

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2010
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019
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L 000	Initial Comments A Licensure survey was conducted on April 19 through 16, 2010. The deficiencies are based on observation, record review and resident and staff interview for 30 sampled residents based on a census of 267 residents on the first day of survey. Additionally, there were 24 supplemental residents.	L 000	Deanwood Rehabilitation Wellness Center makes its best efforts to operate in substantial compliance with both Federal and State Law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth alleged or the validity of the conditions set forth on the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by federal and state law.	
L 035	3207.10 Nursing Facilities Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician. This Statute is not met as evidenced by: Based on record review and interview for two (2) of 30 sampled residents, it was determined the Facility staff failed to include tracheostomy care in the total plan of care for one (1) resident and to follow through with a request for a specialty consultation for another. Residents #12 and 18. The findings include: 1. The physician failed to include tracheostomy care in the total plan of care for Resident #12. Resident #12 was admitted to the facility on March 17, 2010. A review of the resident's clinical record revealed the following: The resident had an annual "Health & Physical" assessment of March 19, 2010 that documented that the resident was status post tracheostomy.	L 035		

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William D. Page
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director
TITLE
(X6) DATE
6/21/10

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L 035	Continued From page 1 Resident #12 had an "Admission Minimum Data Set" [MDS] completed on March 26, 2010, that coded the resident at Item P1j, "Special Treatment and Procedures" for tracheostomy care. The resident was observed in bed on April 20, 2010 at approximately 10:00 AM, with the tracheostomy in place. He/she expressed desire to have the tracheostomy discontinued. Resident #12's "Physician's order" form signed and dated by the physician on April 1, 2010 failed to include tracheostomy care. The physician failed to include tracheostomy care in the total plan of care for Resident #12. A face-to-face interview was conducted with Employee #3 on April 22, 2010 at approximately 4:00 PM, after reviewing the resident's clinical record, he she acknowledged the above findings. He/she obtained a telephone order from the physician for tracheostomy care and suctioning. The record was reviewed April 22, 2010. 2. A review of the clinical record for Resident #18 revealed that the physician failed to follow through with a request for a vascular surgery consultation. According to the history and physical examination dated October 23, 2009, Resident #18 ' s diagnoses included hypertension, dementia, osteoarthritis, status post hip fracture with hemiarthroplasty and hypoalbuminemia. An arterial study (ultrasound) of the right lower extremity dated December 4, 2009 revealed mild	L 035	1) Medical Doctor reviewed and revised resident #12 to included tracheotomy in monthly review. Resident #18 Lovenox was D/C on 5/27 2) All residents with tracheotomy were reviewed by Medical Director and Director of Nursing for compliance with Medical Director orders and exclusion on Medical Director Documentation. Director of Nursing along with the Medical Director prepared a list of all residents receiving Lovenox to assess if vascular follow up was completed as recommended and for continued use of Lovenox. 3) All appropriate licenses staff will Be re-educated on MDS orders required for care tracheotomy residents. Medical Director will In-service and review with attending Medical Doctor requirements of documentation. Medical Director will review policy procedure for continued Lovenox administration. Medical Director will in-service attending Medical Doctor to same.	6/18/10 6/30/10 7/15/10

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L 035	Continued From page 2 To moderate arterial occlusive disease in the right leg. A physician's telephone order dated February 15, 2010 directed the administration of Lovenox [anticoagulant] 0.3 milliliters subcutaneously daily "until seen by vascular surgeon." The clinical record lacked evidence that the physician initiated a consult request for an evaluation by the vascular surgeon. A review of the April 2010 Medication and Treatment Record revealed the resident's medication regimen included Lovenox. The physician failed to follow through on a request for a vascular surgery consultation as stipulated in the medication administration directive. The findings were reviewed and confirmed during an interview with Employee #6 on April 20, 2010 at 11:30 AM.	L 035	4) The Director of Nursing has Developed an audit tool to assess for completeness of Tracheotomy orders and Medical Doctor documentation. All negative findings will be immediate addressed by the Medical Director. All findings will be submitted to the Medical Director for follow-up and recommendation. The Medical Director has developed and audit tool to monitor residents receiving Lovenox. Any negative findings will be corrected by Medical Director and brought to the attention of the residents attending Medical Doctor. QI's will be done weekly X4weeks than monthly and thereafter by recommendation of QI committee.	7/23/10
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	L 051		

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L 051	<p>Continued From page 3</p> <p>Them as needed;</p> <p>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e)Supervising and evaluating each nursing employee on the unit; and</p> <p>(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:</p> <p>Based on record review and staff interview for six (10) of 30 sampled and one (1) of 24 supplemental residents, it was determined that the Charge Nurse failed to develop a care plan for: One (1) resident that eloped; for one (1) resident with Diagnosis and treatment of diabetes; anticoagulant therapy for 1 (one) resident, chair coded as a restraint for 1 (one) resident, three (3) residents for side rails, and one (1) resident for Mental Retardation (MR);. failed to review and revise the comprehensive plans of care for visual impairment associated with blindness for one (1) resident; skin integrity for one (1) resident; impaired memory for one (1) resident; and falls, smoking, skin integrity, pain, psychotropic medication, advanced directives, seizures and cardiac output for one (1) resident; and failed to notify the physician that one (1) resident did not receive dialysis treatment as ordered. Residents #1, 3, 4, 9, 10, 13, 19, 24, 26, 28, and M1.</p> <p>The findings include:</p> <p>1. The Charge Nurse failed to initiate a care plan with goals and initiatives for the use of side rails for Resident #1.</p>	L 051	<p>1) Side rail assessment was completed. Resident #1 to assess for continued use of ¼ rail, side rail bed is to encourage resident to assist in turning and positioning activity. The care plan updated to reflect. Same Resident # 9 MDS was corrected for chair that prevents rising, correction submitted. Resident does not have or does not use side rail. Assessment completed to evaluate continued use of ¼ rails. Resident participates in T&P act and uses ¼ side rail as evaluated for ADL task. Resident #13 was re-assessed for side rails. Resident utilizes rails as they are available to assist in T&P activity. Care plan was amended to Include side rails. Resident #19 is discharged from the facility. Resident #3 care plan was updated to include blindness. Resident #10 care plan was revised for alteration in skin integrity. Resident #26 care plan was updated and revised. Resident #28 care plan was reviewed, revised and updated to include but not limited to smoking, side effects psychotropic drugs use full code, alteration in skin integrity and seizure disorder.</p> <p>2) All residents identified as potential risk for elopement. All resident in the elopement risk. Care Plans and 6/30/10 interventions for those resident and risk be reviewed and revised to assure compliance with facility P&P. This shall include but not limited to wander guard, photo identification and security book is current with photos of potential elopements.</p>	6/18/10

