STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	B. WING _____	01/14/2008

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WASHINGTON NURSING FACILITY	2425 25TH STREET SE WASHINGTON, DC 20020

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L 000	Initial Comments An annual licensure survey was conducted January 7 through 14, 2008. The following deficiencies were based on record review, observations, and interviews with residents and facility staff. The sample included 30 residents based on a census of 343 residents on the first day of survey and 54 supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on staff interview and record review for five (5) of 30 sampled residents and four (4) supplemental residents, it was determined that	L 051		

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L 051	Continued From page 1 the charge nurse failed to: update the care plan for five (5) residents with multiple falls and for one (1) resident with a cigarette burn, accurately transcribe orders for two (2) residents, ensure that an expired medication was discarded and not administered to one (1) resident and clarify an order for one (1) resident who was identified as an elopement risk. Residents #1, 2, 10, 18, 24, 30, A1, JH9, S1 and S2. The findings include: 1. The charge nurse failed to update a care plan for Resident #2 who had multiple falls. A review of the care plan for Resident #2 last updated on November 7, 2007 revealed that the resident fell on May 20, 2007, June 23, 2007, and August 4, 14, and 27, 2007. All of the falls were without injury. However; the interdisciplinary care plan was not updated to include new approaches to prevent further falls. On January 8, 2007 at approximately 10:30 AM, a face-to-face interview was conducted with Employee #15 who acknowledged that the care plan was not updated for falls. The record was reviewed on January 7, 2008. 2.The charge nurse failed to update a care plan for Resident #10 who had multiple falls. A review of the " Falls " care plan for Resident #10 revealed, " August 14, 2007 fall- with no injury, August 31, 2007- fall with no injury, September 23, 2007- fall which resulted in injury. An additional care plan for falls was added on September 24, 2007. On November 12, 2007 - fall no injury and November 21, 2007- Resident	L 051	1. RESIDENT #2 1. The care plan of Resident #2 was updated to include new goals and approaches to prevent further falls. — 1/9/08 2. Medical records of all residents on the Unit who had multiple falls were reviewed for the same deficient practice. — 1/17/08 3. An inservice was given to the Nursing Staff emphasizing the importance of Reviewing and updating care plans with new goals and approaches for residents with multiple falls. — 2/8/08 4. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting to ensure that the same deficient practice does not reoccur. Monitoring outcomes will be included in the DON's report to the QA committee monthly. — 1/17/08 5. 2/28/08 2. RESIDENT #10 1. The care plan of Resident # 10 was updated to include new goals and approaches to prevent further falls. — 1/10/08 2. Medical records of all residents on the Unit who had multiple falls were reviewed for the same deficient practice — 1/17/08	

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L 051	Continued From page 2 found beside the bed - no injury. The aforementioned care plan lacked evidence that new goals and approaches were implemented to address the resident's falls. On January 9, 2007 at approximately 3:00 PM, a face-to-face interview was conducted with Employee # 6 and 15 who acknowledged that the " Falls " care plan was not updated with new goals and approaches to address the resident's falls. The record was reviewed on January 9, 2008. 3. The charge nurse failed to update a care plan for Resident #30 for multiple falls. A review of the interdisciplinary care plan for Resident #30 (closed record) initiated May 25, 200 and last reviewed September 5, 2007 revealed that the resident fell on June 6 and 18, and August 24, 2007. The interdisciplinary care plan was not updated to include new approaches after each fall. The record was reviewed on January 8, 2008. 4. The charge nurse failed to update the falls care plan for Resident A1 who had multiple falls. Resident was observed on January 10, 2008 at about 9:00 AM with unsteady gait exiting the bathroom without assistance. A review of the resident's record revealed an annual Minimum Data Set (MDS) completed November 30, 2007. Section G3 " Test for Balance" , coded the resident: " Unsteady balance while standing" . A review of the entry on the Interdisciplinary Care Plan for Falls dated December 31, 2007 revealed	L 051	3. An inservice was given to the Nursing Staff emphasizing the importance of Reviewing and updating care plans with new goals and approaches for residents with multiple falls. 4. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting to ensure that the same deficient practice does not reoccur. Monitoring outcomes will be included in the DON's report to the QA committee monthly. 5. 2/28/08 3. RESIDENT #30 1.Resident # 30 has been discharged from the facility. The medical record was not amended. 2. Audit of closed records of residents discharged from the facility for the last 2 months was conducted to look for the same deficient practice. 3. Inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plan with new goals and approaches for residents after each fall occurring. 4. Closed records of residents will be audited monthly to look for the same deficient practice reoccurring and a Report of audit outcomes will be Included in the DON's report to the QA Committee. 5. 2/28/08 4. RESIDENT #A1 1. The care plan of Resident #A1 was updated to include new goals and approaches to prevent future falls. 2. Medical records of all residents on the unit who had multiple falls were reviewed for the same deficient practice.	2/8/08 1/17/08 2/8/08 2/8/08 2/28/08 1/11/08

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L 051	Continued From page 3 a chair alarm as one of the approaches identified by charge nurse. A review of Resident A1's record revealed the following nurse's notes: February 14, 2007 at 10:30 AM, " Resident was observed lying on the floor ... Responsible Party and physician made aware." March 26, 2007 at 10:00 PM, " ...Resident was observed ... in [own] room sitting on the floor ..." May 14, 2007, at 5:00 AM " Resident was observed on the floor during routine visual room round ..." June 24, 2007 at 3:30 PM, " ...Resident was observed lying on the floor ...no injuries. Resident stated I am ok, my leg gave up on me when I was trying to get up from chair. PMD [Primary Medical Doctor] notified ..." July 5, 2007 at 10:00 PM " ...found sitting on the floor ...no visible injury ..." October 9, 2007 at 3:00 PM " Resident was observed by a nurse sitting on the floor in the bathroom ..." October 11, 2007 at 6:00 PM, " Resident was observed on the floor in own room ...MD on the unit ...denies any pain ..." October 14, 2007, at 3:00 PM, " Resident was observed in the floor in [ ] room beside his bed. No injury noted. Resident complained of pain ...MD notified ..." November 3, 2007 at 4:00 PM, " ...upon round making Resident observed on the floor lying on left side. He was assessed ...noted abrasion on (R) [right] 2nd finger ...pain on (L) [left] hip ... MD. And Supervisor aware ...Resident to ER [emergency room] for evaluation of left hip pain ..." November 12, 2007 at 1:15 PM " resident was observed on the floor ...Resident stated I want to use the bathroom ...denied pain ..."	L 051	3. An inservice was given to the Nursing Staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls after the occurrence of each fall. 4. Monitoring for compliance will be done by the Falls Review Committee at the Weekly committee meeting to ensure That the same deficient practice does Not reoccur. Monitoring outcomes will Be included in the DON's report to the QA committee monthly. 5. 2/28/08	2/8/08 1/17/08

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L 051	Continued From page 4 November 27, 2007, at 11:00 AM Resident was observed on the floor by one of the Rehab tech ...Denies pain. MD notified ..." November 29, 2007 at 3:10 PM, " resident was observed on the floor lying on [ ] back, close to[ ] bed ...MD notified. December 19, 2007 at 3:00 PM, " Resident was observed sitting ...floor and back resting against bed ...Resident stated, I slipped and fell..." December 31, 2007 at 11:00 AM, " Resident was observed by a nurse sitting on the floor beside bed in [ ] room. MD notified..." A face-to-face interview was conducted with Employee #7 on January 10, 2008 at approximately 9:30 AM. He/she acknowledged that the care plan was not updated, evaluated and revised to reflect additional goals and approaches in response to the above cited falls. He /she said,"I understand now that the bed/chair alarm was not an effective approach in preventing the resident from falling. They are not effective monitoring tools for this resident. We never hear them go off when the resident falls. I did not know that the resident could take the alarm off before getting out of bed ...." The record was reviewed on January 10, 2008. 5. The charge nurse failed to update the care plan for Resident S1 who had multiple falls. A review of Resident S1's record revealed the following nurses' notes: December 21, 2007 at 11:00 PM: " Resident found sitting on the floor beside [his/her] bed at 8 pm ....resident said [he/she] was trying to walk to the toilet, lost [his/her] balance and fell on [his/her] buttock ...Neurochecks initiated and within normal limits ..." January 7, 2008 at 8:30 AM: Resident found	L 051	5. RESIDENT #S1 1. The care plan of Resident S1 was up updated to include new goals and approaches to prevent future falls. 2. Medical records of all residents on the unit who were identified to have had multiple falls were audited for the same deficient practice. 3. Inservice was given to the Nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls after the occurrence of each fall.	1/11/08 1/11/08 2/8/08

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L 051	Continued From page 5 sitting upright in front of [his/her] wheelchair. No injury ..." January 9, 2008 at 12:30 PM: " Resident was observed on the floor in the shower at 9:20 AM in the shower room. Complained of pain. Was transferred to his room and fell again. PMD (private medical doctor) made aware ...x-rays ordered ..." January 9, 2008 at 11:00 PM: " ...X-ray results received with positive for fracture of 7th posterior left rib ..." According to the " Rehabilitation Screening" dated January 8, 2008, " Pt. (patient) currently functioning at baseline. Rec (recommend) self release seat belt. Therapist tightened both breaks. No skilled PT ordered at this time." A physician's telephone order dated January 8, 2008 at 4:00 PM directed, "Patient screened from physical therapy. Therapist adjusted left and right brakes on w/c; rec [recommend] self release seat belt." The record was audited by a licensed practical nurse. A face-to-face interview was conducted with Employee #13 on January 10, 2008 at 1:30 PM. He/she stated, " I found [Resident S1] in the shower room on Wednesday (January 9, 2008). There was no seat belt in the wheelchair. Another nurse and I assessed [him/her]. There was no complaint of pain. We took [Resident S1] back to the room and I wasn't even at the nursing station when [he/she] fell again." A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 2:00 PM regarding the physician's order regarding the implementation of a seat belt. Employee #5 stated, " The seat belt comes from the Rehab	L 051	4. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting to ensure that the same deficient practice does not reoccur. Monitoring outcomes will be included in the DON's report to the QA committee monthly. 5. 2/28/08 1. Self release seat belt applied to the resident while on the wheelchair . 2. All medical records of residents with multiple falls & PT consult were audited for needed follow-up and acted upon. 3. An inservice was given to the nursing staff addressing the importance of reviewing consultation reports from PT to ensure continuity of care by following up on recommendations. 4. Performance monitoring on follow – up on recommendations after consult will be done by Clin. Mgr/designee. Monitoring outcomes will be reported to the DON who will report to the QA committee monthly. 5. 2/28/08	1/17/08 1/18/08 1/18/08 2/8/08 2/28/08

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L 051	Continued From page 6 department or Central Supply. It should have been put on when it was ordered and noted on the falls care plan." The record was reviewed January 10, 2008. 6. The charge nurse failed to adequately supervise Resident #24 who was previously observed by facility staff with burning clothing from a cigarette. At approximately 10:15 AM on January 11, 2008 one (1) cigarette butt was observed on the floor of Resident #24's room by the head of Bed A. Five (5) cigarettes were observed in a pack in the drawer of the resident 's bedside table and one (1) cigarette lighter was observed in the right pocket of the resident's pant. Employee #10 was present during these observations. A review of the record revealed a nurse's note dated November 18, 2007 at 3:00 PM which stated, " While resident was wheeling his/her wheel chair up the hallway toward the Nurses' Station small amount of smoke was noted coming from his/her lap... Cigarette was sitting on his/her lap burning his/her pants." A review of the care plan revealed an entry dated November 18, 2007 which stated " All smoking materials to be kept by customer service. Inspect resident 's skin, or clothing as well as furniture for signs of cigarette burns, an indication of unsafe smoking. Smoking apron to be applied by customer service when on the patio." The care plan was reviewed on January 11, 2008. A face-to-face interview was conducted with Employee # 10 at approximately 10:00 AM on January 11, 2008. He/she stated that Resident # 24 was not permitted to have any smoking	L 051	6. RESIDENT #24 1.Inservice was given to the Nursing Staff about the facility Smoking Policy 2. Medical records of residents identified be smokers were audited for the presence of a Smoking Care Plan: Identified non-compliance were corrected. 3. Resident smokers paraphernalia will be kept in a designated area in Customer Service. 4. Compliance monitoring will be done by Clinical Manager / designee. Monitoring outcomes will be reported to the QA Committee monthly. 5. 2/28/08	2/8/08 1/18/08 2/8/08 2/28/08

