food area and the refrigerator were checked and all other food was stored correctly. The production spreadsheets were checked by the supervisor and no other errors were identified on the menu. **3. Systemic Changes** The dietary staff were re-educated on the storage, preparation, and distribution of food. The supervisory staff will verify the accuracy of the production spreadsheet with scoop size at the beginning of each tray line.	

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L 099	Continued From page 18 3. According to the production sheet for December 1, 2008 for the breakfast meal, an eight (8) ounce serving of oatmeal was to be served. It was observed that the scoop size being used on the tray line was six (6) ounces. Employee #14 acknowledged these findings at the time of the observations.	L 099	**4. Monitoring** A weekly sanitation inspection of the kitchen is conducted. Additionally, the supervisors monitor the production spreadsheet in relationship to the menu. This information is presented at the Quarterly QI meeting.	1/19/09
L 118	3222.3 Nursing Facilities 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 ensure that dietary provisions were available in the event of an emergency. This observation was made in the presence of Employee #14 on December 1, 2008 at 9:00 AM. The findings include: During the tour of the dry storage area of the main kitchen, it was observed that the facility failed to have the required amount of food to meet all potential emergencies and disasters. Employee #14 stated that there were three (3) cases of cereal, and other canned and boxed goods were available for one (1) or two (2) days until a delivery could be arranged in the case of an emergency. An inventory of dry storage food stuffs was taken by Employee #14 on December 2, 2008. The inventory of dry storage food stuffs was	L 118	**1. Corrective Action(s)** The facility had a 3-Day Disaster menu with most of the essential items on the menu available on site. Residents at the facility were not affected by this observation. **2. Identification of Deficient Practices & Corrective Actions** A review of the 3-Day Disaster menu, and Emergency Food Supply and inventory of food was conducted. No other resident was affected. **3. Systemic Changes** A designated area for a 3-day supply of food for emergency was identified and all available items on the 3-day emergency menu were secured. **4. Monitoring** The emergency supply will be monitored by the Food Services Manager. This will be reported at the Quarterly QI Committee meeting.	1/19/09

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L 118	Continued From page 19 compared to the "Three Day Disaster Menu with Water Emergency." Items missing included apple juice, mandarin oranges, chicken (canned), pears, tortilla chips, and canned pork/ham. A face-to-face interview with Employee #14 was conducted on December 3, 2008 at 11:00 AM. He/she acknowledged that there was an insufficient amount of dry storage food stuffs for the three (3) day emergency menu. Additionally, Employee #14 stated that all the missing items were on order, to be received within the next two (2) days. A storage area had been identified to house the emergency food items.	L 118		
L 142	3226.2 Nursing Facilities Each dose of medication shall be properly and promptly recorded and initiated in the resident's medical record by the person who administers it. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that for six (6) of 12 residents facility staff failed to document the administration of controlled substance medications on the September, October and November 2008 Medication Administration Record (MAR) for Residents JH1, JH2, JH3, JH4 and JH5 and JH6. A. On December 1, 2008, at approximately 10:00 AM, during a review of Resident's JH6, record revealed a physician s order dated November 3, 2008 that directed, "Oxycodone 5mg tablet, po [by mouth] every 6 hours prn [as needed] for pain." The November 2008 MAR was reviewed and indicated that Oxycodone 5mg was administered five (5) times in November 6 (0500), 11(0900),	L 142	**1. Corrective Action(s)** The Medication Administration Records for JH1, JH2, JH3, JH4, JH5, and JH6 were reviewed. The documentation of controlled substances on MAR cannot be corrected retrospectively. **2. Identification of Deficient Practices & Corrective Actions** A review of all MAR's in conjunction with medications dispensed was reviewed. No other pharmacy occurrence was identified. An audit of all controlled substances administered over the last 30 days was completed. No other resident was affected. **3. Systemic Changes** Staff was re-educated on pharmaceuticals services and facility's policies with emphasis on medication storage, expiration, separation of medication and documentation of controlled substances.	