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L 051	<p>Continued From page 4</p> <p>A review of Resident #1's clinical record revealed that there was no care plan for the resident's use of side rails on the record. The resident was observed in bed daily April 19 through April 23, 2010. Elevated rails were in use on both sides of the bed at each observation.</p> <p>A face-to-face interview was conducted with Employee #7 at approximately 2:00PM on April 22, 2010. He/she acknowledged that the rails were elevated but said he/she did not write a care plan because the rails are not used as a restraint but to assist the resident in turning and positioning while in bed. The record was reviewed on April 19, 2010.</p> <p>2. The Charge Nurse failed to review and update a plan of care for visual impairment associated with blindness for Resident #3.</p> <p>According to the quarterly Minimum Data set (MDS) completed, " March 8, 2010 Section D1 Vision is coded four (4) for severely impaired - no vision or sees only light, colors, or shapes, eye do not appear to follow objects."</p> <p>According to the History and Physical dated "March 20, 2010 Resident #3 has a working diagnosis of Blindness."</p> <p>Review of the clinical record overflow records revealed a care plan with a date and problem onset as 12/14/2009 (December 14, 2009) for alteration in vision r/t (related to) visual impairment associated with blindness.</p> <p>A face-to-face interview was conducted on April 23, 2010 with Employees #7 and 8 at approximately 12:15 PM. After review of the clinical record they acknowledged that the record</p>	L 051	<p>All resident's utilization side rails were re-assessed for continued use as enable for turning and positing, and care planned accordingly.</p> <p>3) All staff & Department Heads will be re-educated to facility policy procedure for elopement risk, as well as notification procedure where identified. Director of Nursing will review and revise P&P accordingly. All staff shall be in-serviced. Any changes were required all residents will continue to be assessed for elopement potential and but not limited to admission. Quality and significant change.</p> <p>4) The Director of Nursing has developed a audit tool to monitor compliance with facility elopement P&P. All admissions and re-admissions will be included in audit sample. Audit will be completed weekly sample audit will be completed monthly.</p>	<p>7/15/10</p> <p>7/23/10 on-going</p>

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L 051	<p>Continued From page 5</p> <p>Lacked evidence of further documentation for a care plan for visual impairment for Resident # 3. The record was reviewed on April 23, 2010.</p> <p>3. The Charge Nurse failed to notify the physician that the resident did not receive dialysis treatment as per the physician's order Resident # 4</p> <p>A review of the resident's clinical record revealed a 'Physician's order' form signed and dated March 1, 2010 and April 1, 2010, directed "Dialysis every Tuesday, Thursday, and Saturday".</p> <p>A review of the resident's clinical record revealed a March 30, 2010 "Progress notes" that stated: "...Resident OOB [Out of bed] on the geri chair for dialysis but finally refused to attend, all attempts failed. RP called and left message to call back, social worker and supervisor notified, dialysis notified ..."</p> <p>March 30, 2010 at 9:00PM, "...RP called back at 5:10PM and resident rescheduled for dialysis at 2:00 PM tomorrow 3/31/2010 ..."</p> <p>A further review of the resident's clinical record lacked documented evidence that the physician was notified that the resident did not receive dialysis treatment as ordered for Tuesday March 30, 2010.</p> <p>A face-to-face interview was conducted with Employee # 9 on April 23, 2010 at approximately 2:00PM. After reviewing the resident's clinical record, he/she acknowledged the above findings. The record was reviewed April 23, 2010.</p>	L 051			

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L 051	<p>Continued From page 6</p> <p>4. The Charge Nurse failed to initiate care plans with goals and objectives for (a) the use of side rails and (b) for the use of a chair that prevents the resident from rising for Resident #9.</p> <p>(A) The resident was observed lying in bed with both side rails elevated. A review of the care plans on the clinical record revealed that the record lacked a care plan for the use of side rails when in bed.</p> <p>A face-to-face interview was conducted with Employee #6 at approximately 2:30PM on April 23, 2010. He/she acknowledged that the record lacked a care plan for the use of side rails. The record was reviewed on April 21, 2010.</p> <p>(B) The Charge Nurse failed to initiate a care plan with goals and objectives for the use of a chair that prevented the resident from rising for Resident #9.</p> <p>A review of the resident's clinical record revealed a quarterly Minimum Data Set (MDS) with a completion date of March 10, 2010. The MDS was coded with a zero in all areas of Section P4a, b, c and d (Devices and Restraints) except P4e (Chair prevents rising) which was coded with a two (2).</p> <p>A face-to-face interview was conducted with Employee #6 at approximately 2:30PM on April 23, 2010. He/she acknowledged that the record lacked a care plan for the use of a chair as a restraint (that prevents the resident from rising). The record was reviewed on April 21, 2010.</p> <p>5. The Charge Nurse failed to revise the skin integrity plan of care for Resident #10.</p>	L 051			

