Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 02/22/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECIALTY HOSPITAL OF WASHINGTON-HAD	4601 ML KING AVE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments An annual licensure survey was conducted February 20 through 22, 2007. The following deficiencies were based on record review, observations, and interviews with the facility staff and residents. The sample included 15 residents based on a census of 61 residents on the first day of survey and three (3) supplemental residents.	L 000	L036 same as F385 (1 2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Primary Physician and Medical Director were notified of the deficient practice. The primary care physician completed the H&P for resident #3 and #6.	
L 036	3207.11 Nursing Facilities Each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. This Statute is not met as evidenced by: Based on staff interview and record review for two (2) of 15 sampled residents, it was determined that the physician failed to: complete the annual history and physical assessment for two (2) residents. Residents #3 and 6. The findings include: 1. The physician failed to complete an annual history and physical examination for Resident #3. During the review of the resident's record the physician's orders signed and dated December 1, 2006 included, "H&P (History and Physical) every year November." The last history and physical examination form in the record was dated November 22, 2005. On February 22, 2006 at approximately 9:30 AM, a face-to-face interview was conducted with the RCC (Resident Care Coordinator) who	L 036	2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** An audit of all remaining residents charts were done to determine the presence of H&P's. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical Records will be reviewing monthly physician documentation for required H&P. Deficiency will be reported to Medical Director and Administrator. Physicians failing to comply within a timely manner will have privileges suspended immediately. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported by Medical Records staff at monthly QA meetings.	April 5, 2007

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kari Marie Guerra (signature) | TITLE: Administrator | (X6) DATE: 3/15/07

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L 036	Continued From page 1 acknowledged that a H&P was not in the record for November 2006. The record was reviewed on February 20, 2007. 2. The attending physician failed to complete an annual history and physical assessment for Resident #6. A review of the facility's policy "Medical Staff Attending Physician," Section K, documented, " Each resident shall have a medical examination and evaluation of his/her heath status at least every twelve months which shall be documented both in the appropriate History and Physical Form and the progress notes.. " A review of the clinical record for Resident #6 revealed a H&P examination dated January 26, 2006. There was no evidence of an annual history and physical (H&P) examination. for January 2007. A face-to-face interview was conducted with the Resident Care Coordinator on February 22, 2007 at 10:00 AM. He/she acknowledged that the H&P was not completed for January 2007. The record was reviewed on February 22, 2007.	L 036	L051 (1) same as F-309 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done for this incident as the resident never returned to the nursing facility. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Records of all residents receiving Dilantin level orders were reviewed on 2/24/07 to check if; results were in the record and if not results were obtained; results were reported to physician and orders carried out accordingly; appropriate documentation are recorded in the medical records of interventions if any. See attachment # 1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Medical records of future residents who will receive Dilantin with Dilantin level test order will be reviewed daily by licensed staff on the night shift. Review outcomes will be documented on the lab log sheet, see attachment #2.	
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	L 051	4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to the Administrator at daily standup meetings. Monthly compliance monitoring outcomes will b reported to QA committee by DON. See attachment #3.	April 5, 2007

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L 051	Continued From page 2 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 four (4) of 15 sampled residents and one (1) supplemental resident, it was determined that the charge nurse failed to follow up on a Dilantin level for one (1) resident who was subsequently diagnosed with Dilantin toxicity; ensure that a complete order was written for blood sugar monitoring and follow-up on the resident's request to decrease frequency of fingersticks and a report of feeling depressed for one (1) resident; initiate a care plan for aspiration precautions during meal time for one (1) resident; re-weigh one (1) resident who lost 48 pounds in one month; and ensure that a PT/INR was drawn as ordered by the physician. Residents #14, 1, 3, 6 and H1. The findings include: 1. The charge nurse failed to follow up on a Dilantin (Phenytoin) level result for Resident #14 who was subsequently admitted to the hospital with a diagnosis of Dilantin toxicity.	L 051		

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L 051	Continued From page 3 The physician's order sheet dated December 2006 directed, "Dilantin level every 3 months-March/June/Sept/Dec [original order dated September 8, 2006]." A review of the laboratory (lab) section of the record revealed that a Dilantin level was drawn on December 1, 2006. There was no evidence in the record that the results for the aforementioned Dilantin level were present at the time of this review. A face-to-face interview was conducted with the Resident Care Coordinator and the Director of Nursing on February 21, 2007 at 12:30 PM. After reviewing the record, they both acknowledged that there were no Dilantin level results. According to the following nurses' notes: February 7, 2007 at 2:00 PM "Physical therapist came up on the unit and stated that the resident was much weaker on the left side than yesterday in therapy. A call has been made to Doctor [name] to make [him/her] aware." February 7, 2007 at 8:00 PM, "Speech therapist expressed concern to writer about resident's weakness on the right side. This writer contacted Doctor [name] to convey concerns of weakness and decline in speech pattern. Doctor [name] ordered that resident be transferred to ER [emergency room] for evaluation of altered neurological status. Follow up call made to determine status... resident was taken to hospital [name] and admitted for Dilantin toxicity and dehydration." On February 21, 2007 at 4:15 PM the facility staff obtained the Dilantin results, drawn on December 1, 2006, at the request of the surveyor. The lab	L 051		