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L 051	Continued From page 7 materials in his/her room. He/she added " His/her cigarettes and lighter are kept by customer service. They give him/her cigarettes and light them for him/her on the patio." 7. The charge nurse failed to transcribe an order for Remeron for Resident #1. A review of Resident # 1's record revealed the following physician's order dated March 1, 2007: "Remeron 15mg P.O. QHS [every night] [to] increase appetite ..." , and a Psychiatrist's Treatment Plan dated November 29, 2007: " ...continue with Remeron as Rx [order]." There was no current order for Remeron. A review of the resident's March 2007 Medication Administration Record (MAR) revealed that Remeron 15mg was administered March 1 and 2, 2007. Review of subsequent days and months revealed that the Remeron was not administered. A face-to-face interview was conducted with Employee #9 on January 11, 2008 at approximately 10:00 AM. He/she acknowledged that charge nurse failed to administer Remeron as per the physician's order. He/she said, " The nurse dropped Remeron accidentally from the resident's order when the resident returned from the hospital in March 2007 and again when the order was transcribed on November 29, 2007 ..." The record was reviewed on January 11, 2008. 8. The charge nurse failed to administer Ambien as per physician's order for Resident #18. A review of Resident # 18's record revealed the followings:"Initial Psychiatric Evaluation dated November 29, 2007: ...Ambien CR 6.25mg P.O. QHS [By mouth every night] x 2 weeks for sleep	L 051	7. RESIDENT #1 1.. An occurrence report was completed Physician was notified and orders carried out. Pharmacy and RP notified. resident was assessed for adverse effect from the missed doses of Remeron. None noted. Procedure for transcription of orders were reviewed with the nurse who also received counseling for failing to follow facility procedure in transcription of orders.	1/11/08
			2. 24 hour chart audit conducted by night staff was reviewed for accuracy on all resident's medical record on all the Nursing units.	1/18/08
			3. Inservice review of the facility protocol in physician order transcription focusing on transcription of medication orders on residents readmission from an acute care setting was given to all license nursing staff to prevent future occurrence of transcription errors.	2/08/08
			4. Performance monitoring of 24 hour chart audits will be conducted by CLin. Mgr./ designee to ensure that deficient practice does not reoccur. Identified errors will be included in the employee's performance appraisal.	2/28/08
			5. 2/28/08	
			8. RESIDENT #18 1. Occurrence report completed. Physician notified. Resident assessed that no adverse outcome affected the resident due to missed doses of Ambien. None detected. Resident notified.	1/8/08
			2. MARs of the unit audited to ensure that Orders from Physician order sheets were	1/8/08

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L 051	Continued From page 8 then PRN [As Needed]." A physician's order dated November 29, 2007 directed :"Ambien CR 6.25mg P.O. QHS [By mouth every night] x 2 weeks for sleep then PRN [As Needed]." According to the December 2007 MAR, the order was transcribed as follows: "Ambien CR 6.25mg po q HS x 2 wks for sleep." The December 2007 MAR revealed that Ambien 6.25mg was signed as administered on December 1 through December 21, 2007. There was no PRN order transcribed onto the December 2007 MAR. A face-to-face interview was conducted with Employee #10 on January 8, 2008 at approximately 10:50 AM. He/she acknowledged that charge nurse failed to correctly transcribe the physician's order and administered the Ambien as per the physician's order. The record was reviewed on January 8, 2008. 9. The charge nurse failed to ensure that an expired medication was discarded and not administered to Resident JH9. On January 8, 2008, approximately 9:14 AM, during the medication pass, Employee #19 administered Alupent Metered Dose Inhaler to Resident JH9. The medication was expired " December 2007 " as indicated on the medication packaging. During a face-to-face interview was conducted on January 8, 2008, with Employee #19, at approximately 9:20 AM, he/she acknowledged that the inhaler was expired. 10. The charge nurse failed to clarify an order for	L 051	3.An inservice was given to the Nursing Staff focusing on accuracy of order transcription and prevent medication errors of omission. Highlight on the night staff who performs 24 hour chart audits daily. 4. Performance monitoring will be done by the Clinical Mgr./designee on a daily basis. Monitoring outcomes will be reported to the QA committee monthly. 5. 2/28/08 9. RESIDENT JH9 1. Resident was assessed for adverse effects of the drug. Literature review showed that the medication shelf life is stable for 52 months after the expiration date on the package. This information was provided by the facility Pharmacy consultant and was submitted to the Pharmacy surveyor. Occurrence report was completed. Physician and RP notified so was the Pharmacy consultant who was present during the survey. 2. Medications in the Medication cart refrigerator were checked for expired drugs by checking both package and medication containers. 3. Inservice was given to the License Staff administering meds to make sure to check both package and containers of meds for expiration dates prior to administering medications. 4. Daily checking of meds both from Med cart and medication refrigerators will be done by Charge Nurses and outcome reported to Clin. Mgr. Outcomes will be reported to the QA committee monthly.	2/8/08 2/28/08 1/8/08 1/8/08 2/8/08 1/8/08

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L 051	Continued From page 9 Resident S2 to leave the facility. The resident was identified as an elopement risk. Resident S2 was admitted to the facility on October 3, 2007. According to an " Elopement Risk Assessment" completed on October 4 and 16, 2007 by the social worker, the resident was identified as an elopement risk. The " Initial Social Work Initial History and Assessment" completed October 4, 2007 documented, " The resident is currently being processed to receive a legal guardian ..." The admission Minimum Data Set assessment completed October 11, 2007 coded the resident for long and short term memory problems with independent cognitive skills for daily decision-making (Section B). A physician's telephone order dated October 5, 2007 at 10:00 PM directed, " Hourly monitoring for elopement risk. Wanderguard bracelet monitoring every shift for placement. Wanderguard bracelet to be checked every day by night supervisor." A physician's telephone order dated October 9, 2007 at 4:30 PM, " D/c'd (discontinue) wanderguard bracelet monitoring secondary to non-compliance. D/C (discontinue) Wanderguard bracelet to be checked by nurse." An initial psychiatric evaluation for capacity to make decision was completed on October 18, 2007. According to the psychiatrist, " Patient seems to understand the benefits and the risks of having a court appointed guardian to make decisions on his behalf. The court will make a final decision regarding his/her	L 051	5. 2/28/08 10. RESIDENT #S2 1.Resident's physician and responsible party were both notified. Order was clarified that Resident S2 is an elopement risk and is now not allowed to go out on pass except if with a responsible party. **Update 2/6/08** Resident is now his own RP, cleared by Psychiatrist to be not an Elopement risk anymore and may go out on pass. 2.Medical records of residents allowed to go out on pass were reviewed for the same deficient practice. 3. An inservice was given reviewing the Facility Elopement Risk Protocol. 4. Compliance monitoring will be done by Clinical Mgr./designee. Monitoring outcomes will be reported to the QA Committee monthly. 5. 2/28/08	1/8/08 1/18/08 2/8/08 2/28/08

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L 051	Continued From page 10 competence/capacity issue." A hand written letter from the responsible party dated December 10, 2007 directed, "[Resident S2] may go to the [grocery] store once a week in the day light hours by [him/herself]." A second hand written entry from the responsible party on the same piece of paper directed, "[Resident S2] may go to the [grocery] store twice a week in the day light hours by [him/herself]. [He/she] is not to buy sweets or candy." A physician's telephone order dated December 20, 2007 at 2:10 PM directed, " Psych consult to eval (evaluate) need of Aricept and dx (diagnosis) of dementia secondary to resident and R/P (responsible party) request." The physician signed the order on January 2, 2008. There was no evidence that the psychiatrist evaluated the resident for the use of Aricept and to allow the resident to leave the facility. A telephone order dated December 21, 2007 at 1:00 PM, which was not signed by the physician directed, "Resident may go to the store twice a week." There was no evidence in the record that charge nurse notified the physician of the above order for the resident to go to the store while being identified as an elopement risk. A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 10:00 AM. He/she acknowledged that the order for the resident to leave the facility should have been discussed with the physician and the interdisciplinary care team. The record was	L 051		

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L 051	Continued From page 11 reviewed January 10, 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: (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;	L 052		

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L 052	Continued From page 12 (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 for help. This Statute is not met as evidenced by: Based on observations, staff interview and record review for seven (7) of 30 sampled residents, it was determined that facility staff failed to: assess one (1) resident for a pressure wound first identified with eschar, and for two (2) of five (5) wound treatment observations, the facility failed to utilize a barrier under the pressure wounds; obtain an order for a merry walker for one (1) resident, elevate feet and follow up on lab studies for one (1) resident, apply bed alarm for one (1) resident and use aseptic technique during trach care for one (1) resident. Residents #7, 10, 13, 14, 17, 18 and 25. The findings include: 1. Facility staff failed to monitor and assess Resident 10's skin prior to the development of a pressure wound on the right heel first identified as a 3 cm X 3.5 cm area of eschar. A review of Resident #10's record revealed the following: According to a nurse's note dated September 23, 2007, Resident # 10 fell and sustained a right leg/ankle fracture. X-ray results from September 23, 2007, indicated	L 052	1. RESIDNET #10 1. Facility staff of the nursing unit of the unit of Resident #10 were inserviced on how to do a Head to Toe skin assessment. 2. All the residents of all the nursing units of the facility were given a Head to Toe Skin assessment by the Nursing Staff. A report of the findings were submitted to the DON & the Facility Administrator. 3. An inservice on Skin Assessments was given to all Nursing Staff and scheduled to be done quarterly to ensure continuous staff competency while performing this important aspect of resident care. 4. Weekly monitoring for staff compliance In performing skin assessments will be done by the ADON and report given to DON who will include monitoring	1/10/08 1/25/08 2/8/08 2/1/08

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L 052	Continued From page 13 a fracture of the right Fibula. On September 24, 2007, the orthopedic physician applied a splint (soft cast) to the right lower extremity to include the heel and plantar area of foot. A care plan initiated on September 24, 2007, identified the problem, " Resident has cast to (R) [right] Leg .... " Approaches listed on the care plan included: " Check cast/circulation daily ...Report any abnormal findings to MD " . There was no evidence that facility staff initiated goals and approaches to assess the resident's skin after the splint was applied. According to the Significant Change Minimum Data Set Assessment (MDS), completed October 3, 2007, the resident was coded as totally dependent for bed mobility in Section G (Physical Function and Structural Problems). The Resident Assessment Protocol Summary and approaches to prevent the development of pressure ulcers. No evidence was found in the medical record that the resident ' s skin was assessed from October 3, 2007 - October 20, 2007. Nursing notes dated October 20, 2007 at 3:00 PM: " Eschar noted on Resident ' s RT [Right] Heel " . A physician progress note dated October 22, 2007, " (R) heel has developed an eschar 2 [secondary] to resting in the splint " . Nursing note dated October 26, 2007 at 5:00 PM	L 052	outcomes to be reported to the QA Committee monthly. 5. 2/28/08	

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L 052	Continued From page 14 " Rt. heel eschar on Rt. heel [secondary] to resting on splint " . There is no evidence in the medical record from September 24, 2007 through October 20, 2007 that facility staff monitored changes in Resident #10's skin, specifically the right heel after placement of a right leg splint which enclosed the right heel. A face to face interview with Employees # 6 and #15 was conducted on January 9, 2008 at 3:00 PM. After reviewing the record, Employees #6 and #15 acknowledged that there was assessment of the right heel prior to the development of eschar. The record was reviewed January 9, 2008. 2. Facility staff failed to place a barrier under Resident #13's left heel during a wound treatment observation. A wound treatment was observed on January 8, 2008 at 11:35 AM. Resident #13 was seated in a chair with the sock and dressing removed from the left foot. Employee #13 failed to place a barrier under Resident #13's left heel. Employee #13 cleansed the left heel pressure ulcer. The resident placed the cleansed left heel on the floor. Employee #13 re-cleansed the wound and while he/she was reaching for the clean dressing, the resident placed his/her left foot on the floor. Employee #13 did not cleanse the wound before applying the treatment and dressing. Additionally, after the dressing was placed on the resident's left foot, Employee #13 wrote his/her initials and date on the dressing. A review of the wound assessment sheets revealed that the wound was healing. The record was reviewed January 8, 2008.	L 052	2. RESIDENT #13 1. All licensed nursing staff with the responsibility of performing wound treatments to residents were given one to one inservice by the Clinical Managers of the respective unit (3N) and the Staff Development /Infection Control Coordinator. 2. Clinical Mgrs/designee and Nursing Supervisors will conduct daily and random wound treatment observations. Deficient practice observed will be corrected as soon as identified during observation. Repeated non compliant staff will be subjected to the facility protocol on employee discipline. 3. Inservice was given to the staff reviewing the facility procedure on performing wound treatments with special emphasis on placing a barrier to prevent re-contamination of the newly dressed wound during a treatment procedure. 4. Performance monitoring will be done and monthly report of the monitoring outcomes will be submitted to the DON who will report to the QA committee monthly. 5. 2/28/08.	1/8/08 1/16/08 2/8/08 2/28/08

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L 052	Continued From page 15 3. Facility staff failed to place a barrier under Resident #18's left foot during a wound treatment observation. A wound treatment was observed on January 8, 2008 at approximately 11:15 AM. Resident #18 was in bed. Employee #18 removed the prior dressing from the left foot and placed the resident's left foot on a pillow without a barrier. Some drainage from the wound was observed on the pillow. Employee #18 applied a new dressing to the cleansed left foot pressure ulcer. On completion of the wound treatment, Employee #18 exited the resident's room with the newly dressed left foot on the contaminated soiled pillow. A review of the wound assessment sheets revealed that the wound was responding to treatment. A face-to-face interview was conducted with Employee #18. He/she acknowledged that he/she failed to place a barrier under Resident #18's foot during the wound treatment observation. He/she acknowledged that the resident's newly dressed left foot was returned to the contaminated soiled pillow. The record was reviewed on January 8, 2008. 4. Facility staff failed to obtain an order for Resident #7 to be placed in a merry walker. On January 9, 2008 at 8:45 AM a merry walker was observed in Resident #7's room. A face-to-face interview was conducted with Employee #8 on January 9, 2008 at 10:40 AM. He/she stated, " He/she is in the merry walker	L 052	3. RESIDENT #18 1. All licensed nursing staff with the responsibility of performing wound treatments to residents were given one to one inservice by the Clinical Managers of the respective unit (1N) and the Staff Development /Infection Control Coordinator. 2. Clinical Mgrs/designee and Nursing Supervisors will conduct daily and random wound treatment observations. Deficient practice observed will be corrected as soon as identified during observation. Repeated non compliant staff will be subjected to the facility protocol on employee discipline. 3. Inservice was given to the staff reviewing the facility procedure on performing wound treatments with special emphasis on placing a barrier to prevent re-contamination of the newly dressed wound during a treatment procedure. 4. Performance monitoring will be done and monthly report of the monitoring outcomes will be submitted to the DON who will report to the QA committee monthly. 5. 2/28/08. 4. RESIDENT #7 1. Physician order for a merry walker was obtained for Resident #7. 2. Medical records of residents using a merry walker were audited if a physician order was obtained prior to the resident being put on one. 3. An inservice was given to all staff with special focus on the requirement that merry walkers are not to be used on residents without a physician's order. 4. Compliance monitoring will be reviewed by the Clin. Managers of each unit. Review outcomes will reported to the QA committee monthly 5. 2/28/08	1/8/08 1/16/08 2/8/08 2/28/08 1/10/08 1/18/08 2/8/08 2/28/08