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L 051	<p>Continued From page 7</p> <p>Actual skin breakdown related to surgical wound was identified as a problem for Resident #10.</p> <p>A review of the clinical record revealed a stage II pressure sore was identified and treated on March 25, 2010.</p> <p>The plan of care for "Actual Skin Breakdown", most recently reviewed April 2, 2010, lacked evidence of revisions to include the stage II pressure sore identified on March 25, 2010. The record was reviewed April 21, 2010.</p> <p>6. The Charge Nurse failed to initiate care plans with goals and objectives for (a) the use of side rails for Resident #13.</p> <p>At approximately 10:00AM on April 23, 2010 the resident was observed lying in bed with the upper rails elevated on both sides of the bed. Employee #6 was present during the observation.</p> <p>A review of the resident's care plans on the clinical record failed to reveal a care plan for the use of side rails.</p> <p>A face-to-face interview was conducted with Employee #6 at approximately 3:00PM on April 23, 2010. He/she acknowledged that the side rails on the bed were elevated and that no care plan was initiated for the use of the side rails. The record was reviewed on April 23, 2010.</p> <p>7. The Charge Nurse failed to develop a care plan for a Resident #19 with elopement behaviors.</p> <p>Facility Policy 2.4, "Elopement Prevention &</p>	L 051		

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L 051	<p>Continued From page 8</p> <p>Management "revised 09/07, stipulated: "Procedure: 1. Evaluate all residents/patients on admission for risk of elopement. All new admissions that are at risk for elopement will have interventions put in place immediately until further assessment is complete. Interventions include but are not limited to: Environmental modifications to prevent undetected exit (doors alarms, wander alerts) increased frequency of ' resident location ' rounds ... 2. Obtain a current photograph of resident/patients identified for risk elopement. 3. Complete the Elopement Risk alert (FSE 3-2-1)...5. Develop the care plan with input from the interdisciplinary team and the resident/patient and family/legal representative..."</p> <p>A Social Progress note dated March 9, 2010 at 3:00 PM read, "...Resident says [he/she] will sign out tomorrow and go to the [named] ShelterSecurity notified of possible elopement risk.</p> <p>A Social Progress Note dated March 9, 2010 at 3:30 PM read, "Met with resident due to alcohol use, resident denied using alcohol ...redirect resident to room, resident stated [he/she] wanted leave tomorrow but is unable to live with family members ...security to obtain resident's picture to safeguard for elopement risk ..."</p> <p>An "Incident/Accident Report dated April 8, 2010 revealed Resident #19 left the facility without authorization.</p> <p>The following nurse's notes detail the unauthorized departure:</p> <p>April 8, 2010 at 5:45 PM "called to unit at 5:15 PM. Informed that resident last seen on unit at 1:30 PM (after) charge nurse administered medications... "</p>	L 051		

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L 051	<p>Continued From page 9</p> <p>April 8, 2010 at 7:00 PM " ...Evening C.N.A (Certified Nursing Assistant) stated resident is not in [his/her] room ...called to safety to know if resident is at lobby, reply no ...called to Employee #35 to know if having a meeting ...resident can't be found ...code 13 called [elopement management] .. "</p> <p>April 8, 2010 at 6:10PM, " received phone call from CNA who had gone out in search of resident ...informed that CNA found him/her [at local park away from facility] at 6:05 PM ..."</p> <p>The resident's whereabouts were unknown for a period of approximately five (5) hours, from 1:30 PM through 6:30 PM on April 8, 2010.</p> <p>Observations during the survey period of the facility's Security Division lacked evidence that Resident #19 was identified as an elopement risk. There was no picture of the resident and no elopement risk alert [form] as per the aforementioned facility policy.</p> <p>The clinical record revealed the resident exhibited elopement risk behaviors and was a potential elopement risk as evidenced by documentation in the social progress notes and admission assessments.</p> <p>The record lacked evidence that facility staff implemented a care plan with interventions directed toward minimizing the resident's risk of elopement. Additionally, there was no evidence that an elopement risk assessment was conducted at the time of admission as per facility policy.</p> <p>A face-to-face interview was conducted on April</p>	L 051		

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L 051	<p>Continued From page 10</p> <p>22, 2010 with Employee # 12 at approximately 1:40 PM. After review of the clinical record he/she acknowledged that the resident did not have an elopement screen completed prior to the elopement.</p> <p>The findings were reviewed and acknowledged by interviews with Employees #1, 2 and 3 on April 23, 2010 at approximately 4:30 PM.</p> <p>The Charge Nurse failed to develop a care plan with goals and approaches for Resident #19 to prevent unauthorized departure from the facility. The record was reviewed April 23, 2010.</p> <p>8. The Charge Nurse failed to initiate a care plan for mental retardation for Resident # 24.</p> <p>A review of the resident's clinical record revealed the followings:</p> <p>A "History and Physical" signed and dated by the physician on July 30, 2009 that included mental retardation in the "Chief complains" and "Working diagnosis."</p> <p>"Social Progress Notes" that stated that care plan conference was conducted on October 22, 2009, January 14, 2010 and April 15, 2010.</p> <p>Quarterly Minimum Data Set (MDS) assessments completed on August 12, 2009 and October 16, 2009 and a significant change in status assessment completed on January 11, 2010 included Mental Retardation as a diagnosis in Item I3 "Other Current Diagnosis and ICD-9 Codes".</p> <p>A further review of the resident's clinical record revealed that a care plan was not initiated for</p>	L 051		