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L 051	Continued From page 4 report revealed a Dilantin result of 29.6 H [high], [normal range 10.0-20.0]. There was no evidence that facility staff followed up on the Dilantin level drawn on December 1, 2006. Subsequently, the resident was hospitalized with a diagnosis of Dilantin toxicity on February 7, 2007. The record was reviewed on February 21, 2007. 2. The charge nurse failed to ensure that a complete order was written for blood sugar monitoring and follow-up on Resident #1's request to decrease the frequency of fingersticks and the resident's statement of feeling depressed timely. A. A review of Resident #1's record revealed a physician's order dated June 6, 2006 and subsequently renewed every 30 days, with the most recent order signed February 2, 2007. The order directed, "Glucose finger stick every day at 6:00 AM." There was no direction from the physician regarding the action facility staff should take for the results of the finger stick. A review of the glucose monitoring record and the nurses' notes from June 2006 through February 2007, revealed that finger sticks ranged from 90 to 252. On November 13, 2006, the resident's fingerstick was 252 (Normal range is 60-120). There was no evidence that facility staff notified the physician of the elevated finger stick results. A face-to-face interview was conducted with the charge nurse on February 20, 2007 at 11:00 AM. The surveyor asked the nurse what action would be taken if the resident's fingerstick was below 60	L 051	L051 (2A) same as F-309 (2A) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The physician was notified and new order for finger stick was received and carried out for resident #1. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Medical records of all residents receiving finger sticks were reviewed for completeness of the orders (completeness of parameters). No other residents were found to be affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff on both units were in-serviced about receiving and carrying out complete physician orders. New monitoring tool created to track deficient practice. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Monitoring outcomes will be reported to Administrator at daily stand up meetings and monthly at QA committee meetings.	April 5, 2007