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L 142	Continued From page 20 13 (2130), 15 (1000), 19 (0500)] as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Oxycodone 5mg was administered on the following dates in November 3 (2330), 6 (0500, 1100), 8 (1000), 11(0900), 13 (2130), 15 (1000), and 19 (0500). There was no evidence on the November 2008 MAR that the Oxycodone 5 mg was administered on November 3 (2330), 6 (1100) and 8 (1000), 2008. B. On December 3, 2008, at approximately 11:50 AM, during a review of Resident JH1's record revealed a physician's order dated October 16, 2008 that directed, "Ambien (Zolpidem) 10 mg, [1] tablet by mouth at bedtime as needed for insomnia." The November 2008 MAR was reviewed and indicated that Zolpidem 10 mg was administered five (5) times in November [November 22, 24, 25, 28 and 29] as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Zolpidem 10 mg was administered on the following dates in November 22, 24, 25, 26, 27, 28, 29 and 30. There was no evidence on the November 2008 MAR that the Zolpidem 10 mg was administered on November 26, 27 and 30, 2008. C. On December 3, 2008, at approximately 12:00 AM, during a review of Resident JH2 ' s record revealed a physician's order dated September 3, 2008 that directed, " Alprazolam 0.5 mg tablet, [1] tab by mouth every day as needed for anxiety. "	L 142	**4. Monitoring** The Pharmacy Consultant will increase visits to the facility and monitor medication carts, interim boxes, and storage areas, and controlled substances. This will be reported at the Pharmaceutical Services Committee meeting and the Quarterly QI meeting.	1/19/09

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L 142	Continued From page 21 The September 2008 MAR was reviewed and indicated that Alprazolam 0.5 mg was administered six (6) times in September [September 1, 5, 6, 13, 16 and 19] as evidence by initials entered in the allotted areas for the dates mentioned. The "Controlled Drug Record" indicated the Alprazolam 0.5 mg was administered on the following dates in September 1, 5, 6, 7, 9, 13, 16 and 19. There was no evidence on the September 2008 MAR that the Alprazolam 0.5 mg was administered on September 7 and 9, 2008. D. On December 1, 2008, at approximately12:40 PM, during a review of Resident JH3's record revealed a physician ' s order dated November 3, 2008 that directed, "Ambien (Zolpidem) 5 mg, [1] tablet by mouth at bedtime as needed for insomnia." The November 2008 MAR was reviewed and indicated that none was administered in November as evidence by no initials entered in the allotted areas. The "Controlled Drug Record" indicated the Zolpidem 5 mg was administered on the following dates in November 21, 26, 27, and 28. There was no evidence on the November 2008 MAR that the Zolpidem 5 mg was administered on November 21, 26, 27 and 28, 2008. E1.On December 3, 2008 at approximately 3:30 PM, during a review of Resident JH4 ' s record revealed a physician's order dated October 2, 2008 that directed, " Oxycodone w/APAP 5 mg/325 mg tablet, [2] tablets by mouth every four	L 142		

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L 142	Continued From page 22 hours as needed for severe pain. " The October and November 2008 MARs were reviewed; there were no indications that Oxycodone w/APAP 5 mg/325 mg tablet, [2] tablets was administered as evidence by no initials entered in the allotted areas. The "Controlled Drug Record" indicated the Oxycodone w/APAP 5 mg/325 mg tablet, [2] tablets were administered on the following dates in October 4 (2000), 18 (2200), 20 (2200), 31 (2000) and November 6 (2200) and 7 (2000). There was no evidence on the October and November 2008 MARs that the Oxycodone w/APAP 5 mg/325 mg tablet, [2] tablets were administered in October and November 2008. E2. On December 3, 2008 at approximately 3:15 PM, during a review of Resident JH4 ' s record revealed a physician's order dated October 2, 2008 that directed, " Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet by mouth every four hours as needed for mild pain. " The October 2008 MAR was reviewed and there was no indication that Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet was administered, as evidence by no initials entered in the allotted areas. The "Controlled Drug Record" indicated the Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet was administered on the following dates in October 3 (2000)... There was no evidence on the October 2008 MAR that the Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet was administered in October 2008. F. On December 3, 2008 at approximately 3:45	L 142		