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L 051	<p>Continued From page 11</p> <p>Mental retardation.</p> <p>The Charge Nurse failed to initiate mental retardation care plan for Resident #24.</p> <p>A face-to-face interview was conducted with Employee #10 on April 23, 2010 at approximately 12:30PM, after reviewing the resident's clinical record he/she acknowledged the above findings. The record was reviewed April 23, 2010.</p> <p>9. A review of the clinical record for Resident #26 revealed facility staff failed to revise the care plan as it relates to memory.</p> <p>Impaired memory, short/long term memory problem and impaired decision making was identified as a problem for Resident #26 at the time of admission September 21, 2009. The care plan was most recently revised March 4, 2010 and continued impaired memory as a problem.</p> <p>A review of the quarterly Minimum Data Set [MDS] completed March 11, 2010 and interview with Resident #26 lacked evidence of a current memory problem.</p> <p>The findings were reviewed and confirmed with Employee #10 on April 22, 2010 at 3:00 PM. H/she stated the resident was no longer identified with impaired memory. The record was reviewed on April 22, 2010.</p> <p>10. A. The Charge Nurse failed to initiate a care plan with goals and approaches for Resident #28 with a diagnosis of Diabetes Mellitus II.</p> <p>The History and Physical signed and completed on November 13, 2009, revealed, "Chief</p>	L 051			

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L 051	<p>Continued From page 12</p> <p>Complaint: ...1. CVA (Cerebral Vascular Accident) 2. Depressive Disorder, 3. Gout, 4. Hyperlipidemia, 5. HTN (Hypertension), and DM II (Diabetes Mellitus II) ..."</p> <p>According to the physician's order sheet signed and dated April 2, 2010 directed, "Novolog Insulin 100 units vial inject sq (subcutaneous) per sliding scale. Check b/s (blood sugars) 3 times daily before meal ..."</p> <p>A review of the clinical record lacked evidence that a care plan was initiated with goals and approaches for Resident #28 for Diabetes Mellitus II.</p> <p>A face-to-face interview was conducted on April 23, 2010 at 12:10 PM with Employee #11. He/she acknowledged that there was no care plan developed for goals and approaches for the diagnosis of Diabetes Mellitus II. The record was reviewed on April 23, 2010.</p> <p>9. B The Charge nurse failed to review and revise multiple care plans for Resident #28.</p> <p>A review of the care plans revealed the following: Fall Risk Identification-had no date of implementation, Smoking- last updated December 10, 2009, Altered Cardiac Output, and Alteration in Comfort R/T (related to) Acute Pain Episodes -was last reviewed/revised November 13, 2009; Potential for Side Effects from Psychotropic Drug Use, Full Code, Risk for Alteration in Skin Integrity R/T Continuous Itching over Areas of Body, and Seizure Disorder - were last reviewed/revised November 12, 2009.</p> <p>There was no evidence that the aforementioned care plans had been reviewed or revised after the</p>	L 051		

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L 051	<p>Continued From page 13</p> <p>quarterly assessment last completed February 2, 2010.</p> <p>A face-to-face interview was conducted on April 23, 2010 at 12:10 PM with Employee #11. He/she acknowledged that the aforementioned care plans were not reviewed and revised after the last assessment. The record was reviewed on April 23, 2010.</p> <p>10. Facility staff failed to initiate a care plan for the potential adverse interactions for the use of Anticoagulant medications for Resident M1.</p> <p>A review of Resident #M1's April 2010 Medication Administration Record and "Physician Admission Orders and Plan of Care " signed and dated April 4, 2010 by Physician revealed a medication order that reads " Heparin 5000 units subcutaneously (3) three times a day until patient is able to ambulate independently " .</p> <p>There was no care plan for the potential adverse interactions for the use of Heparin medications found in the resident #M1's clinical records.</p> <p>A face-to-face interview was conducted with Employee #9 on April 21, 2010 at approximately 11:45 AM. He/she acknowledged that the care plan was not initiated. The record was reviewed on April 21, 2010.</p>	L 051		
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and</p>	L 052		

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L 052	Continued From page 14 rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral care; and (j) Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by:	L 052	1) Resident #2 medical doctor was notified with regards to missing stool for quaic. No further orders resident #2's dialysis communication sheet is reviewed by the unit manager daily, prior to dialysis and post dialysis. Resident # 2's acetaminophen order has been clarified with physician for indication of use. Resident #6 TAR have been reviewed for any continued omission; none identified. Resident #6's MAR and pain assessment documentations were reviewed for omission and clarifications of omissions. No other deficiency identified. Resident # 14 may weights are 150.6 lbs. No significant weight variation was identified by the Director of Nursing. Resident #28 incident report was completed and on-sight counseling and in-service was provided. Speech evaluation has been completed. Resident #30 incident medication error form was completed and staff of question was in-service. Resident's Resident # 19 is no longer a resident of Deanwood. Resident in the community, discharged to the community on 5/8/10. Resident #22, K1, K2 were inspected by Director of Rehab and Director of Engineering. Any and all areas requiring repairs were immediately repaired.	6/18/10