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L 052	Continued From page 16 everyday. When he/she gets out of bed he/she is placed in the merry walker." Employee #8 then acknowledged that there was no order for the resident to be placed in a merry walker. A review of the physician's orders lacked evidence that an order was written for Resident #7 to be placed in a merry walker. The record was reviewed January 9, 2008. 5. Facility staff failed to elevate Resident #14's feet and obtain laboratory studies as per physician's orders. A. Review of the resident's record revealed a physician's order dated November 20, 2007 that directed, " Elevate feet at night. Mild pitting edema pedal area - provide extra pillow for resident's feet at night." The resident was observed in bed on January 9, 2008 at 7:20 AM. The resident was positioned on his/her left side with feet not elevated. No extra pillow was observed under the resident's feet. A face-to-face interview was conducted with Employee #27 on January 9, 2007 at 7:25 AM, who had cared for Resident #14 from 11:00 PM the previous night. Employee #27 stated that he/she was unaware that the resident's feet should have been elevated. According to the January 2008 Medication Administration Record, Employee #27 initialed that the resident's feet were elevated throughout the night. He/she stated that it was a mistake and confirmed that the resident's feet were not elevated throughout the night. B. A review of Resident #14's record revealed a	L 052	5A. RESIDENT #14 1. Resident #14's feet were assessed for presence of edema by the Clin. Mgr. of the unit. No pitting edema observed. Physician was notified and the order was discontinued. Nurse in question was counseled for signing the Medication Administration record without checking to ensure that the resident's feet were kept elevated at night as ordered. 2. 24 hour chart audit was monitored for accuracy to ensure that physician's orders were transcribed accurately, reports are given accurately between shifts and orders are being carried out by the facility nursing staff 3. An inservice regarding the nursing staff's responsibility in carrying out physician's orders and corresponding outcome for non-compliance was discussed with all members of the nursing staff. 4.Performance monitoring will be done by Clinical Manager/designee. Outcomes will be reported to the QA committee monthly. 5. 2/28/08	1/9/08 1/18/08 2/8/08 2/28/08

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L 052	Continued From page 17 physician's telephone order dated November 20, 2007 that directed, " UA/CS (urinalysis/culture and sensitivity) There were no results in the record for a UA/CS for the above order. A face-to-face interview was conducted with Employee #29 on January 9, 2008 at 10:30 AM. After reviewing the record, he/she acknowledged that the UA/CS was not done. The record was reviewed January 9, 2008. 6. Facility staff failed to apply a bed alarm for Resident #17 as per physician's orders. A physician's telephone order written on December 2, 2007 directed, " Bed alarm - resident to have bed alarm while in bed -safety ..." Resident #17 was observed on January 8, 2007 at 6:45 AM in bed. There was no bed alarm observed. A face-to-face interview was conducted in the resident's room with Employee #28 at the time of the observation, who had cared for Resident #17 throughout the previous night. He/she confirmed that no bed alarm had been in use for the night. A review of the January 2008 Treatment Administration Record revealed that Employee #28 had signed that the bed alarm had been in place throughout the night. Employee #28 stated that he/she must have made a mistake. The record was reviewed January 8, 2008. 7. Facility staff failed to practice aseptic technique during tracheostomy care for Resident #25.	L 052	5B. RESIDENT #14 1. Physician notified that the order for UA /CS was not carried out. Order renewed. and carried out. Nursing Staff was inserviced by the Clin. Mgr of the unit. 2. 24 hour chart audit reviewed for accuracy of audit being performed and evidence of follow-up to check for the same deficient practice. Lab book review included in the audit. 3. An inservice was given to the Nursing staff with special focus on the accuracy of the 24 hour chart audit conducted by the night staff daily. Lab book review will be included in the 24 hour chart audit.. 4. Compliance monitoring will be done by the Clinical Mgr./designee daily . Monitoring outcomes will be reported to QA committee monthly. 5. 2/28/08 6. RESIDENT #17 1. All nursing staff of the unit where Resident #17 is were inserviced about legality of accurate charting by the Clinical Mgr. Charge nurses are not to sign the Treatment Administration Record with out checking if the device they are signing to be with the resident / bed are truly present. Nursing staff involved in this situation was counseled for his/her deficient practice of documentation. 2. Rounds was made by the Charge Nurses to ensure that devices signed for are truly with the resident / bed. 3. An inservice was given to the Nursing Staff about legality of accurate charting and focusing on what to check while on walking rounds during beginning and end of shift reports. 4. Performance monitoring will be done by the Clinical Mgr/designee on a daily basis. Monitoring outcomes will be reported to the QA committee monthly. 5. 2/28/08	2/1/08 2/1/08 2/8/08 2/28/08 1/9/08 1/9/08 2/8/08 2/28/08

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L 052	Continued From page 18 A review of Resident #25's record revealed a physician's order dated September 2, 2007, directing "Trach care every shift as needed." An observation of tracheostomy care for Resident #25 was conducted at approximately 2:30 PM on January 10, 2008. Employee #21 stated that the treatment was a clean technique. During the treatment it was observed that Employee #21 failed to clean the over-bed table or use a barrier on the table prior to providing tracheostomy care to the resident. He/she washed his/her hands and put on a pair of gloves from a box on the table. He/she removed the tracheostomy collar and tubing, and attached the oxygen tubing to an Ambu bag. He/she opened a packet that contained the tracheostomy dressings, placed the opened packet on the table, removed the dressing from the packet and placed them on the resident without a barrier. He/she removed his/her gloves, washed his/her hands and put on the gloves that were in the packet. He/she poured Normal Saline Solution (NSS) from a bottle into a small container from the packet. He/she placed the covering from the package on the comforter, removed the Ambu-bag from a plastic bag and placed it on the covering from the packet. He/she used a tissue and with his/her right gloved hand removed brown tinged mucus from the resident's comforter. Without changing his/her glove and/or washing his/her hands, the employee connected the Ambu-bag to the resident's tracheostomy and attempted to oxygenate the resident. The employee interrupted oxygenating the resident to turn the oxygen on and used unwashed hands	L 052	7. RESIDENT #25 1. Nursing staff on both units 2N/2S were inserviced on the facility protocol for Tracheostomy Care. 2. Charge Nurses were observed by the Clinical Mgrs of both units while doing Tracheostomy Care for strict adherence to Aseptic technique during the procedure. 3. Protocol for Tracheostomy care was reviewed with all license staff focusing on consistent compliance to the protocol and potential adverse effects to the resident for breaks in technique. Non-compliance will subject employee to employee discipline. 4. Compliance monitoring will be done by Clinical Mgr/designee and Nursing Supervisors each shift and daily. Monitoring outcomes will be submitted To the QA committee monthly by the Staff Development/Infection Control Coordinator. 5. 2/28/08	1/11/0 1/11/08 2/8/08 2/28/08

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L 052	Continued From page 19 with unclean gloves to resume the process of oxygenating the resident with the Ambu-bag. The employee did not wash his/her hands or change his gloves. He/she inserted the suction catheter with his/her right gloved hand [wearing the same pair of gloves initially donned] into the resident's tracheostomy tube and proceeded to suction the resident. Employee # 21 used cotton swabs to clean around the inside of the tracheostomy tube and failed to remove the inner canula. The record was reviewed on January 10, 2008.	L 052		
L 083	3216.4 Nursing Facilities Physical restraints shall not be applied unless: (a)The facility has explored or tried less restrictive alternatives to meet the resident's needs and such trails have bene documented in the resident's medical record as unsuccessful; (b)The restraint has been ordered by a physician for a specified period of time; (c)The resident is released, exercised and toileted at least every two (2) hours,except when a resident's rest would be unnecessary disturbed. (d)The use of the restraint doe not result in a decline in the resident's physical, mental psychological or functional status; and (e)The use of the restraint is assessed and re-evaluated when there is a significant change in the resident's condition. This Statute is not met as evidenced by: Based on observation, staff interview and record	L 083		

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L 083	Continued From page 20 review for two (2) of 49 residents identified by facility staff having restraints, it was determined that facility staff failed to obtain a physician's order for the use of restraints. Residents #3 and 6 . The findings include: 1. Facility staff failed to obtain a physician's order for the least restrictive restraint (seat belt) for Resident #3. Resident #3 was observed on January 8, 2008 at 10:30 AM and January 9, 2008 at 11:00 AM wearing a padded seat belt. An interview was conducted with the resident at 11:00 AM on January 9, 2007. The resident was asked if he/she was able to open the seat belt. The resident tugged at the seat belt, shook his/her head and stated, " No." According to a review of the Rehabilitation Screening dated November 6, 2007,"Patient will require a Velcro seatbelt with alarm for less restrictive device secondary to patient not being able to open current seatbelt upon command. Nursing notified ..." A review of the resident's record revealed that there was no order from the physician to initiate the use of a seat belt. A face-to-face interview with Employee #6 was conducted on January 8, 2008 at 2:30 PM. He/she acknowledged that there was no physician's order. The record was reviewed on January 8, 2008. 2. Facility staff failed to obtain a physician's order for the use of a seat belt for Resident #6.	L 083	1. RESIDENT #3 1 .Physician order was obtained for the seat belt for Resident #3 2. Medical Records of all residents on the unit wearing a seat belt were audited for the presence of a physician's order 3. An inservice program reviewing the facility protocol for Physical Restraints was given to the Nursing Staff with special emphasis that a Physician's order must be obtained prior to the application of any form of physical restraints on the resident 4. Compliance monitoring to the Policy on Physical Restraints will be done by the Restraint Review Committee weekly. Monitoring outcomes will be reported to the DON / designee who will submit report to the QA committee. 5. 2/28/08	1/9/08 1/9/08 2/8/08 2/28/08

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L 083	Continued From page 21 Resident #6 was observed on January 9, 2008 at approximately 11:55 AM seated in a wheel chair wearing a padded seat belt. A face-to-face interview was conducted with Employee #36 and the resident at 11:55 AM. Employee #36 and the resident were asked if the resident was able to open the seat belt. The resident responded verbally " No" after two (2) failed attempts to open the seat belt. Employee #36 responded " The resident will fall if the seat belt is released. It's for safety." A review of the clinical record for Resident #6 revealed a Physician's Order Form (POF) signed and dated December 12, 2007. There was no physician's order to initiate the use of a seat belt. A face-to-face interview was conducted on January 9, 2008 at approximately 12:45 PM with Employees #29 and #40. They both acknowledged that there was no physician's order for the use of the seat belt. The record was reviewed on January 9, 2008.	L 083	2. RESIDENT #6 1 .Physician order was obtained for the seat belt for Resident #6 2. Medical Records of all residents on the unit wearing a seat belt were audited for the presence of a physician's order 3. An inservice program reviewing the WNF protocol for Physical Restraints was given to the Nursing Staff with special emphasis that a Physician's order must be obtained prior to the application of any form of physical restraints on the resident 4. Compliance monitoring to the Policy on Physical Restraints will be done by the Restraint Review Committee weekly. Monitoring outcomes will be reported to the DON / designee who will submit report to the QA committee. 5. 2/28/08	1/9/08 1/9/08 2/8/08 2/28/08
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations, staff interview and record review during the environmental and dietary tours, it was determined that facility staff failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by: a damaged floor in the kitchen, soiled tilt grill, caulking above a sink, deep fryers, juice machine compressor,	L 099	1. Floor in the main kitchen 1. The floor area was cleaned and repairs were made Wherever possible. 2. Maintenance and Administration will consult with Corporate contractors to discuss future plans for the Repair of the kitchen floor. 3. The Nutritional Services Management staff and The Maintenance staff will monitor the condition of The kitchen floor on an on-going basis ensuring its Cleanliness and repair. 4. The Nutritional Services Director will report on the performance monitoring efforts and any action plans for improvement to the QA Committee which is chaired by the Administrator. 5. 2/28/08	1/29/08 2/28/08 2/28/08 2/28/08

2. Tilt Skillet
1. The tilt surface was cleaned and the grease was Removed at the time of discovery. 1/9/08
2. All other skillet surfaces were reviewed for Cleanliness. No other cleaning was necessary. 1/9/08
3. Cleaning standards and cleaning schedules Were reviewed with the cooks to ensure on-going Compliance. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 2/28/08
4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08
5. 2/28/08
3. Caulking Above the Sink
1. Caulking was removed and replaced with new Caulking upon discovery. 1/23/08
2. All other caulking was reviewed for cleanliness And no other replacement was necessary. 1/23/08
3. The Nutritional Services Supervisors Will monitor all aspects of cleanliness in the kitchen On an on-going basis to ensure compliance. 2/28/08
4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08
5. 2/28/08
4. Grease Build Up in Fryers.
1. Fryers were removed from the cooking area and Thoroughly cleaned inside and returned to service. 1/09/08
2. Cooks were inserviced on the proper cleaning Of the deep fryers. 1/15/08
3. Cleaning standards and cleaning schedules Were reviewed with the cooks to ensure on-going Compliance. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 2/28/08
4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08
5. 2/28/08
5. Compressor on the Juice Machine
1. The compressor motor was wiped down upon discovery. 1/09/08
2. All other compressors were reviewed to ensure Proper cleanliness. 1/09/08
3. Nutritional Services Supervisors will advise Assigned staff to include the compressor in the
5. Compressor on the Juice Machine (continued) Station clean up. The Supervisors will monitor The areas for on-going cleanliness and com- pliance. 2/28/08
4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08
5. 2/28/08