Revision 3/28/07 td

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L 051	Continued From page 5 or above 120. The nurse stated, "It is a nursing judgement to notify the physician." There was no evidence in the record that the resident experienced hypoglycemic or hyperglycemic reactions. The record was reviewed February 20, 2007. B. According to a nurse's note dated June 9, 2006 at 6:00 AM, "Resident stated, "I don't want my finger stick. I am not that bad a diabetic." Will have AM nurse call [physician] and see if daily BS [blood sugar] can be changed." There was no evidence that facility staff followed up on the resident's request. A review of the Medication Administration Record for June 2006 through February 2007 revealed that the resident had a finger stick done every morning at 6:00 AM A face-to-face interview with the RCC was conducted on February 20, 2007 at 11:30 AM. he /she stated, "I wasn't aware that the resident didn't want daily finger sticks. No one told me." C. According to a nurse's note dated June 19, 2006 at 3:45 PM, "Resident MD has been called to come and see resident because resident said [he/she] is depressed. MD promised to come and see resident tonight." There was no evidence that the physician saw the resident on June 19, 2006. There was no evidence that facility staff followed-up on the resident's statement of depression. The psychiatrist saw the resident on July 19, 2006. The resident was prescribed Zoloft for depression.	L 051	L051 same as F-309 (2B) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Physician was notified on 2/22/07 of resident #1s request. The physician did not change the order. The medical Director was notified and changed the order from daily to finger sticks every Monday and Friday. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on 3/5/07 of all nursing notes to ensure nursing staff follow-up of all residents request do occur. No other deficient practices were noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The RCC/designees will review resident's records in the respective units of evidence of documentation addressing follow up of resident's requests from the previous shifts daily. Identified deficient practices will be called to the attention of staff involved to correct immediately. Failure for staff compliance will result in progressive disciplinary action. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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L 051	Continued From page 5 or above 120. The nurse stated, "It is a nursing judgement to notify the physician." There was no evidence in the record that the resident experienced hypoglycemic or hyperglycemic reactions. The record was reviewed February 20, 2007. B. According to a nurse's note dated June 9, 2006 at 6:00 AM, "Resident stated, "I don't want my finger stick. I am not that bad a diabetic." Will have AM nurse call [physician] and see if daily BS [blood sugar] can be changed." There was no evidence that facility staff followed up on the resident's request. A review of the Medication Administration Record for June 2006 through February 2007 revealed that the resident had a finger stick done every morning at 6:00 AM A face-to-face interview with the RCC was conducted on February 20, 2007 at 11:30 AM. he /she stated, "I wasn't aware that the resident didn't want daily finger sticks. No one told me." C. According to a nurse's note dated June 19, 2006 at 3:45 PM, "Resident MD has been called to come and see resident because resident said [he/she] is depressed. MD promised to come and see resident tonight." There was no evidence that the physician saw the resident on June 19, 2006. There was no evidence that facility staff followed-up on the resident's statement of depression. The psychiatrist saw the resident on July 19, 2006. The resident was prescribed Zoloft for depression.	L 051	L051 (2B) same as F-309 (2B) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Physician was notified of resident #1s request. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on 3/5/07 of all nursing notes to ensure nursing staff follow-up of all residents request do occur. No other deficient practices were noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The RCC/designees will review resident's records in the respective units of evidence of documentation addressing follow up of resident's requests from the previous shifts daily. Identified deficient practices will be called to the attention of staff involved to correct immediately. Failure for staff compliance will result in progressive disciplinary action. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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L 051	Continued From page 5 or above 120. The nurse stated, "It is a nursing judgement to notify the physician." There was no evidence in the record that the resident experienced hypoglycemic or hyperglycemic reactions. The record was reviewed February 20, 2007. B. According to a nurse's note dated June 9, 2006 at 6:00 AM, "Resident stated, "I don't want my finger stick. I am not that bad a diabetic." Will have AM nurse call [physician] and see if daily BS [blood sugar] can be changed." There was no evidence that facility staff followed up on the resident's request. A review of the Medication Administration Record for June 2006 through February 2007 revealed that the resident had a finger stick done every morning at 6:00 AM A face-to-face interview with the RCC was conducted on February 20, 2007 at 11:30 AM. he /she stated, "I wasn't aware that the resident didn't want daily finger sticks. No one told me." C. According to a nurse's note dated June 19, 2006 at 3:45 PM, "Resident MD has been called to come and see resident because resident said [he/she] is depressed. MD promised to come and see resident tonight." There was no evidence that the physician saw the resident on June 19, 2006. There was no evidence that facility staff followed-up on the resident's statement of depression. The psychiatrist saw the resident on July 19, 2006. The resident was prescribed Zoloft for depression.	L 051	L051 (2C) same as F-309 (2C) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Psychiatrist was notified of the resident's request. The Psychiatrist saw the resident on March 3, 2007. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted to ensure resident's request to see Psychiatrist were followed. No other residents were found to have this deficient practice. All residents with the diagnosis of depression and /or verbalize feelings of sadness, anger, or depression documented in record were referred to the clinical social worker for intervention and/or follow-up with Psychiatrist as deemed appropriate. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** Nursing staff were in-serviced to report expressions of mood and behavior changes of their residents to team leaders for intervention/referral to social worker. A new QA tool was created see attachment #2. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcomes will be reported to DON daily and DON will report to Administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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L 051	Continued From page 6 A face-to-face interview was conducted with the RCC on February 20, 2007 at 11:35 AM. He/she stated, "The resident is on an antidepressant. The psychiatrist saw [him/her]" After reviewing the Resident's record, the RCC stated, "The psychiatrist didn't see the resident for about a month after [he/she] said [he/she] was depressed." The record was reviewed February 20, 2007. 3. The charge nurse failed to initiate a care plan for aspiration precautions during meal time for Resident #3. A review of Resident #3's record revealed a physician's orders dated December 12, 2006 that directed, "4 Gram Na (sodium) pureed diet with nectar thick [nectar thickened liquids]. Aspiration precautions require close supervision and assistance at meal time; elevate HOB (head of bed) to 90 degrees at meal time and one (1) hour after meals." The review of the resident's interdisciplinary care plan dated February 9, 2007 lacked a problem with goals and approaches for aspiration precautions during meal time. A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at approximately 9:30 AM who acknowledged that the resident's care plan lacked goals and approaches for aspiration precautions during meal time. The record was reviewed on February 20, 2007. 4. The charge nurse failed to re-weigh Resident # 6 after significant weight loss.	L 051	L051 (3) same as F279 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The care plan for resident #3 was reviewed and additional approaches for aspiration precautions were added and shared with the surveyor during the surveyor on 2/20/07, See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Audits of all resident's care plan that are on a puree diet were reviewed to include aspiration precautions. A tool was done on 2/20/07. See attachment #2. No other residents were found to have this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The interdisciplinary team was re-educated (2/23/07) on all components of the care plan. All residents who will be placed on a puree diet will include Aspiration precautions in their comprehensive care plans as the order for a puree diet is carried out by the nursing staff. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur. (i.e., what Quality Assurance Program will be put into place?** Monitoring for compliance will be conducted by the IDT weekly during care plan meeting. The RCC's will report all deficient practices to the DON and Administrator weekly and the monthly QA meeting for monitoring. See new QA tool attachment #3.	April 5, 2007