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L 052	<p>Continued From page 15</p> <p>This Statute is not met as evidenced by: Based on observation, record review and staff interview for Seven (7) of 30 sampled residents and three (3) supplemental residents, it was determined that the facility failed to provide sufficient nursing time to: obtain stool testing, perform clinical assessments and clarify physician ' s orders for one (1) resident; to perform a wound treatment, pre-medicate for pain prior to wound treatments and verify a weight variance greater than 5 pounds for one (1) resident; adequately supervise one (1) resident who eloped; provide an environment free of accident hazards as evidenced by three (3) residents with wheelchairs in a state of disrepair; to administer Amoxicillin and follow up on an order to be seen by Speech Language Pathology for one (1) Resident; administer Clindamycin for one (1) resident; and administer Vitamin D in accordance with physician ' s orders for one (1) resident; Residents #2, 6, 14, 19, 22, 28, 30, K1, K2 and M3</p> <p>The findings include:</p> <p>1. A review of the clinical record for Resident #2 revealed that the facility staff failed to provide sufficient nursing time to obtain stool testing, perform clinical assessments and clarify physician ' s orders.</p> <p>A. Resident #2 ' s diagnoses included end stage renal disease with hemodialysis, atrial fibrillation, lower extremity weakness, coronary artery disease, sacral decubitus and clostridium difficile.</p> <p>Physician's orders dated March 13, 2010 directed "stool guaiac daily X3."</p> <p>A review of the activities of daily living care record</p>	L 052	<p>2) All residents May weights were re-evaluated by the chief clinical Registered Dietician for variances requiring re-weights. Director of Rehab reviewed all outstanding requests for speech and language for screens and evaluations. All April and May's MARs were reviewed by the Director of Nursing/ designee for omission is any identified, a medication error report was completed and Medical Doctor made aware. To assure all residents at risk for elopement are assess for elopement risk. All resident will re-evaluate assess for potential for elopement, Potential Resident that were identified for elopement. QI nurse will review compliance with facility policy and procedure.</p> <p>a) Wander guard b) ID Photo c) Create a bright color ID Badge d) Current list of elopement resident at the nursing station, and at security booth.</p> <p>Director of Engineering and Rehab reviewed all resident wheelchairs for repairs. All wheelchairs requiring repairs were repaired wheelchairs parts ordered.</p>	7/7/10

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L 052	<p>Continued From page 16</p> <p>for March and April 2010 revealed Resident #2's bowel elimination was regular.</p> <p>The record lacked evidence of stool guaiac testing as per physician's orders.</p> <p>Licensed staff failed to act on a physician's order for stool testing. The findings were reviewed and confirmed during an interview with Employee #6 on April 19, 2010 at approximately 2:30 PM.</p> <p>B. Resident #2 ' s record revealed facility staff failed to consistently conduct pre/post hemodialysis assessments in accordance with facility policy.</p> <p>The facility's policy entitled Residents Receiving Dialysis stipulated " weights will be done prior to and after dialysis by dialysis staff. If resident is mechanically lifted, the weight is obtained by the unit staff prior to and after treatment ...unit nurses will complete Pre-dialysis section of dialysis communication ...upon return licensed nurses will assess resident and document findings on Post Dialysis section of communication sheet ... "</p> <p>Resident #2's diagnosis included end stage renal disease and he/she received hemodialysis on Mondays, Wednesdays and Fridays.</p> <p>A review of the dialysis communication sheets for the month of April 2010 revealed facility staff inconsistently assessed vital signs and weights before and after hemodialysis treatments. The spaces designated for documenting weights and/or blood pressure assessments on the dialysis communication forms were left blank and/or inaccurate.</p>	L 052	<p>3) All appropriate staff will be re-educated to monitoring diagnostic testing, obtaining completed medication orders pertaining to pain medication and completion of dialysis communication sheets. Unit managers and charge nurses will be responsible for noting and signing completed dialysis communication sheet. All pain medication orders will be reviewed and counter signed by RN supervisors and monitored for completeness. Director of Nursing has developed a Guaic tracking sheet to monitored pending orders. Supervisors will review Tracking sheets during routine rounds. Incoming and off going Nursing Staff will review MARs together to assess for charting omissions. Nursing Supervisors will review all new admission, elopement assessment and potential for elopement times 72 hours post admission. Director of Engineering has developed a plan program to evaluate wheelchairs for any needed repair.</p>	7/14/10

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L 052	<p>Continued From page 17</p> <p>Facility staff failed to fully assess Resident #2 before and after hemodialysis treatments as evidenced by the absence of consistent weight and/or blood pressure assessments. The record was reviewed April 19, 2010.</p> <p>C. A review of the clinical record for Resident #2 revealed facility staff failed to clarify a prn (as needed) physician ' s order.</p> <p>Physician ' s orders dated April 3, 2010 directed " acetaminophen 325mg, 2 tablets by mouth every 6 hours as needed. "</p> <p>The order lacked evidence of an indication for use of the acetaminophen. There was no evidence that licensed staff queried the physician to clarify the order.</p> <p>The above findings were reviewed and confirmed during an interview with Employee #6 on April 19, 2010 at approximately 2:30 PM.</p> <p>2. Facility staff failed to provide sufficient nursing time to perform a wound treatment, pre-medicate for pain prior to wound treatments and administer Vitamin D in accordance with physician ' s orders for Resident #6.</p> <p>According to the history and physical examination dated December 20, 2009, the resident ' s diagnoses included hypertension, anemia, pelvic and perianal abscesses, seizure disorder and cancer.</p> <p>A. Physician' s orders dated March 10, 2010 directed for the administration of wet to dry wound treatments to multiple surgical wounds on the resident ' s ischium and iliac crest daily and as needed.</p>	L 052	<p>4) A QA tracking tool had been developed by the Director of Nursing and the Administrator to monitor compliance in pain medication orders, guaic test monitoring, and dialysis communication document for completeness. These audits shall be completed weekly X 4weeks, monthly X 3months and quarterly there after. All negative findings shall be reported to the Director of Nursing for immediate follow-ups. All findings shall be reported to the QI Committee for recommendations and follow-ups. QI Nurse along with the Administrator will develop order tool to track elopement assessment and to ensure compliance with facility and procedure. Director of Engineering has developed a QI tool to monitor prior wheelchair to assure all wheelchairs are in proper repair wheelchair. QI shall be on-going, all results will be reported to QI community for follow up recommendation monthly as scheduled.</p>	7/23/10	