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	095022	A. BUILDING _____ B. WING _____	01/14/2008

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L 099	Continued From page 22 threshold of the walk-in refrigerator and freezer, convection ovens, cooking hoods and pantry ice machines, chicken base was stored in the oven and food in the unit pantry refrigerators were unlabeled, undated and/or expired. These observations were observed in the presence of Employee #2 in the main kitchen and Employees #3, 4 and 26 for the unit pantries on January 14, 2008 from 7:00 AM through 10:30 AM. The findings include: 1. The floor in the main kitchen, dish machine area and dried storage area was observed cracked, uneven, with peeling paint and soiled. 2. The outside of the tilt grill was observed soiled with accumulated grease and debris in one (1) of one (1) tilt grill observed. 3. Caulking above the sink by the tray line was observed soiled in one (1) of four (4) sinks observed. 4. Grease and debris build-up was observed on wires and valves for two (2) of two (2) deep fryers observed. 5. The compressor to the juice machine was soiled with dust, debris and grease in one (1) of one (1) juice machine observed. 6. The threshold of the walk-in refrigerator and freezer were observed soiled and damaged in two (2) of two (2) thresholds observed. 7. Two (2) of two (2) convection ovens were observed soiled on the exterior with grease and debris.	L 099	6. Thresholds 1. Thresholds to the Walk-in refrigerator and freezer were cleaned immediately and the repair was scheduled with Maintenance. 2. All thresholds were evaluated for cleanliness And repair. No other action was necessary. 3. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen thresholds On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 7. Convection Oven Doors 1. The exterior oven door was wiped down upon Discovery. 2. All other doors were evaluated for cleanliness and No other action was necessary. 3. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 8. Cooking Hoods Over Ovens 1. Filters in the hood were removed and cleaned as needed. 2. All other filters were evaluated and no other Action was necessary. 3. The Nutritional Services Supervisors Will monitor the cleanliness of the kitchen equipment On an on-going basis to ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08	1/23/08 1/23/08 2/28/08 2/28/08 1/8/08 1/8/08 2/28/08 2/28/08 1/09/08 1/09/08 2/28/08 2/28/08

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L 099	Continued From page 23 8. Cooking hoods above the oven were observed soiled with grease and debris in four (4) of eight (8) hoods observed. 9. The spout and trays of ice machines on 3 North and 3 South were observed soiled with debris in two (2) of six (6) ice machines observed. 10. 4-16 ounce containers of chicken base were observed stored in the main oven. 11. Unit pantries were observed with unlabeled, undated or expired food as follows: 3 North refrigerator contained the following opened and undated items: One (1) package of hot dogs One (1) package of bologna One (1) package of yellow cheese One (1) package of salami One (1) plate of chicken, rice, stuffing and biscuit was undated. 2 North refrigerator contained the following items that were opened: One (1) package of bologna dated December 10, 2007 One (1) red apple dated December 10, 2007 One (1) package of lettuce dated December 17, 2007 One (1) package of white cheese dated December 17, 2007 1 North refrigerator contained the one (1) container of yogurt that expired December 21, 2007. Employees #3, 4, and 26 acknowledged the above findings at the time of the observations.	L 099	9. Ice machine 1. The spout and tray of the ice machine were Cleaned upon discovery. 2. All other ice machines were evaluated and Cleaning done if necessary 3. Housekeeping supervisors will monitor the Cleanliness of the ice machines on an on-going Basis to ensure their sanitation. 4. The Director of Environmental Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 10. Chicken Base 1. The misplaced containers of chicken base were Immediately removed and stored properly. 2. All other areas of the kitchen were searched for Improperly stored containers to ensure proper Storage at all times. 3. Cooks were inserviced on the proper storage And handling of container foods. The Nutritional Services Supervisors will monitor the Proper storage of foods on an on-going basis to Ensure compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08 1.Unlabeled and/or expired foods were discarded from refrigerators on all nursing units. 2. Nursing staff were instructed by unit Clinical Managers to check refrigerators on all nursing units daily for expired and/ unlabeled foods to be discarded. 3. An inservice was given to all nursing staff that unlabeled and expired foods are to be discarded from the refrigerator daily. 4. Compliance monitoring will be done by Clinical Manager/designee daily and monitoring outcomes reported to the QA committee monthly. 5. 2/28/08	1/09/08 1/9/08 1/31/08 2/28/08 1/09/08 1/09/08 1/15/08 2/28/08 1/7/08 1/7/08 2/8/08 2/28/08

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L 108	Continued From page 24	L 108		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that hot foods were served below 140 degrees Fahrenheit (F) and cold foods served above 45 degrees F for a test tray at the point of delivery to the resident. This observation was done in the presence of Employee #34. The findings include: A test tray was conducted on January 7, 2008 at 9:17 AM. The following food temperatures were observed: The test tray left the main kitchen at 9:17 AM, and arrived on 3 South at 9:19 AM. Facility staff distributed the first tray at 9:21 AM. The temperature of the food was tested at 9:30 AM as follows: Milk 49 degrees F Apple Juice 56 degrees F Corned beef hash 134.2 degrees F Scrambled eggs 123 degrees F Employee #34 acknowledged the findings at the time of the observation.	L 108	1. Inservices were done with the cooks and the Line staff regarding proper tray line set-up and Temperature control for both hot and cold foods. 2. Supervisors will be on the station at 7:00 am with Temperatures being taken at beginning, mid tray line and before the last two carts are served. Cold beverages will be submerged in ice to ensure compliance. 3. Breakfast test tray temperatures will be taken daily To ensure proper temperatures and then bi-weekly Thereafter. The Supervisors will ensure that this Process is completed and that proper temperatures Of the food is delivered to the resident. 4. The Director of Nutritional Services will monitor The performance improvement activities and report His findings to the QA Committee with any action Plans for improvement.	1/9/08 2/11/08 2/28/08 2/28/08
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage.	L 161		

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L 161	Continued From page 25 This Statute is not met as evidenced by: Based on observation and staff interview, of five (1) of six (6) medication carts, it was determined that facility staff failed to remove expired medication(s) from the medication cart. The findings include: The facility staff failed to remove expired medication from the medication cart. On January 8, 2008, at approximately 9:14 AM, during the medication pass, it was observed that Employee #19 administered Alupent Metered Dose Inhaler to Resident JH9. The medication in the canister expired December 2007. During a face-to-face interview on January 8, 2008 at approximately 9:20 AM with Employee #19 acknowledged that the medication was expired.	L 161	1. Resident was assessed for adverse effects of the drug. Literature review showed that the medication shelf life is stable for 52 months after the expiration date on the canister. This information was provided by the facility Pharmacy consultant and was submitted to the Pharmacy surveyor. Occurrence report was completed. Physician and RP notified so was the Consultant Pharmacist who was present during the survey. 2. Medications in the Med cart and refrigera- tor were checked for expired drugs by checking both package and medication canister. 3. Inservice was given to the License staff administering meds to make sure to check both package and canister of meds for expiration dates prior to administering medications. 4. Daily checking of meds both from Med cart and medication refrigerators will be done by Charge Nurses and outcome reported to Clin. Mgr. Outcomes will be reported to the QA Committee monthly. 5. 2/28/08	1/8/08 1/8/08 2/8/08 1/8/08
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws,regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on observation and staff interview for two (2) of 10 residents observed during medication pass, it was determined that the facility staff failed to ensure the privacy and confidentiality of residents' Medication Administration Records (MARs). Residents JH8 and JH10. The findings include: During the medication pass on January 8, 2008,	L 167		

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L 167	Continued From page 26 at approximately 9:45 AM, Employee #20, went into Resident JH8's room to administer medications. At approximately 10:55 AM, he/she went into Resident JH10's room to administer medications. While administering medications to the residents, Employee #20 left the MAR open and exposed on top of the medication cart, located in the hallway of Unit 3 North. The MAR includes the resident's diagnoses, allergies and currently prescribed medications. A face-to-face interview was conducted on January 8, 2008 at approximately 11:00 AM, at the completion of the medication pass observation, Employee #20 acknowledged that the MAR was left open on both occasions.	L 167	1. Inservice was given to the nursing staff regarding maintaining privacy and confi dentiality of resident's records while administering medications by keeping resident's MARs closed while the nurse is in the residents room. 2. Clinical Managers/designee will do rounds and observe LPNs during med pass to ensure compliance. Nursing Supervisors on off shifts will do observation of LPNs during rounds to ensure compliance. 3. Deficient practice observed will be corrected as it occur. Repeated non-compliance will be cause for discipline per HR policy.	1/9/08 1/15/08 2/28/08
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations and staff interview, of five (5) of six (6) medication carts, it was determined that the facility staff failed to date and initial 12 of 22 multi-dose medication vials when first opened and remove expired medication. The findings include: On January 10, 2008, between 9:00 AM and 12:00 PM, the medication carts and refrigerators were inspected on each unit. 1. The facility staff failed to date and initial opened multi-dose medication vials as follows:	L 168	4. Monitoring outcomes will be included in the DON/designee's report to the QA committee. 5/ 2/28/08	2/28/08

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L 168	Continued From page 27 1 North Unit Xalatan ophthalmic drops - three (3) vials Heparin Sodium injection 10,000 Units/ 4ml - one (1) vial PPD 5 TU/0.1ml - one (1) vial Lorazepam injection 2mg/ml, 30 vials - two (2) vials 1 South Unit Xalatan ophthalmic drops - four (4) vials Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 2 North Unit Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 2 South Unit Heparin Sodium injection 10,000 Units/ 4ml - two (2) vials 3 South Unit Heparin Sodium injection 10,000 Units/ 4ml - one (1) vial Employees # 6, 7, 8, 10, and 42 acknowledged that the vials listed above were not dated and/or initiated at the time of the observations.	L 168	1. Multi-dose vials that were found open without date when initially open were discarded. 1/10/08 2. Medication carts and medication refried-raptor on all nursing units were inspected to look for the same deficient practice. 1/10/08 3. Inservice was given to the Nursing Staff about the importance of writing the date when a multi-dose vial is initially open. 2/8/08 4. Compliance monitoring is done daily by Charge nurses before administering meds by checking the medication cart and the medication refrigerator for open multi-dose that were not dated when initially opened. Monitoring outcomes will be reported to the QA committee. 2/28/08	
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 30 sampled residents and 15 of 54	L 199		

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L 199	Continued From page 28 supplemental residents, it was determined that facility staff failed to consistently document the use of bilateral leg splints for one (1) resident; and monitor 18 residents requiring behavior monitoring every 15 minutes or every hour. Resident's #5, 20, 21, 24, C3, E5, M1, M2, M3, M5, M6, M7, M8, M9, M10, M11 and S2. The findings include: 1. A review of Resident #5's record revealed a physician's telephone order dated October 22, 2007 and signed by the physician November 5, 2007, directing, "Patient fitted with bilateral knee extension orthotic for night time. Use only 6 hrs [hours] on." A review of the October and November 2007 Treatment Administration Record, revealed that the splints were not applied from October 22 through 31, 2007 and November 1 through November 8, 2007 as indicated by the nurses initials. A face-to-face interview was conducted with Employee #6 on January 8, 2007 at approximately 2:30 PM. After reviewing the record, he/she acknowledged that the leg splints were not signed has having been applied as per the physician's order. The record was reviewed January 8, 2008. 2. Facility staff failed to monitor residents wandering behavior every 15 minutes or every hour. A review of the behavior monitoring sheets for October, November and December 2007 were conducted on January 9, 2008. Monitoring sheets consisted of four (4) columns, time,	L 199	1. RESIDENT #5 1. Nursing staff of the unit in question were counseled for the identified deficient practice. 1/9/08 2. Treatment Administration Records of residents with splints were audited if devices were consistently documented and applied as ordered. 1/18/08 3. Inservice was given to the Nursing Staff regarding the importance of following physician's order and consistent documentation 2/8/08 4. Compliance monitoring will be done by the Clinical Manager/designee to ensure that the same deficient practice does not reoccur. Monitoring outcomes will be reported to the QA committee. 2/28/08 5. 2/28/08.	