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L 142	Continued From page 23 PM, during a review of Resident JH5 ' s record revealed a physician ' s order dated October 21, 2008 that directed, " Oxycodone w/APAP 5mg/325mg tablet, [1] tablet by mouth every four hours as needed for pain. " The October 2008 MAR was reviewed and indicated one (1) time that that Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet was administered in October 21, 2008, as evidence by an initial entered in the allotted area for the date mentioned. The "Controlled Drug Record " indicated the Oxycodone w/APAP 5 mg/325 mg tablet, [1] tablet was administered on the following dates in October 2,16, 21, and 22. There was no evidence on the October 2008 MAR that the Oxycodone w/APAP 5 mg/325 mg tablet [1] tablet was administered in October 2, 16 and 22, 2008. Face-to-face interviews were conducted on December 1 and 3, 2008 at the time of each observation with Employees # 5, 9, 22 and 23. They acknowledged that the MARs did not indicate with signatures that the controlled substance was administered to Residents JH6, JH2, JH3, JH4, and JH5. The records was reviewed on December 1and 3, 2008.	L 142		
L 156	3227.7 Nursing Facilities Each medication that requires refrigeration shall be kept in a pharmaceutical refrigerator or in a special locked compartment within a refrigerator at each nursing station. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to properly store one (1) of eight (8) medications containers	L 156	1. **Corrective Action(s)** The medication (Xalatan) identified was properly stored in the refrigerator. The resident was not impacted by this practice.	

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L 156	Continued From page 24 in accordance to the manufacturer's specifications. The findings include: The facility's Drug Therapy Handbook, 2003-2004, stipulated, " Store unopened bottles (Xalatan) under refrigeration at 36 degrees to 46 degrees Fahrenheit." On December 1, 2008 between 9:00 AM and 4:00 PM, during the inspection of the medication storage areas an un-open vial of Xalatan ophthalmic drops was observed in the medication cart. A face-to-face interview conducted on December 1, 2008 at that same time of the observation, with Employee # 27. He/she acknowledged that the vial of Xalatan ophthalmic drops were stored improperly.	L 156	**2. Identification of Deficient Practices & Corrective Actions** A review of medication storage was completed. No other occurrences were identified. **3. Systemic Changes** All staff were in-serviced on the requirement for storage of medications. Reference material, '**Recommended Medication Storage Parameters**' were made available on MAR/medication cart for staff usage. **4. Monitoring** The Pharmacy Consultant will increase visits to the facility and monitor medication carts, interim boxes, and storage areas, and controlled substances. This will be reported at the Pharmaceutical Services Committee meeting and the Quarterly QI meeting.	1/19/09
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined in five (5) of seven (7) medication storage areas observed, the Facility staff failed to separate expired medication from currently dated medications. The facility's policy 5.3 " Storage and Expiration Dating of Drugs, Biological Syringes and Needles" stipulate (3.) The Facility should ensure that drugs and biologicals that: (1) have an expired date on the label are stored separate from other medications until destroyed or returned to the supplier " .	L 161	**1. Corrective Action(s)** All opened multi-dose medication were dated and initialed, expired and unlabelled medications were removed from storage areas. **2. Identification of Deficient Practices & Corrective Actions** A review of pharmaceuticals including medications storage, expired medications and unlabelled drugs was conducted on all units. No other areas of concern were identified.	