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L 052	<p>Continued From page 18</p> <p>A review of the Treatment Administration Record [TAR] for April 2010 revealed the wound treatments were omitted April 13, 2010 as evidenced by encircled initials annotating an omission. The record lacked evidence of an explanation related to the omission of the wound treatment.</p> <p>Licensed staff failed to administer a wound treatment in accordance with physician's orders.</p> <p>The findings were reviewed and confirmed during an interview with Employee #11 on April 22, 2010 at approximately 12:30 PM.</p> <p>B. Licensed staff failed to provide sufficient nursing time to administer medications for pain management in accordance with physician's orders for Resident #6.</p> <p>A Physician's order dated March 10, 2010 directed " Percocet 5/325mg, 2 tablets by mouth 30 minutes before wound dressing " [pain management].</p> <p>A review of the Medication Administration Record [MAR] for April 2010 revealed Percocet was not administered prior to wound treatments on April 9th - 12th and 17th - 19th 2010.</p> <p>Additionally, Percocet was documented as administered on April 13, 2010, however; the record lacked evidence that wound treatment was administered on April 13th.</p> <p>The record lacked evidence of an explanation related to the reason for the omissions.</p> <p>A face-to-face interview was conducted with</p>	L 052			

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L 052	<p>Continued From page 19</p> <p>Employee #11 on April 22, 2010 at 12:30 PM. In response to query regarding the omission of the Percocet, h/she responded that the resident refused medications on occasions. H/she acknowledged that refusal of medication would warrant correlating documentation.</p> <p>Licensed staff failed to administer medications for pain management in accordance with physician's orders. The record was reviewed April 22, 2010.</p> <p>3. A review of the clinical record for Resident #14 revealed facility staff failed to provide sufficient nursing time to verify a weight variance greater than 5 pounds in accordance with facility policy.</p> <p>According to facility 's nutrition services manual, policy #4-10-2 " Weight Process " revised June 2009, " ...reweigh resident immediately if weight change is exhibited as follows: under 100 pounds, +/- 3 pounds; over 100 pounds, +/- 5 pounds.</p> <p>According to the clinical record, the resident's weight history was documented as follows:</p> <p>January 2010 159.7 pounds February 2010 165.0 pounds March 2010 157.6 pounds April 2010 150.0 pounds</p> <p>There was a weight variance [greater or lesser] of 5 pounds or more between the periods of January thru April 2010 without evidence of verification per reweight.</p> <p>The record lacked evidence of a reassessment of the resident's weight as per facility policy. The findings were reviewed and confirmed during an</p>	L 052		

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L 052	<p>Continued From page 20</p> <p>interview with Employee #29 on April 19, 2010 at 2:00 PM.</p> <p>4. A review of the clinical record for Resident #19 revealed facility staff failed to provide sufficient nursing time to adequately supervise the resident so as to prevent elopement.</p> <p>Facility Policy 2.4, "Elopement Prevention & Management" revised 09/07, stipulated: "Procedure: 1. Evaluate all residents/patients on admission for risk of elopement. All new admissions that are at risk for elopement will have interventions put in place immediately until further assessment is complete. Interventions include but are not limited to: Environmental modifications to prevent undetected exit (doors alarms, wander alerts) increased frequency of ' resident location ' rounds ... 2. Obtain a current photograph of resident/patients identified for risk elopement. 3. Complete the Elopement Risk alert (FSE 3-2-1)...5. Develop the care plan with input from the interdisciplinary team and the resident/patient and family/legal representative..."</p> <p>Resident #19 was admitted to the facility December 4, 2009. According to the history and physical examination dated December 11, 2009, diagnoses included rheumatoid arthritis, depression, renal insufficiency, gastritis, clostridium difficile, colitis, endocarditis and hypertension.</p> <p>The nurse's admission Behavior Data Collection form dated December 4, 2010 revealed the resident exhibited "wandering on admission."</p> <p>The Social/Psychosocial Data Collection & Evaluation form dated December 10, 2009</p>	L 052		

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L 052	<p>Continued From page 21</p> <p>revealed Resident #19's relative [next of kin] reported that the resident's history included "ETOH [alcohol] abuse with passing out." He/She stated there was history of the resident walking away and people can't find [him/her] ..."</p> <p>A Social Progress note dated March 9, 2010 at 3:00 PM read, "...Resident says [he/she] will sign out tomorrow and go to the [named] ShelterSecurity notified of possible elopement risk.</p> <p>A Social Progress Note dated March 9, 2010 at 3:30 PM read, "Met with resident due to alcohol use, resident denied using alcohol ...redirected resident to room, resident stated [he/she] wanted leave tomorrow but is unable to live with family members ...security to obtain resident's picture to safeguard for elopement risk ..."</p> <p>An "Incident/Accident Report dated April 8, 2010 revealed Resident #19 left the facility without authorization.</p> <p>The following nurse's notes detail the unauthorized departure:</p> <p>April 8, 2010 at 5:45 PM "called to unit at 5:15 PM. Informed that resident last seen on unit at 1:30 PM (after) charge nurse administered medications... "</p> <p>April 8, 2010 at 7:00 PM " ...Evening C.N.A (Certified Nursing Assistant) stated resident is not in [his/her] room ...called to safety to know if resident is at lobby, reply no ...called to Employee #35 to know if having a meeting ...resident can't be found ...code 13 called [elopement management] .. "</p> <p>April 8, 2010 at 6:10PM, "received phone call</p>	L 052		