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L 199	Continued From page 29 location, RN/LPN signature and supervisor signature. The following inconsistent documentation was observed: Resident #20: Required 15 minute monitoring; on December 17, 2007 there was no RN/LPN signature for 12:00 AM through 6:45 PM. Resident #21: Required 15 minute monitoring and on November 26, 2007 the resident was monitored one-on-one. On November 30, 2007 there was no supervisor signature for 6:00 AM and from 11:00 PM through 11:45 PM. On December 19, 2007 there was no RN/LPN signature from 12:00 PM through 11:00 PM. On December 20, 2007 all columns were blank from 11:15 PM through 11:45 PM. On December 24, 2007 there was no RN/LPN signature at 4:45 PM and all columns were blank from 11:15 PM through 11:45 PM. On December 26, 2007 all columns were blank from 9:00 PM through 11:45 PM. On December 27, 2007 all columns were blank from 12:00 AM through 6:45 PM. Resident #24: Required hourly monitoring. On October 4, 2007 the RN/LPN signed at 12:00 AM, 3:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 11:00 AM, 12:00 PM, 2:00 PM, 4:00 PM and 11:00 PM. Resident C3: Required 15 minute monitoring. On October 7, 2007 the location was blank from 8:00 AM through 11:00 PM with the RN/LPN and supervisor signature present for 6:00 PM and 9:00 PM. On October 14, 2007 the location and RN/LPN signature was blank for 8:45 AM through 11:45	L 199	2. RESIDENT #20,21,24,C3, E5,M1, M2, M3, M5, M6, M7, M9, M10, M11, S2 1. Nursing staff of **All Nursing Units** were inserviced about ensuring that the staff assigned to a resident who is on behavior monitoring and considered to to be an elopement risk be closely monitored and to make sure that the elopement monitoring sheet / behavior monitoring observation sheet is completed accurately and timely by CNAs, Charge Nurses, Clinical Managers and Supervisors to ensure that resident's where about is known at all times on residents who are on the Elopement Risk. Non compliance to the policy will result in the employee being subjected to the facility policy on progressive discipline 2. Residents on the Elopement Risk list were checked that their whereabouts are known to nursing staff assigned to them. 3. Inservice was given to all facility staff about the facility policy on Missing residents. Emphasis that If you are not able to account for the resident in 10 minutes the missing resident policy is to be activated. A wandering resident is every employee's responsibility to be on the look out for during their tour of duty. 4. Elopement and behavior monitoring sheets will be reviewed for completeness of assessments and signatures every shift by Charge Nurses, Clinical Mgr. and Nursing Supervisors. Staff who are observed to be non-compliant to the policy will be counseled on the spot and the deficient practice	1/8/08 1/9/08 2/8/08 1/9/08

corrected. Repeat non-compliance

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L 199	Continued From page 30 PM and the supervisor signed at 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM and 9:00 PM. On October 24, 2007 the location and RN/LPN signature was blank for 4:15 PM through 4:45 PM. On October 27, 2007 a line was drawn down the column for RN/LPN signature from 5:30 PM through 11:15 PM. On November 11, 2007 the location and RN/LPN signature were blank for 3:45 PM. On November 24, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. On November 29, 2007 the location and RN/LPN signature was blank for 11:45 PM. Resident E5: Required 15 minute monitoring. On October 13, 2007 all columns were blank for 5:00 PM through 11:00 PM. On November 4, 2007 the RN/LPN signed was every 30 minutes not every 15 minutes from 7:00 AM through 3:30 PM. On November 16, 2007 a line was drawn down from 3:30 PM and up from 4:45 PM in the RN/LPN signature column. A single signature appeared at 8:15 PM. The supervisor signed at 6:00 PM and 9:00 PM. On December 3, 2007 the location and RN/LPN signature was blank for 7:15 PM through 11:45 PM with a supervisor signature at 9:00 PM. On December 6, 2007 there was no supervisor signature for the entire day. On December 25, 2007 location and RN/LPN signature was blank for 12:00 Am through 6:00 AM. There was no column for the supervisor to sign and no supervisor signature for the whole day.	L 199	to the facility policy may be cause for the employee's termination of employment. 5. 2/28/08	

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L 199	Continued From page 31 Resident M1: Required 15 minute monitoring. On October 18, 2007 2:00 PM through 3:30 PM there was no RN/LPN signature. On December 17, 2007 there was no RN/LPN signature for 12:00 AM through 6:45 AM. Resident M2: Required 15 minute monitoring. On October 18, 2007 all columns were blank from 1:45 PM through 3:00 PM. On December 17, 2007 there was no RN/LPN signature from 12:00 AM through 6:45 AM, however, the supervisor signed every two (2) hours. Resident M3: Required 15 minute monitoring. On October 14, 2007 2:15 PM through 3:00 PM location was blank. The RN/LPN signed from 2:15 PM through 3:00 PM and the supervisor signed at 3:00 PM on October 14, 2007. On October 28, 2007 the RN/LPN signed at 6:15 PM. There was a line drawn from 6:15 PM through 9:45 PM with a signature at 9:15 PM. The supervisor signed at 9:00 PM. On November 14, 2007 the RN/LPN signed every 30 minutes from 12:00 AM through 4:45 PM. On November 29, 2007 there was no RN/LPN signature or location from 11:15 PM through 11:45 PM and at 3:45 PM. There was no supervisor signature at 6:00 AM, 6:00 PM and 9:00 PM. Resident M5: Required 15 minute monitoring. On October 14, 2007 there was no RN/LPN signature or location from 5:00 PM through 11:45 PM. The supervisor signed at 6:00 PM and 9:00 PM. On November 4, 2007 there was no RN/LPN signature from 3:45 PM through 4:45 PM. On November 8, 2007 the location and RN/LPN	L 199		

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L 199	Continued From page 32 signature was blank for 11:45 PM. On November 11, 2007 the location and RN/LPN signature was blank for 3:45 PM On November 15, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 21, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. Resident M6: Required 15 minute monitoring. On October 14, 2007 location and RN/LPN signature was blank for 9:30 PM through 11:45 PM. On November 15, 2007 the location and RN/LPN signature was blank for 11:45 PM. On November 21, 2007 the location and RN/LPN signature was blank for 4:45 PM On November 24, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. On November 25, 2007 the location and RN/LPN signature was blank for 11:15 PM through 11:45 PM. December 20, 2007 the location and RN/LPN signature were blank for 12:00 PM through 1:00 PM. The supervisor signed at 12:00 PM and 3:00 PM. Resident M7: Required hourly monitoring. On October 14, 2007 the location was blank for 8:00 AM through 11:00 PM. The RN/LPN signature and supervisor signature were signed for the whole day. Resident M8: Required 15 minute monitoring. On October 7, 2007 there was no RN/LPN signature from 5:30 PM through 11:45 PM but the supervisor signed at 6:00 PM and 9:00 PM. On December 3, 2007 all columns were blank	L 199		

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L 199	Continued From page 33 from 12:00 AM through 3:00 PM and no supervisor signatures at 6:00 PM and 9:00 PM. On December 7, 2007 the location and RN/LPN signature were blank for 11:45 AM through 2:45 PM with a supervisor's signature at 12:00 PM and 3:00 PM and no supervisor signature at 6:00 PM and 9:00 PM. December 9, 2007 the location, RN/LPN and supervisor signatures were blank for 7:45 AM through 11:45 PM. December 25, 2007 there was no RN/LPN signature for 12:00 PM through 7:00 AM but the supervisor signed for 12:00 PM, 3:00 AM and 5:00 AM. Resident M9: Required 15 minute monitoring. On November 16, 2007 a line was drawn down from 3:00 PM and up from 11:00 PM with a nurse's signature at 9:00 PM and no supervisor signature for 3:00 PM, 6:00 PM and 9:00 PM. On December 3, 2007 the location and RN/LPN signature were blank for 3:30 PM through 11:45 PM but the supervisor signed at 3:00 PM, 6:00 PM and 9:00 PM. Resident M10: Required 15 minute monitoring. On November 16, 2007 a line was drawn down from 3:30 PM and up from 4:45 PM with the nurse's signature at 4:15 PM and on the same day a line drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 8:45 PM. The supervisor signed for 3:00 PM, 6:00 PM and 9:00 PM. On November 24, 2007 a line was drawn down from 3:15 PM and up from 4:545 PM with the nurse signature at 4:40 PM and on the same day a line was drawn down from 5:00 PM and up from 11:45 PM with a nurse's signature at 9:30 PM. The supervisor signed at 3:00 PM, 6:00 PM and 9:00 PM.	L 199		

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L 199	Continued From page 34 On December 25, 2007 the location and RN/LPN signature were blank for 12:00 AM through 6:00 AM. There was no supervisor signature for the entire day. Resident M11: Required 15 minute monitoring. On October 8, 2007 the location and RN/LPN signature were blank from 8:00 AM through 11:00 AM with no column for the supervisor signature for the entire day. On November 16, 2007 a line was drawn down from 4:00 PM and up from 4:45 PM with the nurse's signature at 8:00 PM. On a second sheet for the same day a line was drawn down from 4:00 PM and up from 4:45 PM with the nurse's signature at 4:15 PM and for the same day, a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 9:00 PM. The supervisor signed at 3:00 PM, 6:00 PM and 11:00 PM. On November 24, 2007 a line was drawn down from 4:00 PM and up from 11:00 PM with the nurse's signature at 8:00 PM. A second sheet from November 24, 2007 had a line drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 9:00 PM. The supervisor signed at 3:00 PM, 6:00 PM and 11:00 PM. On November 25, 2007 the nurse's signed at 4:00 PM with an arrow going up to 3:15 PM and down to 4:45 PM and on the same day a line was drawn from 6:15 PM down and up from 11:45 PM with the nurse's signature at 7:15 PM. On December 25, 2007 a line was drawn through the location column from 5:15 PM through 7:00 AM. There was no RN/LPN or supervisor signature for the entire day. A second sheet for December 25, 2007 the location and RN/LPN signature were blank for 12:00 AM through 6:00 AM.	L 199		

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L 199	Continued From page 35 Resident S2: Required hourly and 15 minute monitoring. On November 20, 2007 a line was drawn down from 4:00 PM and up from 11:00 PM with the nurse's signature at 7:00 PM. On November 24, 2007 a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 7:45 PM. The supervisor signed at 6:00 PM and 9:00 PM. On November 25, 2007 a line was drawn down from 4:00 PM and up from 4:445 PM with the nurse's signature at 4:15 PM and on the same day a line was drawn down from 5:00 PM and up from 11:45 PM with the nurse's signature at 7:45 PM. The supervisor signed at 6:00 PM and 9:00 PM. On December 3, 2007 there was no nurse's signature from 7:15 AM through 1:45 PM. The supervisor signed the entire day. On December 25, 2007 the location, RN/LPN and supervisor signatures were blank for 12:00 AM through 6:00 AM.	L 199		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 30 sampled residents and one (1) supplemental resident, it was determined that the facility staff failed to report four (4) unusual occurrences to the state agency and failed to document the usage of a controlled substance on the Medication Administration Record (MAR) for three (3) supplemental residents. Residents #18,	L 206		

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L 206	Continued From page 36 21, F3, F1, JH4, JH6 and JH7. The findings include: According to 22 DCMR, 3232.4, "Each incident shall be documented in the resident' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." 1. Facility staff failed to report to the State Agency that Resident #18 sustained a cigarette burn to the right thigh. A review of the resident ' s record revealed a physician ' s order dated October 21, 2007 at 7:00 AM: " Clean open area on RT [right] thigh from smoking burns with NSS [normal saline solution] apply Bactroban ointment and coversite daily " . A face-to-face interview was conducted on January 10, 2008 at approximately 10:00 AM with Employee #25, who confirmed that an incident report was not sent to the state agency for the above cited incidence. The record was reviewed on January 8, 2008. 2. Facility staff failed to report to the State Agency that Resident #21 was found in an electrical closet and found in another resident' s bed. A. Review of Resident #21 revealed the following nurse's note dated November 26, 2007 at 8:00 AM,"Resident observed sleeping in [his/her] room at 6 AM. At 6:30 AM resident observed sitting in the chair by the part of the nursing station. Resident was seen in the hallway (2 South) at 7	L 206	1. Resident #18 1. Nursing Staff of the unit in question were inserviced about writing an occurrence report if/when an unusual incident occurred at all times and to notify his/her immediate supervisor who can direct him/her to complete an occurrence report if ever there is a question whether to write one or not. Resident is alert and oriented x3. He chose not to inform the staff about the incident. The state agency was notified upon discovery. 2. Residents identified to be smokers were assessed for the presence of cigarette burns. 3. Inservice was given to the Nursing Staff about the facility policy of writing Incident/occurrence reports. The inservice Also emphasized the importance of Including consistent practice of documenting on both nurses progress notes and 24 hour report which would serve as a reminder to report occurrence as this to the State. 4. 24 hr. report will be reviewed daily for compliance monitoring and follow-up on corresponding occurrence report to be reported to the State as required. 5. 2/28/08 2. RESIDENT #21 1. Nursing Staff of the unit in question were inserviced by the Clin.Mgr about writing an occurrence report if/when an unusual incident occurred and to notify his/her immediate supervisor who can direct him/her to complete an occurrence report if ever there is a question whether to write one or not. The state agency was notified upon Discovery.	1/8/08 1/9/08 1/9/08 2/8/08 1/8/08 1/8/08 1/9/08

2. Medical records of the residents identified for behavior monitoring were audited for the same deficient practice. 1/8/08
3. Inservice was given to the Nursing Staff about the facility policy of writing Incident/occurrence reports. The inservice Also emphasized the importance of Including consistent practice of documenting on both nurses progress notes and 24 hour report which would serve as a reminder to report occurrence as this to the State. 2/8/08
4. 24 hr. report will be reviewed daily for compliance monitoring and follow-up on corresponding occurrence report to be reported to the State as required. 1/8/08
5. 2/28/08