Recv'd Revision 3/06/07

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L 051	Continued From page 7 The annual Minimum Data Set assessment dated December 26, 2006 included the following diagnoses in Section I: Diabetes Mellitus, Congestive Heart Failure, Hypertension, Peripheral Vascular Disease, other Cardiovascular Disease, Arthritis, Allergies, Anemia and Renal Failure. According to the "Yearly Weight Chart" for Resident #6, the resident weighed: August 2, 2006 277# (pounds) September 1, 2006 229.2#. October 3, 2006 230# November 2, 2006 214#. There was an 18% weight change between August and September 2006 and 7% between October and November 2006. There was no evidence in the record that facility staff re-weighed the resident after the aforementioned weight loss. A face-to-face interview was conducted with the Resident Care Coordinator on February 20, 2007 at 4:00 PM. He/she stated, "When the weight loss is greater than five pounds we have to re-weight the resident. I don't know why the resident wasn't re-weighed at these times (September and November 2006). A face-to-face interview was conducted with the dietician on February 20, 2007 at 3:45 PM. He/she stated, "I did a lot of counseling with [Resident] at least two or three times a week in August, September, October and November. We talked about the carry out Chinese food that [he/she] ate and how important it was not to eat foods high in sodium because of [Resident's] edema. I informed the doctor of the resident's	L 051	L051 (4) same as F-309 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The resident was weighed on 2/20/06. Employee was counseled on the importance of weighing residents. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all remaining residents to ensure weights were being done and were correct. See attachment #1. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A newly created Weight committee began 3/7/07 to include dietary and nursing to commence monthly, see attached #2. Education of staff was conducted on 3/7/07. Weight Policy was updated to reflect weights to be done 1st thru the 5th of each month. Re-weights will be done when there is a difference of 2-4 lbs from 2 successive weights and will be done no later than the 6th of every month. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Wight committee will monitor staff compliance. Outcomes will be reported to DON and administrator daily at stand up meetings. All deficient practices will be tracked and monitored at monthly QA meetings.	April 5, 2007

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SPECIALTY HOSPITAL OF WASHINGTON-HAD	4601 ML KING AVE SW WASHINGTON, DC 20032

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L 051	Continued From page 8 condition and that I was counseling the resident at least twice a week. I talked at great length with the resident to eat only the food we provided here, not to eat the carry out food. [His/her] on-going weight loss is desired because of the resident's medical condition. [The Resident] doesn't have any more edema and the breathing is better." According to the facility's policy, SNS. 59 " Resident ' s Weight ": "If a variance of 2-4 lb exists between two successive weights a re-weight should be obtained and verified by the licensed nurse or designee and reported to the Charge Nurse and DON " and " Addressing Significant Weight Changes" states: "All residents with significant weight changes will be reweighed under the supervision of a licensed nurse within 48 hours." The above cited policy defines significant change as: 5% in one month 7.5% in three months and 10% in six months There was no evidence in the record that facility staff re-weighed the resident after weight losses. The record was reviewed February 20, 2007. 5. The charge nurse failed to ensure that a PT/INR level was drawn as ordered by the physician for Resident H1. A review of Resident H1's record revealed a physician's order dated February 8, 2007 that directed, "Increase Coumadin to 6mg daily via G-tube (gastrostomy tube) for pulmonary embolism ... Do PT/INR in one week when 6 mg Coumadin has been given for one week."	L 051	L051 (5) same as F-309 (4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively corrective action could not be done. On 2/22/07 blood was redrawn and found to be hemalized. Blood was redrawn on 2/23/07 and results were shared with physician and placed on resident's record. See attachment #1. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** A chart audit was conducted on all residents receiving Coumadin with a PT/INR ordered were reviewed for lab results and if they were in the record the MD was notified. No other residents were identified with this same deficient practice. See attachment #2. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The lab log was revised to include follow-up of results on tests ordered. This will be done by the licensed staff on the night shift on a daily basis. RCC will check logs on a daily basis. A dedicated fax line to receive lab reports from reference lab daily was installed. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC will report to DON and Administrator at daily stand up meeting. Outcomes monitoring will be reported to the QA committee monthly.	April 5, 2007

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L 051	Continued From page 9 There was no evidence in the record that the PT/INR was drawn on February 15, 2007. A face-to-face interview was conducted with the RCC on February 23, 2007 at 1:45 PM. He/she acknowledged that the PT/INR should have been drawn on February 15, 2007. The record was reviewed February 22, 2007.	L 051	L052 same as F324 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively no corrective action could be done as there was insufficient staff on the day the incident occurred. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice when the PPD falls below 3.5. The 24 hour nurse staffing rule was reviewed with staff to ensure that a minimum of PPD of 3.5 is achieved on a daily basis. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The DON is in the process of recruiting for PRN staff. A unit clerk position for weekends on both nursing units was approved to keep nurses from doing majority of administrative duties on weekends. On weekends /Holidays/ inclement weather days when there are call outs we have instituted an emergency bonus plan for nursing staff. See attached #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to DON and Administrator daily by RCC for immediate action and correction.	April 5, 2007
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;	L 052		

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L 052	Continued From page 10	L 052		

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:
Based on staff interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to ensure that Resident # 12 received adequate supervision. Resident #12 had a history of multiple falls with a subsequent injury.