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L 161	Continued From page 25 (3.1) Once any drug or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medication. " On December 1, 2008 between 9:00 AM through 3:00 PM, during the inspection of the medication carts and interim box the following medication were expired: (30) Clotrimazole 10 troches, Exp. 9/2008 (16) Lorazepam 0.5 mg tablets, Exp. 10/30/2008 (2) Sodium Chloride 0.9%, 10 ml vial, Exp. 11/2008 A face-to-face interview was conducted on December 1, 2008 at the time of the observation with Employees #2, 5 and 23. They acknowledged that the containers were not dated or initialed when first opened.	L 161	**3. Systemic Changes** Staff was re-educated on pharmaceuticals services and facility's policies with emphasis on medication storage, expiration, separation of medication and documentation of controlled substances. **4. Monitoring** The Pharmacy Consultant will increase visits to the facility and monitor medication carts, interim boxes, and storage areas, and controlled substances. This will be reported at the Pharmaceutical Services Committee meeting and the Quarterly QI meeting.	1/19/09
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 observation, record review and staff interview, it was determined in five (5) of seven (7) medication storage areas observed, Facility staff failed to remove unlabeled medication from the medication carts. On December 1, 2008 between 9:00 AM through 3:00 PM, during the inspection of the medication carts, the following medications were observed in medication cart drawers without a pharmacy label:	L 168	**1. Corrective Action(s)** All opened multi-dose medication were dated and initialed, expired and unlabelled medications were removed from storage areas. **2. Identification of Deficient Practices & Corrective Actions** A review of pharmaceuticals including medications storage, expired medications and unlabelled drugs was conducted on all units. No other areas of concern were identified.	

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L 168	Continued From page 26 2nd Floor (1) Levothyroxine 150 mcg tablets (2) HCTZ 25 mg tablet 3rd Floor (1) Diovan 160 mg tablet (1) Labetatol 200 mg (1) Ecoepred Phos. 1% eye drops (1) Lovenox 30 mg/0.3ml syringe (10) Lovenox 40 mg/0.4ml syringe (8) Ipratropium Br./Albuterol inhalers (14) Warfarin 1 mg tablet (20) Warfarin 4 mg tablet (1) Lubrifresh P.M. tube 3.5 gm (9) Prilosec O-T-C tablets A face-to-face interview was conducted on December 1, 2008 at the time of the observation with Employees # 22, 24, 25 and 28. They acknowledged that the unlabeled medication was not removed from the medication carts.	L 168	**3. Systemic Changes** Staff was re-educated on pharmaceuticals services and facility's policies with emphasis on medication storage, expiration, separation of medication and documentation of controlled substances. **4. Monitoring** The Pharmacy Consultant will increase visits to the facility and monitor medication carts, interim boxes, and storage areas, and controlled substances. This will be reported at the Pharmaceutical Services Committee meeting and the Quarterly QI meeting.	1/19/09
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 and staff interview it was determined that facility staff failed to ensure that the environment was free from accident hazards as evidenced by: two (2) unlocked treatment carts with residents in the area; five (5) multiple plug outlets not mounted; one (1) multiple plug outlet draped over a spice rack in the main kitchen; loose electrical plate used for the food cart; and glass vases stored on the floor in	L 214	**1. Corrective Action(s)** The hazards identified in the specific environment were removed and safety of the areas restored, i.e. treatment carts locked, 6 multi-plug outlets were mounted, electrical outlets for food cart, and glass vases secured in resident's rooms 153A and 144A. **2. Identification of Deficient Practices & Corrective Actions** All residents rooms and living space were assessed for hazardous potential and were secured as indicated.	

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L 214	Continued From page 27 residents' rooms. The findings include: 1. During the environmental tour, conducted on December 2, 2008 at 8:25 AM, two (2) treatment carts were observed unlocked on Unit 3A. The treatment carts were located on the side of the day room near the recreational therapist's office. Six (6) residents were seated at tables waiting for breakfast. Staff was not present in the vicinity of the treatment carts. A face-to-face interview with Employee #4 was conducted at the time of the observation. He/she acknowledged that the treatments carts should have been locked. 2. Facility staff failed to mount six (6) multiple plug outlets off the floor. During the environmental tour, conducted on December 1, 2008 from 9:30 AM through 3:30 PM and on December 2, from 8:00 AM through 10:00 AM in the presence of Employees #10, 11,12 and 13. Multiple plug outlets were observed on the floor in the following areas: rooms 105, 106, 120, 123 and 324. Employees #10, 11, 12 and 13 acknowledged the findings at the time of the observations. On December 1, 2008 at 7:30 AM, a multiple plug outlet was observed in the main kitchen draped over the corner of the spice rack, in the presence of Employee #14, who acknowledged the findings at the time of the observation.	L 214	**3. Systemic Changes** Scheduled rounds are conducted to identify potential hazards and secure the environment. The staff were re-educated to increase awareness and vigilance to environmental hazards. **4. Monitoring** Environmental rounds are conducted to identify potential hazards and secure the environment. This information is presented at the Environment of Care Safety Committee Meeiting. This information is also presented at the Quarterly QI Committee meeting.	1/19/09