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L 206	Continued From page 37 AM. When resident was not seen returning back to the unit, writer and CNA went in search for resident. Resident was found at 8 AM on 3rd floor in stable condition, was brought back to the unit and had [his/her] breakfast." A face-to-face interview was conducted with Employee #44 on January 9, 2008 at 1:00 PM. He/she stated. "We found the resident in the electrical closet at about 8:00 AM." A face-to-face interview was conducted with Employee #4 on January 9, 2008 at approximately 1:10 PM. He/she stated,"That room [electrical closet] should always be locked. I can't explain why it was unlocked that morning." The resident was concurrently being monitored every 15 minutes as a result of facility staff identifying him/her as an elopement risk. The elopement monitoring sheets for November 26, 2007 for 7:00 AM, 7:15 AM, and 7:30 AM are signed with the notation of"eating breakfast" and initiated. The three (3) entries are lined through. The entry for 7:45 AM has no location or initials. There is a line drawn through the entry slot for 7:45 AM. B. According to a nurse' s note dated December 8, 2007 at 11:00 PM,"Upon conducting my rounds, noted resident [Resident #21] in [Resident F3's] bed. Was told several occasions to go in [his/her] own bed. But [he/she] refused. Supervisor told [Resident #21] to go to [his/her] room and still [he/she] refused. [He/she] then got out of [Resident F3's] bed and they both sit in hallway. [Resident #21] was very agitated. Medication was offered to [him/her]. [He/she] refused ... [Physician notified]." Resident F3's roommate was in his/her bed at the time of this	L 206		

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L 206	Continued From page 38 occurrence. Resident #21's quarterly Minimum Data Set (MDS) assessment, completed October 19, 2007, was reviewed. He/she was coded for long and short-term memory problems and with moderately impaired cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS assessment completed August 8, 2007 included dementia. Telephone interviews were conducted with the CNAs assigned to be with Resident #21 with one-on-one monitoring. Both Employee #31 and Employee #40 stated that they did not recall the incident. A face-to-face interview was conducted on January 10, 2008 at 10:00 AM with Employee #25, who confirmed that an incident report was not sent to the state agency for either aforementioned incident. The record was reviewed January 9, 2008. 3. Facility staff failed to notify the state agency regarding Resident F3 who was found in bed with Resident #21. A face-to-face interview was conducted on January 10, 2008 at 8:30 AM with Employee #24. He/she stated,"I didn't do any follow-up[with the responsible party or the resident] because I didn't think this was a behavior issue [when Resident #21 was found in bed with Resident F3]. The two(2) residents have developed a friendship and I didn't think this was anything unusual." Resident F3's quarterly MDS assessment completed November 20, 2007 coded the	L 206	2B. RESIDENT #21 1. Nursing Staff of the unit in question were inserviced by the Clin.Mgr about writing an occurrence report if/when an unusual incident occurred and to notify his/her immediate supervisor who can direct him/her to complete an occurrence report if ever there is a question whether to write one or not. 2. Medical records of the residents identified for behavior monitoring were audited for the same deficient practice. 3. Inservice was given to the Nursing Staff about the facility policy of writing Incident/occurrence reports. The inservice Also emphasized the importance of Including consistent practice of document-ting on both nurses progress notes and 24 hour report which would serve as a reminder to report occurrence as this to the State. 4. 24 hr. report will be reviewed daily for compliance monitoring and follow-up on corresponding occurrence report to be reported to the State as required. 5. 2/28/08 3. RESIDENT F3 1. Nursing Staff of the unit in question were inserviced by the Clin.Mgr about writing an occurrence report if/when an unusual incident occurred and to notify his/her immediate supervisor who can direct him/her to complete an occurrence report if ever there is a question whether to write one or not. 2. Medical records of the residents identified for behavior monitoring were audited for the same deficient practice. 3. Inservice was given to the Nursing Staff about the facility policy of writing	1/8/08 1/8/08 2/8/08 1/8/08 1/8/08 1/8/08 2/8/08

Incident/occurrence reports. The inservice Also emphasized the importance of Including consistent practice of documenting on both nurses progress notes and 24 hour report which would serve as a reminder to report occurrence as this to the State.

4. 24 hr. report will be reviewed daily for compliance monitoring and follow-up on corresponding occurrence report to be reported to the State as required. 1/8/08
5. 2/28/08

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FORM APPROVED

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L 206	Continued From page 39 [illegible] daily decision-making (Section B). Disease [illegible] the MARs. A review of Resident F3 nurses' notes and social [illegible] notes revealed that there was no evidence [illegible] the medication cart, Employee #8 was asked to check the blister packs of the PRN Lorazepam [illegible] hours as needed for severe agitation." [illegible] 2008. 1 South [illegible] Lorazepam blister package for Resident F1 had 11 [illegible] the medication cart, the Employee #19 was asked to check the blister packs of the PRN Lorazepam [illegible] PRN Lorazepam was December 26, 2007. There was no documentation on the MAR that the	L 206	1. Medication occurrence report completed on all nursing units who were not able to account for usage of Lorazepam.: 1South, 2North, 3North. Pharmacy was notified. 2. The remaining 3 units : 1North, 2South, and 3South audited the use of their drug Lorazepam tablets for the same deficient practice. 3. Inservice was given to the License Staff about signing Lorazepam out as Controlled substance and be counted and accounted at the beginning and and end of the shift when counting Narcotics. 4. Compliance Monitoring will be reviewed by the Clinical Mgr/designee of each nursing unit. Monitoring outcomes will reported to the QA committee monthly. 5. 2/28/08	1/10/08 1/10/08 1/10/08 2/28/08

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L 206	Continued From page 41 The Lorazepam blister package for Resident JH6 had 19 of 30 tablets missing. The physicians order form for JH6 dated December 24, 2007, documented, "Lorazepam 1 mg tab po every 8 hours as needed for agitation." The order date on the medication label of the prn Lorazepam was October 25, 2007. There was no documentation on the MARs that the medication was administered to resident JH6 for October 2007, November 2007, December 2007 and January 2008. The Lorazepam blister package for Resident JH7 had three (3) of 30 tablets missing. The physician's order form for JH7 dated November 5, 2007, documented, "Lorazepam 1 mg tab po every 6 hours as needed for agitation " . The refill order date on the medication label of the prn Lorazepam was September 26, 2007. There was no documentation on the MARs that the medication was administered the resident JH7 for September 2007, October 2007, November 2007, December 2007 and January 2008. During a face-to-face interview, on January 10, 2008, at approximately 2:20 PM, Employee #29 acknowledged that there was no documentation of administration for Lorazepam tablets on the MARs.	L 206		
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:	L 214		

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L 214	Continued From page 42 Based on observations, staff interviews and record review for three (3) of 30 sampled residents and 28 supplemental residents, it was determined that facility staff failed to provide adequate supervision for two (2) residents who had multiple falls with subsequent injury, one (1) resident who sustained a burn, one (1) resident observed with burning pants, one (1) resident who was found in an electrical closet and in another resident's bed, 13 of 44 smokers found with smoking paraphernalia and nine (9) of 35 residents identified as elopement risks without pictures at the front door. Facility staff also failed to maintain a hazard free environment as evidenced by: missing eye guards from television antennas, oxygen tanks unsecured, and extension cords observed in residents rooms. Residents #10, S1, H1, 24, 21, C1, C2, C3, C4, C5, C6, C7, C8, C9, C10, C11, C12, C13, E1, E2, E3, E4, E5, E6, E7, E8, and E9. The findings include: 1.Facility staff failed to provide supervision for Resident #10 who had multiple falls with subsequent fracture of the right fibula. A review of the nurses' notes in Resident #10's medical record indicates: August 14, 2007 at 11:39 PM: "Resident was observed in [on] patio sitting on her buttocks next to wheel chair. No injury; Consult for therapy." August 31, 2007at 2:30 PM: "Resident was observed in a sitting position [on floor] in the bathroom; No injury" September 23, 2007 at 5:00 PM: "Resident fell	L 214	1. RESIDENT #10 1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee Meeting 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/28	1/15/08 1/31/08 2/28/08 2/28/08

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	095022	A. BUILDING _____ B. WING _____	01/14/2008

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L 214	Continued From page 43 outside on patio; X-ray reveals fracture Right Fibula; Resident Hospitalized; No consult for therapy." November 12, 2007 at 11:00 PM: "Resident was observed sitting on floor ...in her bathroom. No injury; Consult for therapy." November 21, 2007at 6:00 PM: "Resident observed on floor ...: No injury; No consult for therapy." "Risk Management: Fall: Interdisciplinary Care Plan," initiated 5/30/2006; Dates of falls indicated on care plan but no new interventions were added to care plan after multiple falls until September 24, 2007. Care plan #5: Resident at risk for falls initiated 9/24/2007 updated 11/12/07 and 11/21/07" No new interventions were added after falls on November 12 and November 21, 2007. The care plan was last reviewed January 4, 2008. A review of the Physical Therapy (PT) Notes in Resident # 10's medical record indicated: August 14, 2007: "Nursing to ensure seat belt is applied at all times." August 31, 2007: "R resident educated to call for assistance." September 23, 2007: "No consult for therapy." November16, 2007: "Pt. will require Velcro seat belt alarm ...nursing notified. " November 23, 2007: "Recommended for Pt. to use call light and wait for assist with transfer." Facility staff failed to obtain a physician's order for the use of a wheel chair alarm as recommended by Physical Therapy staff on November 16, 2007. A face-to-face interview with Employees #6 and	L 214		

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L 214	Continued From page 44 #15 was conducted on January 9, 2008 at 3:00 PM. After reviewing the record, Employees #6 and #15 acknowledged that facility staff failed to initiate new interventions for Resident # 10 after multiple falls. The record was reviewed January 9, 2008. 2. Facility staff failed to provide adequate supervision for Resident S1 who had multiple falls with subsequent injury. A review of Resident S1's record revealed the following nurses' notes: December 21, 2007 at 11:00 PM: " Resident found sitting on the floor beside [his/her] bed at 8 pm ....resident said [he/she] was trying to walk to the toilet, lost [his/her] balance and fell on [his/her] buttock ...Neurochecks initiated and within normal limits ..." January 7, 2008 at 8:30 AM: Resident found sitting upright in front of [his/her] wheelchair. No injury ..." January 9, 2008 at 12:30 PM: " Resident was observed on the floor in the shower at 9:20 AM in the shower room. Complained of pain. Was transferred to his room and fell again. PMD (private medical doctor) made aware ...x-rays ordered ..." January 9, 2008 at 11:00 PM: " ...X-ray results received with positive for fracture of 7th posterior left rib ..." According to the " Rehabilitation Screening" dated January 8, 2008, " Pt. (patient) currently functioning at baseline. Rec (recommend) self release seat belt. Therapist tightened both breaks. No skilled PT ordered at this time." A physician's telephone order was dated January 8, 2008 at 4:00 PM and directed, " Patient	L 214	2. RESIDENT #S1 1. The care plan of this resident was updated to include new goals and approaches to prevent further falls. 2. Medical records of all residents on the unit who had multiple falls were reviewed for updated goals and approaches to prevent further falls. Corrections were made if necessary. 3. An inservice was given to the nursing staff emphasizing the importance of reviewing and updating care plans with new goals and approaches for residents with multiple falls. Monitoring for compliance will be done by the Falls Review Committee at the weekly committee meeting. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/28	1/15/08 1/31/08 2/28/08 2/28/08

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L 214	Continued From page 45 screened from physical therapy. Therapist adjusted left and right brakes on w/c; rec self release seat belt." A face-to-face interview was conducted with Employee #13 on January 10, 2008 at 1:30 PM. He/she stated, " I found [Resident S1] in the shower room on Wednesday (January 9, 2008). There was no seat belt in the wheelchair. Another nurse and I assessed [him/her]. There was no complaint of pain. We took [Resident S1] back to the room and I wasn't even at the nursing station when [he/she] fell again." There was no evidence in the record that facility staff implemented additional monitoring of Resident S1 until the seat belt was applied. A face-to-face interview was conducted with Employee #5 on January 10, 2008 at 2:00 PM about the physician 's order regarding the implementation of a seat belt. Employee #5 stated, " The seat belt comes from the Rehab department or Central Supply. It should have been put on when it was ordered." The record was reviewed January 10, 2008. 3. Facility staff failed to adequately supervise Resident H1 who sustained burns to the back after the use of a heating pad. The review of the resident 's diagnoses at Section I, " Disease Diagnoses," on the admission (Minimum Data Set) MDS dated April 23, 2007 included Hypertension, Paraplegia, Depression, and Anemia. A nurse 's note dated October 16, 2007 at 3:00 PM indicated, " Resident alert and oriented x 3 and verbally responsive. No distress noted.	L 214	3. RESIDENT #H1 1. This resident was discharged from the facility to her own apartment in November 2007 with no lasting effects from this incident. 2. Nursing staff on all units checked each resident room to ensure that no unauthorized appliances were present. Family members and residents were educated about the use of appliances such as a heating pad without a physician's order and/or the facility's approval. 3. Inservice was given to all nursing staff about the use of such appliances at this facility. Emphasis was placed on the CNA's role in working with residents who produce such an appliance and the need to report it immediately to the charge nurse. All staff will monitor the resident rooms on an on-going basis to ensure compliance. Acknowledgement of this policy will begin through the admissions process. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08	11/30/07 1/31/08 2/28/08 2/28/08

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L 214	Continued From page 46 Resident was noted with multiple blisters (burns) on Lumbar (back). Resident stated, ' heating pad was given to him/her by his/her [family member] and the care giver put it on his/her back in the morning' Writer called unit manager to the resident's room. MD (medical doctor) notified and ordered to transfer resident to the nearest hospital for evaluation. Resident was transferred to the hospital." Nurse's note October 17, 2007 10:20 AM, Late entry for October 16, 2007, " Writer was notified and requested to come to resident's room. Writer assessed resident secondary to burns/blister to lower back from heating pad. Writer questioned resident about use of heating pad. Resident stated I asked [name] to put it on. CNA [name] stated complied with request. CNA stated that he/she did not turn the heating pad on. Resident sustained a large burn blister along with smaller multiple blisters surrounding the large blister. All blisters were intact. Cold cloth applied to reduce heat. Resident was later transferred to nearest ER for evaluation." Nurse's note October 16, 2007 11:30 PM, " ER called at 11:15 PM, charge nurse at ER stated that the resident was on his/her way back to the facility and that no treatment order was given as regards to the burn on the back. MD made aware of incident ... " Nurse's note October 17, 2007 11:00 PM, " Was unsuccessful in getting the heating pad. Pt. (patient) stated that it was his/her personal property ..." On October 20, 2007 the resident was seen by the primary physician who indicated, " Recent events described in nursing notes. Have blister	L 214		