The findings include:

A review of Resident #12's record revealed the following:

March 11, 2006 - found on the floor in room
August 8, 2006 - observed climbing over the side rails
October 15, 2006 - attempting to climb over side rails
October 28, 2006 - attempting to climb out of bed
November 12, 2006 - found on the floor
November 28, 2006 - found crawling on the floor

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L 052	Continued From page 11	L 052		

November 29, 2006 - attempted to get out of bed
February 3, 2007 - sitting on the floor
February 17, 2007 - found on the floor with swelling and complaint of pain to left wrist

An x-ray of the left wrist and arm was taken on February 18, 2007 and revealed a fracture of the left wrist.

According to the annual Minimum Data Set (MDS) assessment completed June 1, 2006 and the quarterly MDS assessment completed February 2 , 2007, the resident was coded in Section B for long and short term memory problems. The resident was coded in Section G as requiring limited or extensive assistance with all Activities of Daily Living.

A review of the care plan revealed that on March 12, 2006, facility staff initiated the approach of placing the resident across from the nurse's station when up in the geri chair. There was no evidence that facility staff implemented any additional approaches to prevent the resident from falling after March 12, 2006 and the resident had four (4) more falls. The last fall was on February 17, 2007; the resident fell out of the geri chair, onto the floor in the dayroom and fractured his/her left wrist.

A face-to-face interview was conducted on February 21, 2007 at 8:30 AM with the social worker, who responded to the resident's call for help the day his/her wrist was fractured.
The social worker stated, "I was doing some charting at the nurse's station. I heard someone calling for help in the dayroom. I saw [Resident # 12] lying on [his/her] left side on the floor. The geri chair was pushed up to a table and the resident's breakfast tray was in front of the geri

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L 052	Continued From page 12 chair. There were two nursing assistants working that day. I called for help and everyone came running into the day room." Nurse staffing for Saturday, February 17, 2007 during the day of the incident was 3.0 nursing hours per resident per day, below the DC requirement of 3.5 nursing hours per resident per day. A face-to-face interview was conducted with the Resident Care Coordinator on February 22, 2007 at 8:15 AM. He/she acknowledged that after reviewing the record, there were no interventions initiated after March 12, 2006 to prevent the resident from falling. The record was reviewed February 22, 2007.	L 052	L054 same as F-492 (4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Retrospectively no corrective action could be done as there was insufficient staff on the day the incident occurred. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this deficient practice when the PPD falls below 3.5. The 24 hour nurse staffing rule was reviewed with staff to ensure that a minimum of PPD of 3.5 is achieved on a daily basis. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The DON is in the process of recruiting, and interviewing for PRN staff. A unit clerk position for weekends on both nursing units was approved to keep nurses from doing majority of administrative duties on weekends. On weekends /Holidays/ inclement weather days when there are call outs we have instituted an emergency bonus plan for nursing staff. See attachment #1 from F-Tag 324. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to administration daily for on-going intervention, and immediate response.	
L 054	3211.3 Nursing Facilities To meet the requirements of subsection 3211.2, facilities of thirty (30) licensed occupied beds or more shall not include the Director of Nursing Services or any other nursing supervisor employee who is not providing direct resident care. This Statute is not met as evidenced by: Based on staff interviews and record review, it was determined that the facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day. The findings include: According to 22 DCMR 3211.3, Beginning no later that January 1, 2005, "Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day."	L 054		April 5, 2007

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L 054	Continued From page 13 The Nursing Daily Staffing Sheets were requested for February 17 through 20, 2007. The actual staffing schedules were reviewed with the Director of Nursing [DON] for February 17, 18, 19, and 20, 2007. Two (2) of the four (4) days reviewed, revealed that the actual staffing was less than 3.5 nursing hours per resident per day. The same days were reviewed again by the DON and the result of the staffing schedule indicated: February 17, 2007 3.0 February 18, 2007 3.25 Two (2) of the four (4) days revealed staffing below the required 3.5 nursing hours per resident per day. The staffing sheets/schedules were reviewed on February 22, 2007.	L 054	L083 same as F221 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The straight back chair was removed immediately on 2/20/07 and the CNA was instructed by RCC to stop the deficient practice. An assessment of the resident was done. It was determined that restraint is not necessary. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Rounds on all residents' room and day rooms were conducted on 2/20/07 to ensure that no other resident is being prevented from getting up by using straight back chairs. No other resident's were found to be affected by this deficient practice.	
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	L 083	3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All nursing staff was in-serviced on 2/28/07, 3/5/07, and 3/7/07 on the facility's restraint policy, which includes the types of restraints recognized by the facility. (Emphasis was placed on the use a straight back chair as a form of restraint as not acceptable practice). See attachment #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** RCC's will conduct daily rounds to monitor, and outcomes will be reported to DON and Administrator during daily Stand up meetings. Statistics will be reported to new monthly Quality Assurance meetings, ~~using new QA tool. See attachment~~ #2.	April 5, 2007