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L 052	<p>Continued From page 22</p> <p>from CNA who had gone out in search of resident ...informed that CNA found him/her [at local park away from facility] at 6:05 PM ..."</p> <p>The resident's whereabouts were unknown for a period of approximately five (5) hours, from 1:30 PM through 6:30 PM on April 8, 2010.</p> <p>Observations during the survey period of the facility's Security Division lacked evidence that Resident #19 was identified as an elopement risk. There was no picture of the resident and no elopement risk alert [form] as per the aforementioned facility policy.</p> <p>The clinical record revealed the resident exhibited elopement risk behaviors and was a potential elopement risk as evidenced by documentation in the social progress notes and admission assessments.</p> <p>The record lacked evidence that facility staff implemented interventions directed toward minimizing the resident's risk of elopement. Additionally, there was no evidence that an elopement risk assessment was conducted at the time of admission as per facility policy.</p> <p>A face-to-face interview was conducted on April 22, 2010 with Employee # 12 at approximately 1:40 PM. After review of the clinical record he/she acknowledged that the resident did not have an elopement screen completed prior to the elopement.</p> <p>The findings were reviewed and acknowledged by interviews with Employees #1, 2 and 3 on April 23, 2010 at approximately 4:30 PM.</p> <p>Facility staff failed to adequately supervise</p>	L 052		

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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 052	<p>Continued From page 23</p> <p>Resident #19 to prevent unauthorized departure from the facility. The record was reviewed April 23, 2010.</p> <p>5. Facility failed to provide sufficient nursing time to provide an environment free of accident hazards as evidenced by three (3) residents with wheelchairs in a state of disrepair.</p> <p>Three (3) of 10 wheelchairs observed during the survey period for Residents #22, K1 and K2 had inoperable brakes, broken or absent foot rests, torn/damaged arm rests and/or inadequate seating. The observations were reviewed and confirmed by Employee #18.</p> <p>6. The facility staff failed to provide sufficient nursing time to administer Amoxicillin and follow up on an order for Resident #28 to be seen by Speech Language Pathology in accordance with the physician ' s order.</p> <p>A. The facility staff failed to administer Amoxicillin in accordance with the physician's order.</p> <p>The telephone order [from the physician] dated April 14, 2010 at 9:00 AM directed, "Amoxicillin 500 mg po [by mouth] TID (three times daily) times 10 days for UTI (Urinary Tract Infection) " .</p> <p>A review of the April 2010 Medication Administration Record revealed that Amoxicillin was initialed [indicating that the medication was given] on April 16, 2010 at 0600, 1400 and 2200.</p> <p>There was no evidence that facility staff administered Amoxicillin on April 14 and 15, 2010 in accordance with the physician's order.</p> <p>A face-to-face interview was conducted on April</p>	L 052			

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L 052	<p>Continued From page 24</p> <p>23, 2010 at approximately 12:10 PM with Employee #11. He/she acknowledged that Amoxicillin was not administered on April 14 and 15, 2010 as ordered by the physician. The record was reviewed on April 23, 2010</p> <p>B. The facility staff failed to follow up on an order to be seen by Speech Language Pathology in accordance with the physician' s order for Resident #28.</p> <p>The telephone order [from the physician] dated March 25, 2010 at 2300 (11:00 PM) directed, "Schedule resident for SLP chewing and swallowing due to chewing difficulties " .</p> <p>A review of the medical record lacked evidence that the Speech and Language Pathologist had screened and/or evaluated Resident #28 at the time of the record review.</p> <p>A face-to-face interview was conducted on April 23, 2010 at approximately 12:10 PM with Employee #11. He/she acknowledged that no screen and/or an evaluation had been conducted by the Speech and Language Pathologist as ordered by the physician. The record was reviewed on April 23, 2010.</p> <p>7. Facility staff failed to provide sufficient nursing time to administer Clindamycin for Resident #30 in accordance with the physician' s order.</p> <p>The admission orders dated March 25, 2010 [no time indicated] directed, " Clindamycin 600 mg po [by mouth] Q8 hours (every eight hours) times 7 days for labia abscess " .</p> <p>A review of the April 2010 Medication Administration Record (MAR) revealed that</p>	L 052			

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L 052	<p>Continued From page 25</p> <p>Clindamycin was initialed and circled for three (3) doses on March 26, 2010 [indicating that the medication was not given] on March 26, 2010 at 0600, 1400 and 2200.</p> <p>The back of the April 2010 MAR revealed that on March 26, 2010 at 2200 the Clindamycin was on order and the pharmacy was called; and March 26, 2010 at 0600 the Clindamycin was on order.</p> <p>There was no evidence that facility staff administered Clindamycin on March 25 and 26, 2010 in accordance with the physician's order.</p> <p>A face-to-face interview was conducted on April 26, 2010 at approximately 8:50 AM with Employee #5. He/she acknowledged that the Clindamycin was not given as directed by the physician on March 25 and 26, 2010. The record was reviewed on April 26, 2010.</p> <p>8. Facility staff failed to provide sufficient nursing time to administer right dose of vitamin D3 medication per Physician's order for Resident #M3</p> <p>A review of resident # M3 clinical record revealed a "Physician's order that was signed and dated on March 12, 2010 on the physician ' s telephone order sheet that reads, " Vitamin D 2000 unit every day by mouth for low vitamin D".</p> <p>Review of resident #M3 Medication Administration Record [MAR] revealed physician order that reads " Vitamin D3 1,000 Unit tablet, (2) two tablets (2000 units) by mouth every day ".</p> <p>On April 22, 2010, at approximately 9:45 ARE,</p>	L 052			