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L 214	Continued From page 28 3. Facility staff failed to secure an electrical plate outlet used for the food cart on Unit 3A in the presence of Employees #10, 11, 12 and 13. During the environmental tour conducted on December 2, 2008 at 8:55 AM, the plate on the electrical plug used for the food cart was missing the upper screw and detached from the wall. Employees #10, 11, 12 and 13 acknowledged this finding at the time of this observation. 4. Glass vases were observed stored on the floor in two (2) resident's rooms. During the environmental tour conducted on December 1, 2008 from 9:30 AM through 3:30 PM, in the presence of Employees #10, 11, and 12, one (1) glass vase was observed stored on the floor under the sink in the bathroom for 153A and three (3) glass vases were observed stored on the floor under the window in room 144A. Employees #10, 11 and 12 acknowledged these findings at the time of the observations.	L 214		
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 tour, it was determined that facility staff failed to maintain a clean and sanitary environment as evidenced by: damaged/scarred/marred walls and cove base, build up on ice machine spigots, items located under a sink, and store rooms with multiple items on the floor.	L 410	**1. Corrective Action(s)** 1 & 2. All damaged, marred/scarred walls and damaged cove bases that were identified have been repaired. 3.The 3 ice machines identified on 1A, 2A, and 3A were cleaned. 4.The items stored under the sink on Unit 1A were removed. 5. Items in the storage rooms: 124, 204, 225, 333 were properly stored in the storage areas.	

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L 410	Continued From page 29 The environmental tour was conducted on December 1, 2008 from 9:30 AM through 3:30 PM and December 2, 2008 from 9:00 AM through 10:30 AM, in the presence of Employees #10, 11, 12 and 13. The findings include: 1. Walls were observed damaged, marred and/or scarred in the following areas: 106, 117, 137, 138, 207, 233, 227, 237, 311, and 313 in 10 of 60 resident rooms observed. 2. Cove base was observed damaged in the following areas: 106, 123, 207, 227, 237, 255, 257, 311, 355 and 356 in 10 of 60 resident rooms observed. 3. Ice machines with a build-up of mineral deposits on the spigot were observed on units 1A, 2A and 3A in three (3) of five (5) ice machines observed. 4. The following items were observed stored under the sink in the 1A pantry: two (2) containers of wine, metal storage box, five (5) packages of medication cups, one (1) package of liquid soap, and two (2) boxes of rubber bands. 5. Items were observed stored on the floor, such as boxes, floor mats, bed pads, and foot pedals in storage rooms 124, 204, 225, and 333 in four (4) of 12 storage rooms observed. Employees # 10, 11, 12 and 13 acknowledged these findings at the time of these observations.	L 410	**2. Identification of Deficient Practices & Corrective Actions** The walls, cove bases, ice machines, under sink storage, and storage rooms were re-surveyed by facility staff and no other areas were found to be non-compliant. **3. Systemic Changes** A new preventive maintenance schedule was developed to include walls, cove bases, ice machines, under sink, storage and floor surface. The areas in the pantry will also be monitored weekly by the Administrator- on-Call (AOC) to ensure proper storage in all storage rooms. **4. Monitoring** The environmental team will conduct environmental and preventive maintenance rounds to include but not limited to walls, cove base, ice machines, under sinks and storage areas. The Director of Plant Operations will report findings at the Quarterly QI meeting.	1/19/09