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L 083	Continued From page 14 the resident's condition. This Statute is not met as evidenced by: Based on observation, staff interview and record review for one (1) supplemental resident, it was determined that facility staff failed to assess Resident S1 for the use of a restraint. The findings include: During the initial tour, Resident S1 was observed on February 20, 2007 at 9:30 AM, sitting in his/her room in a geri chair with his/her feet resting on a straight back chair. A face-to-face interview was conducted immediately with a Certified Nurse Aide (CNA) regarding the positioning of Resident S1. The CNA stated, "I usually work nights. When [Resident S1] gets restless, we put him/her in the geri chair and put his/her feet on the other [straight back] chair to keep him/her from getting up. It's the only thing that works." The surveyor asked how long staff has been using this method. The CNA stated, "At least since Christmas." A review of the resident's record revealed that there was no assessment for the use of the straight back chair as a restraint. There was no evidence in the record that the use of the straight back chair was recognized by facility staff as a restraint. The record was reviewed February 22, 2007.	L 083	L099 (1, 2, 3 & 4) same as F371 (1,2,3,& 4) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All Chinaware, spoons, scoops, serving ladles, and hotel pans were thoroughly rewashed and checked by the supervisor prior to drying. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other chinaware, spoons, scoops, serving ladles and hotel pans were checked for cleanliness. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** New pots and pans, spoons, chinaware, scoops, serving ladels and hotel pans have been placed in the capital budget for purchase. Daily spot checks will be conducted by the Production Manager/Dietary Supervisor and a log book was created to track the daily monitoring on 3/27/07. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported to monthly Process Improvement and Quality Assurance.	April 5, 2007
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.	L 099		

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L 099	Continued From page 15 This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that dietary services were not adequate to ensure that foods were prepared and served in a safe and sanitary manner as evidenced by: soiled chinaware, spoons, ladles, hotel pans and cooking hood filters and an opening in the ceiling around the Ansul supply lines. These findings were observed in the presence of the Food Service Director. The findings include: 1. Leftover food particles were observed on the top and bottom surfaces of plates (chinaware) in 16 of 50 plate observations at 9:40 AM on February 20, 2007. 2. Spoons were not thoroughly cleaned of food residue after washing in 12 of 43 spoons observed at 9:45 AM on February 20, 2007. 3. Serving scoops and ladles in a rack near the tray line were soiled with food and debris on the inner and bottom surfaces in 5 of 14 scoops and ladles observed at approximately 12:15 PM on February 20, 2007. 4. Hotel pans (12x14x6 inches) were not thoroughly cleaned after washing. Food particles were observed on the inner and outer surfaces and pans were not allowed to dry before storing on racks in the dish room in five (5) of five (5) hotel pans observed at 3:30 PM on February 20, 2007. 5. The inner surfaces of cooking hood filters were soiled with accumulated grease, and dust over cooking areas in 20 of 20 hood filter observations at 9:00 AM on February 20, 2007.	L 099	L099 (5) same as F371 (5) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The inner surfaces of cooking hoods and filters soiled with accumulated grease and dust over cooking areas were cleaned immediately 2/23/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** 20/20 areas were checked and cleaned. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All hoods and filters will be checked bi-weekly for cleanliness by the Production Manager. Replacements and/or cleaning will be conducted at this time. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Dietary Production Manager will report any deficient practices to monthly Quality Assurance.	April 5, 2007

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L 099	Continued From page 16 6. An opening (14x8 inches) was observed in the ceiling adjacent to the cook's preparation around the Ansul supply lines in one (1) of one (1) ceiling observation at 9:30 AM on February 20, 2007.	L 099	L099 (6) same as F371 (6) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The opening around the ansul supply lines observed in the ceiling adjacent to the cooks preparation area was fixed immediately 2/22/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Rounds were conducted throughout the kitchen to ensure no other openings were present. No residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated on 2/26/07 as to reporting any and all items needing fixing or replacing. Environmental rounds will be done to include maintenance and housekeeping department weekly. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Outcome of rounds will be reported to Administration weekly, and monthly to EOC committee, Patient Safety Committee, Process Improvement and QA meetings.	April 5, 2007
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following : (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on staff interviews and record review, it was determined that the contract pharmacist failed to conduct an in-service as required by the District of Columbia regulations.	L 128		