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L 091	Continued From page 27 the entry door. At the completion of the catheter care, Employee # 35 took the trash to the dirty utility room. He/She did not wash his/her hands. He/she entered into Resident A1's room, opened the resident's closet and handed the resident a bottle of baby oil from the closet. Employee #35 returned to Resident #4's room without washing his/her hands. Facility staff failed to observe infection control practices after a suprapubic catheter change for Resident #4 and between providing care to different residents. A face-to-face interview was conducted with Employee #35 on April 22, 2010 at approximately 2:00PM. He she acknowledged the findings. He /she said, "I should not have gone into the resident's room and should have washed my hands after dumping the trash."	L 091			
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), and Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations that were made during a tour of the dietary services on April 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions: seven (7) of 13 vent covers were improperly secured, one (1) of one (1) prep sink was hanging off the wall, one (1) of three (3) temperature gauge on the warmer and one (1) of one (1) pressure gauge on the dishwasher	L 099	1) The seven hoods filters were placed On order. No other filters are located In kitchen. Cardboard was taken out to hold vent filters up. Engineering secured prep sink. Gage a temperature was put inside the unit. A dishwasher thermometer is being used for the final rinse. Employees was in-serviced on wearing gloves to prevent cross-contamination. All Dented cans was removed from the storage shelf's. All worn serving tray was removed. All Spice container was wiped down. Engineering immediately fixed the air Gap under the larger kettle and Dishwasher. All completes date Identified.	5/1/10	

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L 099	Continued From page 29 provided incorrect readings, two (2) of seven (7) staff members observed 200 b5280 destroyings food with bare hands and (9) of 17 damaged edges of food were not segregated, 280 of 280 residents serving trays were soiled damaged and 12 of 18 muffin trays were soiled and 18 of 18 muffin trays were soiled with grease deposits, two (2) of two (2) drain pipes extended into the drain in the kitchen floor was sealed five (5) of nine (9) therapeutic diet orders did not match physician's orders and four (4) of eight (8) ice machines were soiled. 10. The kitchen floor, specifically in the dishwashing area was soiled and damaged. 11. Seven (7) of 13 vent covers located above the grill and the fryers were held by pieces of cardboard to prevent them from falling off. 12. One (1) of one (1) prep sink was loose and detached from the wall located on 2 south, 4 north, 5 south and 5 north. 3. One (1) of three (3) temperature gauge on one of these ovens had a needle that was bent and the employee #14 acknowledged these findings. 4. One (1) of three (3) pressure gauges from the dishwasher fluctuated continuously and did not register correct pressure.	L 099	2) Seven hood Filters was placed on Order. Engineering secured prep Sink. All other sinks were inspected And none identified. A work order was placed on the food warmer temperature gage. The pressure gage. The pressure gage on dishwasher was placed on ordered and fixed April 25, 2010. An In-service was done on employees to insure prevention of cross contamination. All dented cans was identified and removed from storage shelf. All serving tray was inspected. 150 trays was removed from service. All spiced container was wiped down. In-service was given to employees. Engineers fixed the 2 areas of concern on the air gaps all sinks and equipment requiring air gaps was inspected. No other finding were identified. A contract/work order was put in to re-grout dish room floor. Staff was in-service on proper way of mopping and drying floor. The dietitian reviewed all diet orders and tray card tickets for accuracy of therapeutic diet orders and portion sizes.	5/1/10
L 410	Each facility's staff members were observed handling clean plates, utensils and serving food in an unsanitary manner, extending and in the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner (2) of three (3) dented cans of yellow peach slices, (2) of four (4) dented cans of sliced apple, three (3) of three (3) dented cans of grapeapple juice and two (2) of seven (7) cans of turkey gravy were not separated from undamaged cans of food in the storage area. Based on observations made during an environmental tour of the facility from April 20 thru April 26, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms including 15 of 64 marred doors and door jambs, six (6) of 12	L 410		

3) Director of Engineering has placed door and door jams on weekly maintenance rounds by tech. Director of Housekeeping has placed privacy curtains on daily housekeeping rounds. Housekeeping Director has re-educated all housekeeper staff to inspect for roach traps. Facility will notify residents and facility to educate them on the concerns of placing unauthorized roach traps in resident's rooms.

6/30/10

Director of Engineering has re-educated maintenance technician to notify director immediately for any issues regarding resident room bathrooms. Director has added bathrooms inspection on too room rounds. Medication carts have been placed on weekly cleaning scheduled by Director of Housekeeping.

- 4 Director of Engineering has developed a daily rounds for maintenance tech these rounds include but not limited to door and door jabs bathroom inspection. All abnormal findings will be immediately addressed by director. All abnormal findings will be reported to QI committee for recommendations and follow-up these rounds will be on-going. Director of Housekeeping has developed a daily rounds check for housekeeping to include been not limited to privacy curtains, inspection for roach traps, medication carts. Any abnormal findings will be referred to Director of Housekeeping for immediate follow-up. Any abnormal findings will be reported monthly to QI committee for follow-up and recommendation. These audits will on-going
- 7/23/10
on-going