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L 214	Continued From page 47 to lower back from her heating pad ... Skin burns are granulating, no evidence of infection." October 27, 2007 physician's note indicated, " Granulating well, no necrotic tissue; Continue Silvadene ..." November 5, 2007, physician's note indicated, " Pt. will be referred to plastic for evaluation of possible skin graft ..." November 12, 2007 physician's noted indicated," Pt. alert and comfortable ...Skin 1-2nd degree burns healing very well. No need for skin graft as per plastic surgery. Pt. ready for discharge Friday. Prescription written. Need to get a primary a physician." On January 10, 2007 at approximately 7:50 AM a face-to-face interview was conducted with Employee #23. He/she stated, " I was assigned to the resident and he/she asked me to pass her the heating pad The heating pad was at his/her bedside on the stand and I gave it to him/her. It was already plugged in the electrical outlet; he/she turned it on and put it on his/her shoulder. I went back to change him/her; I turned him/her and saw blisters on his/her back; I went to get the charge nurse. He/she had the heating pad before he/she came to this unit. On January 11, 2007 at approximately 3:25 PM a face-to-face interview was conducted with Employee #5 who indicated, " The heating pad was not known to me until it was bought to my attention. Staff came to change him/her and that is when the blisters were noted." On January 14, 2007 at approximately 8:00 AM a face- to- face interview was conducted with	L 214		

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L 214	Continued From page 48 Employee #4 who indicated, " all electrical appliances brought into the facility are to be checked by customer service, tagged and sent to maintenance for observation for safety and pest control. I was not aware of the resident's heating pad." Resident sustained burns to his/her back due to the use of a heating pad that was not cleared by facility staff for use and/or supervised by facility staff. The record was reviewed on January 9, 2007 4. Facility staff failed to adequately supervise Resident #24 who was previously observed by facility staff with burning clothing from a cigarette. At approximately 10:15 AM on January 11, 2008 one (1) cigarette butt was observed on the floor of Resident #24's room by the head of Bed A. Five (5) cigarettes were observed in a pack in the drawer of the resident 's bedside table and one (1) cigarette lighter was observed in the right pocket of the resident's pant. Employee #10 was present during these observations. A review of the record revealed a nurse's note dated November 18, 2007 at 3:00 PM which stated, " While resident was wheeling his/her wheel chair up the hallway toward the Nurses' Station small amount of smoke was noted coming from his/her lap... Cigarette was sitting on his/her lap burning his/her pants." A review of the care plan revealed an entry dated November 18, 2007 which stated " All smoking materials to be kept by customer service. Inspect resident 's skin, or clothing as well as furniture for signs of cigarette burns, an indication of unsafe smoking. Smoking apron to be applied by	L 214	4. RESIDENT #24 1. Inservice was given to the nursing staff about the Facility's smoking policy emphasizing the need to Supervise smokers while they smoke on the smoking patio. 2. The facility's Smoking Policy has been revised to Distinguish between dependent and independent smokers and their ability to smoke safely. Each Resident who smokes will be assessed for smoking safety upon admission and at least quarterly. No Resident is allowed to maintain matches on their Person however those who are deemed to be inde-Pendent smokers will be allowed to keep their tobacco products. A contract will be signed by Each resident deemed to be an independent and safe Smoker so to impose consequences for infractions of the policy. 3. Inservices will be given to all staff with the imple-mentation of the new smoking policy. Clinical Managers, Customer Service Representatives, Charge Nurses and CNAs will monitor the residents for safe smoking practices. 4. The DON and Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08	2/8/08 2/28/08 2/28/08 2/28/08

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L 214	Continued From page 49 customer service when on the patio." The care plan was reviewed on January 11, 2008. A face-to-face interview was conducted with Employee # 10 at approximately 10:00 AM on January 11, 2008. He/she stated that Resident # 24 was not permitted to have any smoking materials in his/her room. He/she added " His/her cigarettes and lighter are kept by customer service. They give him/her cigarettes and light them for him/her on the patio." 5. Facility staff failed to supervise Resident #21 who wandered into an electrical closet and was found in bed with Resident F3. A. Facility staff failed to supervise Resident #21 who wandered into an unlocked electrical closet on another floor and was found in bed with another resident. Review of Resident #21's record revealed the following nurse's note dated November 26, 2007 at 8:00 AM,"Resident observed sleeping in [his/her] room at 6 AM. At 6:30 AM resident observed sitting in the chair by... the nursing station. Resident was seen in the hallway (2 South) at 7 AM. When resident was not seen returning back to the unit, writer and CNA went in search for resident. Resident was found at 8 AM on 3rd floor in stable condition, was brought back to the unit and had [his/her] breakfast." A notation on the resident's care plan, "Elopement Risk" documented, "11/26/07 Wandered and found in elec equip room." A face-to-face interview was conducted with Employee #44 on January 9, 2008 at 1:00 PM. He/she stated. "We found the resident in the	L 214	5A. RESIDENT #21 1. This resident was found sitting on a chair with his legs propped up sleeping in a closet that housed stored items and an electrical transformer. Once he was returned to his unit, the door to that closet was locked so to avoid any future occurrence of the same sort. The resident was on a Q 15 minute monitoring schedule for elopement which was change to a 1:1 monitoring because of his propensity to wander. The nurse in charge of his care was counseled regarding adherence to the facility monitoring policy 2. All residents who were on a monitoring schedule for elopement were checked to ensure that their whereabouts were known and that the documentation on the monitoring sheets was accurate and up-to-date. 3. Inservices were given to all facility staff about the policy on Missing Residents with the emphasis that if the resident is not able to be found in 10 minutes then the policy is to be activated. Elopement and behavior monitoring sheets will be reviewed for completeness of assessment and signatures every shift by Charge Nurses, Clinical managers and House Supervisors to ensure compliance. 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08	11/26/07 11/26/07 2/9/08 2/28/08

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L 214	Continued From page 50 electrical closet at about 8:00 AM." A face-to-face interview was conducted with Employee #4 on January 9, 2008 at approximately 1:10 PM. He/she stated,"That room [electrical closet] should always be locked. I can't explain why it was unlocked that morning." The resident was concurrently being monitored every 15 minutes as a result of facility staff identifying him/her as an elopement risk. The elopement monitoring sheets for November 26, 2007 for 7:00 AM, 7:15 AM, and 7:30 AM were signed with the notation of "eating breakfast" and initialed. The three (3) entries were lined through. The entry for 7:45 AM had no location or initials. There was a line drawn through the entry slot for 7:45 AM. B. According to a nurse's note dated December 8, 2007 at 11:00 PM,"Upon conducting my rounds, noted resident [Resident #21] in [Resident F3's] bed. Was told several occasions to go in [his/her] own bed. But [he/she] refused. Supervisor told [Resident #21] to go to [his/her] room and still [he/she] refused. [He/she] then got out of [Resident F3's] bed and they both sat in hallway. [Resident #21] was very agitated. Medication was offered to [him/her]. [He/she] refused ... [Physician notified]." Resident F3's roommate was in his/her bed at the time of this occurrence. Resident #21's quarterly Minimum Data Set (MDS) assessment, completed October 19, 2007, was reviewed. He/she was coded for long and short-term memory problems and with moderately impaired cognitive skills for daily decision-making (Section B). Disease diagnoses (Section I) listed in the admission MDS	L 214	5B. RESIDENT #21 1. Resident #21 and Resident #F3 have developed a Close friendship since their admission to the facility. Although they are not married, they have the same Last names and they treat each other as their husband or wife. Resident #21 was lying next to Resident #F3 fully clothed and not engaged in any unusual or aberrant behavior. Resident #21 is closely monitored and has 1:1 supervision because of his propensity to wander. However, nurse in charge of his care was counseled regarding adherence to the facility monitoring policy 2. All residents who were on a monitoring schedule for elopement were checked to ensure that their whereabouts were known and that the documentation on the monitoring sheets was accurate and up-to-date. 11/26/07 3. Inservices were given to all facility staff about the policy on Missing Residents with the emphasis that if the resident is not able to be found in 10 minutes then the policy is to be activated. Elopement and behavior monitoring sheets will be reviewed for completeness of assessment and signatures every shift by Charge Nurses, Clinical managers and House Supervisors to ensure compliance. 2/9/08 4. The DON will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 2/28/08 5. 2/28/08	

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L 214	Continued From page 51 assessment completed August 8, 2007 included Dementia. Telephone interviews were conducted with the CNAs assigned to be with Resident #21 with one-on-one monitoring. Both Employee #31 and Employee #40 stated that they did not recall the incident. The record was reviewed January 9, 2008. 6. Facility staff failed to ensure that residents did not have smoking paraphernalia in their possession. A face-to-face interview was conducted on January 14, 2008 at 10:30 AM with Employee #11. He/she was asked if residents were allowed to carry smoking paraphernalia. Employee #11 stated, " No resident should have an incendiary device (matched or lighter). However, if a competent resident has carried their own cigarettes for 30 years we are not going to take them away." Employee #11 was asked if there was a list identifying the residents allowed to carry their own cigarettes. He/she stated no. Employee #25 compiled a list of residents who had incidents with smoking issues, including residents smoking in undesignated places, or found with cigarettes on their person. A face-to-face interview was conducted with Employee #38 on January 10, 2007 at 8:15 AM and Employee #39 on January 11, 2008 at 3:15 PM. Both employees monitor residents who smoke. Both employees were asked if there was a list of smokers allowed to keep their cigarettes and matches or lighter. Both employees stated	L 214	6. RESIDENTS #24, #C1, #C2, #C3, #C4, #C5, #C6, #C7, #C8, #C9, #C10, #C11, #C12, #C13 1. All residents cited at the time of the survey as Having tobacco products and matches/lighters have Been evaluated using the new smoking policy. Inappropriate storage of tobacco products and Matches/lighters have been addressed. Inservice was given to the nursing staff about the Facility's smoking policy emphasizing the need to Supervise smokers while they smoke on the smoking patio. 2. The facility's Smoking Policy has been revised to Distinguish between dependent and independent smokers and their ability to smoke safely. Each Resident who smokes will be assessed for smoking safety upon admission and at least quarterly. No Resident is allowed to maintain matches on their Person however those who are deemed to be inde-Pendent smokers will be allowed to keep their tobacco products. A contract will be signed by Each resident deemed to be an independent and safe Smoker so to impose consequences for infractions of the policy. 3. Inservices will be given to all staff with the imple-mentation of the new smoking policy. Clinical Managers, Customer Service Representatives, Charge Nurses and CNAs will monitor the residents for safe smoking practices. 4. The DON and Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08	2/28/08 2/28/08 2/28/08 2/28/08

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L 214	Continued From page 52 that they had no list identifying residents allowed to keep their smoking items. The above cited interviews initiated observations of all residents identified by facility staff as smokers. The observations were conducted on January 11, 2007 between 9:30 AM and 11:00 AM in the presence of Employees # 5, 6, 7, 8, 9 and 10. The following observations were made: Resident #24 -observed with a pack containing 5 cigarettes in bedside drawer, a butt on floor in the resident 's room and 1 lighter on person. According to the annual Minimum Data Set (MDS) assessment, the resident was coded in Section I,"Disease Diagnoses" for Dementia. Resident C1- 14 lighters and 24 books of matches were observed in the resident's room. According to the annual MDS completed July 6, 2007, the resident was coded for seizure disorder Section I. Resident C2 - 1 package of cigarettes and 1 lighter were observed on the resident. According to the annual MDS completed June 8, 2007, the resident was coded for Cerebrovascular Accident (CVA) and cataracts in Section I. Resident C3- 1 lighter was observed on the resident. According to the annual MDS completed March 21, 2007 in Section I, the resident was coded for Dementia. Resident C4 - 1 lighter observed on the resident. According to the admission MDS completed August 30, 3007, the resident was coded for Dementia in Section I. Resident C5- 1 lighter was observed on the	L 214		

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L 214	Continued From page 53 resident. According to the significant change MDS completed April 18, 2007, the resident was coded for a CVA in Section I. Resident C6- 1 package of cigarettes was observed in the resident's drawer. According to the significant change MDS completed September 7, 2007 coded the resident in Section I for seizure disorders. Resident C7 - 1 package of cigarettes was observed on the resident 's bedside tray. According to the annual MDS completed August 7, 2007, coded the resident in Section I for manic-depression. Resident C8 -1 lighter and a package of cigarettes were observed on resident's bedside table. According to the admission MDS completed April 10, 2007, the resident was coded in Section I for schizophrenia. Resident C9- 1 lighter and a package of cigarettes were observed on the resident. According to the annual MDS completed April 7, 2007, the resident was coded in Section I for schizophrenia. Resident C10- 1 lighter was observed in the resident's drawer with an empty package of cigarettes. According to the significant change MDS completed June 26, 2007, the resident was coded in Section I for CVA with hemiplegia/hemiparesis and seizure disorder. Resident C11- admitted to having lighter and cigarettes on person but refused to show them. According to the admission MDS completed May 11, 2007 the resident was coded in Section I for alcohol abuse.	L 214		