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L 128	Continued From page 17 The findings include: According to 22 DCMR (District of Columbia Municipal Regulations) 3224.3(c), " The supervising pharmacist shall do the following: (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications. " On February 22, 2007, during a review of the consultant pharmacist in-service programs, it was determined that (2) two in-services were conducted in 2006: May 17, 2006, "Tuberculosis in The Elderly " and August 23, 2006, "Bacterial Pneumonia and the Elderly Nursing Home Resident ". Although (2) two in-service sessions were conducted, neither of these sessions included the required indications, contraindications and possible side effects of commonly used medications.	L 128	L128 same as F-492 (1) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** One of the in-services required were not conducted within the year although 2 in-services were done by the consultant pharmacist. No retrospective corrective action can be done. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** The Pharmacy was contacted in reference to the in-service not being conducted by the consultant pharmacist. No residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A new consultant pharmacist was requested by the Administrator to attend pharmacy meetings effective the next meeting April 5, 2007. The DON and the Administrator will track on an annual basis to ensure the required in-services are being given by the consultant pharmacists. Administrative QA tool was updated to reflect monitoring, see attachment #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Administrative QA tool will be utilized to track all findings, and will be reported to monthly QA Meetings.	April 5, 2007
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on staff interviews and record review, it was determined that facility staff failed to remove expired medications from the interim box. The findings include: 22 DCMR, 3227.12 stipulates, "Each expired medication shall be removed from usage." On February 20, 2007, at approximately 1:00 PM,	L 161		

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	095024	A. BUILDING ______ B. WING ______	02/22/2007

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L 161	Continued From page 18 the Narcotic Interim Box on 3 West was found to contain the following expired medications: 1. Roxicet 5mg / 325 mg tablet, Lot#557151A, Exp. January 20, 2007. 2. Morphine Sulfate 15 mg tablet, Lot# 8315051987, Exp. August 8, 2006. During a face-to-face interview with the Resident Care Coordinator (RCC) at approximately 1:15 PM on February 20, 2007, the expired medications were brought to his/her attention. The RCC stated, "I did not know that the medications were expired and will remove the medication from the box and destroy them".	L 161	L161 same as F-492 (2) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Expired drugs were immediately removed and destroyed according to regulatory requirements 2/20/07. The documentation was submitted to the contracted Pharmacy services who were informed of the deficient practice. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** In the presence of the surveyor the rest of the narcotics were inspected and no other expired narcotics were found. No other residents were affected by this deficient practice. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** The administrator requested a meeting to be conducted with the contracted pharmacy services on 3/16/07 to review consultant pharmacist responsibilities and pharmacy policy and procedure manual. A new consultant pharmacist was requested by the Administrator to attend pharmacy meetings effective the April 5, 2007. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** All deficient practices will be reported by RCC's to the DON and Administrator at monthly QA Meetings.	April 5, 2007
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to ensure that the environment was free from accident hazards as evidenced by one (1) resident's bed that prevented the door from closing and one (1) blanket observed on the floor in a resident's room. These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. During the environmental tour, an isolated observation at 2:40 PM on February 21, 2007, revealed that the position of Resident S3's bed in room 333 prevented the resident's door from	L 214		

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Health Regulation Administration

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L 214	Continued From page 19 closing. A face-to-face interview with facility staff touring with the surveyor was conducted immediately. Staff members indicated that the position of the bed had been a concern for many years. The resident refused to move the position of the bed. Resident S3 was interviewed on February 21, 2007 at 3:00 PM. After explanation by the surveyor of the concerns regarding the door, the resident agreed to position the bed to allow the door to close. 2. During the initial tour, at 9:30 AM on February 20, 2007, an isolated observation revealed a blanket on the floor near the bed of Resident S4 in room 324. The blanket was not secured and easily moved when touched. A face-to-face interview was conducted with the Resident Care Coordinator (RCC) who was touring with the surveyor. He/she stated, "[Resident] has had that down on the floor since Christmas. [Resident] complains the floor is cold. Housekeeping cleans the floor then put the blanket back down on it." The surveyor asked why the resident was using a blanket and not a rug with a non-skid backing. The RCC stated, " We'll replace that with a rug."	L 214	~~L214 (2) same as F323 (2)~~ 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident agreed to replace blanket with red rug with a non skid backing that was completed on 2/21/07. After discussion with all residents it was agreed by all residents to remove all rugs from resident's rooms. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All other resident's with rugs on room floors were evaluated for this deficient practice and the residents were informed that the rugs had to be removed. All residents agreed. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** All staff was educated as to the hazards of accident and the prevention of injury. Housekeeping and Maintenance Departments will be responsible for monitoring during weekly environmental rounds. A daily rounds check list was created for nursing staff also. See attachment #1. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** Maintenance and Housekeeping Supervisor will monitor the areas on a schedule and report any deficient practices weekly to the Administrator, and monthly to EOC committee, Patient Safety Committee, Process Improvement Committee, and Quality Assurance meeting.	April 5, 2007
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: During the environmental tour, it was determined	L 410		

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L 410	Continued From page 20 that housekeeping and maintenance services were not adequate to maintain the facility in a safe and sanitary manner, as evidenced by: marred and scarred straight back chairs, damaged walls and doors, stained ceiling tiles and a soiled shower stretcher. These observations were made in the presence of the Director of Maintenance, Housekeeping Supervisor and nursing staff. The findings include: 1. The arms and legs of straight back chairs in the 3 East dining room were marred and scarred in seven (7) of seven (7) chairs observed on February 21, 2007 at 2:00 PM. 2. Walls were observed to be damaged and scarred in the following areas: 3 East dayroom, rooms 301, 312, 316, 324 and 336 in six (6) of 18 walls observed from 2:00 PM until 3:30 PM on February 21, 2007. 3. Doors were observed damaged, marred, scarred or soiled in rooms 301, 318, 3 East dayroom and 3 East shower room in four (4) of 18 door observations from 2:00 PM through 3:30 PM on February 21, 2007. 4. Ceiling tiles were observed stained or damaged in rooms 301, 316, 343 and the 3 East dining room in four (4) of 18 ceiling tile observations from 2:00 PM through 3:30 PM on February 21, 2007. 5. The shower stretcher on unit 3 East was observed with residual soap on the underside of the bath mat and a grey substance on the flat plastic surface of the stretcher frame and underside of the mat in one (1) of two (2)	L 410	L410 (1,2,3,4 &5) same as F253 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The arms and legs of all 7 straight back chairs in 3East dining room were painted on 3/16/07. Damaged walls observed on 3East day room were all painted. Damaged doors observed in 3 east day room were painted on 3/6/07. 3 East shower stretchers and under mats were cleaned by housekeeping on 2/22/07. The stained ceiling tiles on 3East ding room were replaced on 3/5/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** Engineering and Housekeeping Department did environmental rounds and all other stained ceiling tiles were replaced, all damaged, scarred and marred, soiled doors, chairs, and walls were cleaned and painted. No other stretchers or under mats were dirty. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** New environmental rounds to be conducted weekly have been instituted to include housekeeping and maintenance department. A rounds checklist will be utilized to identify any damages or concerns in rooms. All findings will be reported to the Administrator. All findings will be fixed immediately. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** The Maintenance and Housekeeping Supervisor will do weekly rounds to commence 4/3/07; any deficient findings will be reported in monthly Environment of Care Committee, Process Improvement, and QA meeting.	April 5, 2007

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L 410	Continued From page 21 stretchers observed on February 22, 2007 at 2:10 PM.	L 410		
L 999	DC CODE This Statute is not met as evidenced by: Based on staff interviews and record review, it was determined that facility staff failed to obtain a criminal background check for two (2) employees before the date of hire. The findings include: According to the 22 DCMR 4701.2 "Each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Registry before employing or using the contract services of an unlicensed person." The review of personnel records for two (2) employees revealed that the employees were hired and allowed to work in the facility before a criminal background check was completed. A review of employee #1's personnel record [that was hired to work in administration] revealed a hire date of November 20, 2006. A review of employee #2's personnel record [that was hired as a Certified Nursing Assistant] revealed a hire date of December 15, 2006. On February 23 at approximately 11:00 AM, a face-to-face interview was conducted with the Human Resource representative who acknowledged the lack of the criminal background check prior to hire for employees'#1 and 2. He/she indicated that it was discovered	L 999	L999 same as F-492 (3) 1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Criminal background checks were obtained for both employees in question on 2/21/07. 2. **How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken?** All new hires for the past six months were reviewed to ensure that criminal background checks were completed prior to hire on 2/22/07. There were no other deficient practices noted. 3. **What measure will be put in place or what systemic changes you will make to ensure the deficient practice does not recur?** A concurrent audit tool utilized to ensure that all pre-employment requirements are met prior to hire date. All HR employees were educated as the regulatory requirements on 2/21/07. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what Quality Assurance Program will be put into place?** HR director will report any deficient practices noted after monthly audit to Process Improvement and QA meetings.	April 5, 2007

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L 999	Continued From page 22 during an audit that the employees were hired prior to the completion of the criminal background checks. The criminal background checks did not reveal any criminal convictions. The personnel records were reviewed on February 21, 2007.	L 999		