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L 214	Continued From page 54 Resident C12- Observed with 1 lighter on person. According to the annual MDS completed April 6, 2007 the resident was coded in Section I for schizophrenia. Resident C13 - Observed with 1 lighter and cigarettes on person. According to the significant change MDS completed November 5, 2007, the resident was coded in Section I for depression. Facility staff failed to adequately supervise residents who smoked. These observations led to an investigation of the facility's monitoring program for elopement risk residents. According to the"Elopement and Behavior Monitoring List" updated January 5, 2008, the facility identified 35 residents at risk for elopement. A prior intervention initiated by the facility was to place the resident's photograph at the points of exit. Additionally, the facility's policy,"Elopement Risk," Policy #1401023A.000, page 2, under item #4,"d. Photographs posted at the points of exit." The photographs for nine (9) of 35 residents identified as"at risk for elopement" were not placed at the front door. Six (6) photographs were in the binder but stacked upon each other and not immediately visible. The residents' photographs that were placed in a binder at the front door were reviewed and compared to the "Elopement and Behavior Monitoring List" dated January 5, 2008. Photographs for the following residents were not in the binder at the front door: E1, E2, E3, E4, E5, E6, E7, E8, and E9.	L 214	1. Photographs of the residents found at the time Of the survey not to have their pictures in the binder at the front desk have had their pictures taken and have been added to the binder. The desk use for Customer Service has no lock on any of the drawers. 1/31/08 2. An audit of all resident listed on the Elopement And Behavior Monitoring List was done and any Missing pictures were replaced if needed. 1/31/08 3. The Assistant Administrator and overseer of Customer Service will receive an updated Elopement And Behavior Monitoring List each week from Nursing to ensure all pictures are in place . 4. The Assistant Administrator will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 2/28/08 5. 2/28/08	

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L 214	Continued From page 55 The photograph binder was observed to be locked in the Customer Service Representative's (CSR) top desk drawer on January 11, 2008 at 8:55 AM. A face-to-face interview was conducted with the CSR at the front door on January 11, 2008 at 9:00 AM. He/she stated that the photograph binder was kept in the top drawer and that the top drawer was always locked. A face-to-face interview was conducted with Employee#11 on January 11, 2008 at 10:00 AM. He/she confirmed that all residents who were identified as an elopement risk had a picture at the front door. 7. Eye guards were observed missing off of television antennas in three (3) of 12 rooms on the third floor rooms- 319, 355 and 356 8. Oxygen tanks unsecured in the following areas: First floor- 1 North, one (1) of seven (7) oxygen tanks and the door was unlocked Second floor-2 North, two (2) of nine (9) oxygen tanks and the door unlocked 9. Extension cords were observed in rooms 222 and 245 in two (2) of 37 rooms observed. 10. Parallel bars in the Occupational Therapy room were observed unsecured to the base and moved back and forth when pushed. This observation was made on January 7, 2008 at 1:45 PM in the presence of Employee #35, who acknowledged the findings at the time of the observation.	L 214	7. Eye Guards 1. Eye guards were replaced immediately upon discovery. 2. All T.V.s with antennae were inspected for appropriate eye guards and changes were made where necessary. 3. The facility has changed from the use of "rabbit ear" telescoping type antennae to a wire antenna which connected directly to the antennae or cable hook-up. This is done at the expense of the facility to ensure compliance with providing a safe environment for residents. The Maintenance staff will continuously monitor antenna and other electrical equipment for safety. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 8. Oxygen Tanks 1. Any oxygen tanks found not to be properly secured at the time of the survey were secured immediately. 2. All oxygen tanks were evaluated to ensure that they were properly secured. 3. Maintenance Supervisors staff will continuously Monitor the safe storage of oxygen tanks during their Daily rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 9. Extension Cords 1. Domestic extension cords found at the time of the Survey were removed immediately. 2. An audit was done on all resident rooms for the Presence of like extension cords to ensure their Removal. 3. Maintenance Supervisors staff will continuously Monitor the safe storage of oxygen tanks during their Daily rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08	1/11/08 1/11/08 2/28/08 2/28/08 1/11/08 1/11/08 2/28/08 2/28/08 1/11/08 1/15/08 2/28/08 2/28/08

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L 214	Continued From page 56 11. It was observed that the cover of an electrical box located behind the steamer was not secure and electrical wires were exposed. this observation was made in the presence of Employee #2 who acknowledged the findings at the time of the observation on January 7, 2008 at 8:30 AM. 12. It was observed that water had accumulated under the steamer that spread to area where staff walked. This observation was made in the presence of Employee #2 who acknowledged the findings at the time of the observation on January 7, 2008 at 8:35 AM. Items #7 through #12 were observed in the presence of Employees #3, 4, and 26 during the environmental tour on January 7, 2008 between 8:30 AM and 11:30 AM. The findings were acknowledged by the aforementioned employees at the time of the observation. Based on observations during the survey period, it was determined that facility staff failed to provide a sanitary environment for residents as evidenced by the storage of soiled linen and trash bins in residents' tub and shower rooms. These observations were made in the presence of Employees #3, 4, and 13. The findings include: 1. The following was observed on January 7, 2008 from 7:15 AM to 7:45 AM in the residents' tub rooms:	L 214	10. Parallel Bars 1. The parallel bars cited at the time of the survey Have been removed from use. 2. New parallel bars have been ordered and Are expected to be delivered shortly. 3. Maintenance supervisor will check the safety of Therapy equipment during their preventative mainten-Ance rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 11. Electrical Box 1. The covered was secured immediately upon Discovery. 2. All other electrical box covers were reviewed to Ensure their covers were secured. 1/08 3. Maintenance Supervisors staff will continuously Monitor the proper functioning and repair of the electrical Boxes in the kitchen during their daily rounds and Their monthly preventative maintenance rounds. 4. The Director of Maintenance will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator and the Safety Committee which is chaired by the Assistant Administrator. 5. 2/28/08 12. Water under the Steamer 1. Water found accumulated under the steamer At the time of the survey was cleaned up and drip Pans were put in place to prevent further spillage. 2. All other equipment was evaluated to ensure that no water was accumulated underneath. 3. The cook involved was given a 1:1 inservice Regarding the use of drip pans in the steamer. The Nutritional Services Supervisors will monitor the Steamer on a daily basis to ensue compliance. 4. The Director of Nutritional Services will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/0	1/14/08 1/14/08 2/28/08 1/11/08 1/11/08 2/28/08 2/28/08 1/11/08 1/11/08 2/28/08

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L 214	Continued From page 57 2 North five (5) yellow bins for soiled linen and two (2) gray bins for trash. 2 South four (4) yellow bins and four (4) gray bins. 3 North five (5) yellow bins and two (2) gray bins. 3 South four (4) yellow bins and three (3) gray bins. 2. The following was observed on January 8, 2008 in the residents' tub rooms from 3:00 PM to 3:10 PM. 2 South six (6) yellow bins and two (2) gray bins, (four (4) of the yellow bins contained) soiled linen. 2 North six (6) yellow bins and three (3) gray bins (three (3) of the yellow bins contained soiled linen). 3. The following was observed on January 14, 2008 from 8:25 AM to 8:35 AM in the residents' tub room: 3 North six (6) yellow bins and three (3) gray bins, (1) gray bin contained trash. 3 South six (6) yellow bins and three (3) gray bins with trash. According to the 2001 Edition of Guidelines For Design and Construction Of Hospital And Health Care Facilities: 8.2.C6. Soiled utility or soiled holding room. This shall contain a clinical sink or equivalent flushing rim fixture with a rinsing hose or bedpan sanitizer, handwashing station, soiled linen receptacles, and waste receptacles in number and type as required by the functional	L 214	1. The facility will make some slight modifications on each one of the nursing units which will allow the storage of large bins currently used for soiled laundry to be stored in a separate room. 2. Storage of trash and medical waste will continue to be in the Soiled Utility Room. All soiled laundry and trash will be monitored for frequent collection to avoid unnecessary odors or clutter. 3. The Director of Maintenance and the Director of Environmental Services will partner to ensure the Swift conversion of these rooms for the storage of the bins that hold the soiled laundry. Once the conversion is completed, they will monitor on an on-going basis for the proper storage of these bins. 4. The Director of Maintenance and the Director Of Environmental Services will report their finding on	2/28/08 1/09/08 2/28/08

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L 214	Continued From page 58 program. On January 7, 2008 at approximately 7:45 AM, a face-to-face interview was conducted with Employee #13. He/she acknowledged the storage of the bins in the tub room. He/she indicated that the bins were used for soiled linen and trash, and were emptied at the end of each shift in preparation for the on-coming staff.	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 survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by: soiled ceiling tiles and floors, odors, and dryers with accumulated lint. The environmental tour was conducted on January 7, 2008 from 8:30 AM to 11:30 AM in the presence of Employees # 3, 4 and 26. Additionally, odors were detected during the survey period. The findings include: 1. Soiled ceiling tiles in the following areas: First floor- Room 111 bathroom, in one (1) of five (5) rooms observed. Second floor- Rooms 222, 227, 229, 244, 245,	L 410		

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L 410	Continued From page 59 2N and 2S clinical storage areas, and 2N hallway restroom in eight (8) of 17 rooms observed. Third floor-Rooms 331, 356 and the 3N training bathroom in thee (3) of 14 rooms observed. 2. Soiled floors were observed behind the washers in the laundry room. During a tour of the laundry on January 18, 2008 at 8:30 AM, it was observed that the floor behind the washers was soiled with accumulated dust and debris. This was observed in the presence of Employee #3, who acknowledged the finding at the time of the observation. 3. Urine, fecal, body and/or smoke odors were detected during the survey period in the following areas: First floor urine odors were detected as follows: First floor elevators at 6:55 AM on January 7, 2008 Rooms 111 and 118 on January 7, 2008 at approximately 8:15 AM. Resident #2 on January 9, 2008 at 12:45 PM. Resident A2 on January 10, 2008 at 8:30 AM. 1N hallway between rooms 118 and 148 on January 11, 2008 at 10:30 AM. Smoke odors were detected as follows: First floor dining room on January 7, 2008 at 8:30 AM, January 8, 2008 at 9:45 AM and 2:05 PM, January 9, 2008 at 3:40 PM and 6: 24 PM,	L 410	1. Ceiling Tiles 1. All ceiling tiles noted as soiled at the time of the survey have been replaced. 2. All ceiling tile has been evaluated and replaced where necessary. 3. The Maintenance supervisors will closely monitor the condition of the ceiling tiles to ensure compliance. 4. The Director of Maintenance will oversee the monitoring efforts and report his findings to the QA Committee which is chaired by the Administrator. 5. 2/28/08 2. Soiled floors behind washers 1. Floors behind the washers noted as soiled with debris at the time of the survey have been cleaned. 2. All floors of the laundry area were evaluated and cleaned to ensure compliance. 3. The Environmental Supervisors will conduct frequent monitoring rounds to ensure the cleanliness of the laundry area. 4. The Director of Environmental Services will oversee the monitoring efforts and report her findings to the QA Committee which is chaired by the Administrator. 5. 2/28/08 3. Odors 1. Odors noticed at the time of the survey were dealt With appropriately and eradicated. 2. Other areas of the facility were checked for odors And none were present. 3. An upgrade of filters for the HVAC systems have Been ordered for the dining rooms to assist in the Elimination of the smoke odors from the 1st floor Smoking patio. Inservices are scheduled regarding The reporting of and the eradicating any odors re-Lated to patient care and services. The Clinical Managers, Supervisors and Department Heads will monitor for the presence of odors on an on-going basis. 4. The DON and Maintenance Director will report on the performance monitoring and any action plans for improvement to the QA Committee which is chaired by the Administrator 5. 2/28/08	1/15/08 1/31/08 2/28/08 2/28/08 1/11/08 1/11/08 2/28/08 2/28/08 1/10/08 1/10/08 2/15/08 2/28/08 2/28/08

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L 410	Continued From page 60 January 10, 2008 at 10:23 AM, and January 11, 2008 at 9:10 AM and 3:05 PM. Second floor urine odors were detected as follows: Rooms 213, 243, 255 and 259 on January 7, 2008 during the initial tour between 8:30 AM and 10:00 AM. Room 204 on January 10, 2008 at 12:25 PM. Room 211 on January 10, 2008 at 7:30 AM, and room 259 on January 7, 2008 at 11:15 AM Third floor- Room 301 on January 8, 2008 at 3:00 PM, and January 10, 2008 at 11:30 AM, room 359 on January 7, 2008 at 9:30 AM, room 355 on January 9, 2008 at 10:00 AM, and the multipurpose room on January 7, 2008 at approximately 2:50 PM 4. Two (2) of two (2) dryers in the laundry room were observed with accumulated lint in the lint traps. On January 7, 2008 at 11:30 AM, it was observed that according to the monitoring sheets attached to each dryer, the lint trap in Dryer A was last cleaned on January 3, 2008 at 10:30 PM. The lint trap to Dryer B was last cleaned on January 4, 2008 at 10:00 PM. A face-to-face interview was conducted with Employee #3, present during the observation. Employee #3 stated, "The lint traps should be cleaned every two hours everyday." The above findings were acknowledged by Employees # 3, 4 and 26 at the time of the observations.	L 410	4. Lint in the dryers 1. Lint in the dryers noted at the time of the survey was removed upon discovery. 2. All dryers were assessed for accumulated lint to ensure safety and compliance. 3. The entire laundry staff was inserviced on the cleaning and recording of cleaning time of the dryers. The supervisors will monitor the lint screens on to ensure compliance. 4. The Director of Environmental Services will ensure that the monitoring of the dryers for lint accumulation is done on an on-going basis and will report her findings to the QA Committee which is chaired by the Administrator. 5. 2/28/08	1/10/08 1/10/08 2/28/08 2/28/08