

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2007
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NAME OF PROVIDER OR SUPPLIER GRANT PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 BURROUGHS AVE. NE WASHINGTON, DC 20019
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L 000	Initial Comments An annual licensure survey was conducted on April 2 through 5, 2007. The following deficiencies were based on observations, record reviews and facility staff interviews. The sample included 30 residents based on a census of 281 residents on the first day of the survey and 13 supplemental residents.	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on staff interview and record review for four (4) of 30 sampled residents, it was determined that the charge nurse failed to	L 051	L 051 3210.4 Nursing Facilities #1 1. When Resident #6 returned from post fall hospitalization, facility assessed the resident and monitored resident over a 72 hour period. Resident #6 was sent out after nursing assessed that resident needed further X-ray of knee. 2. Review all resident post falls-April 1, 2007 to present with a hospitalization (trips to the emergency room), to ensure no fractures have been misdiagnosed by 4/30/07. 3. Re-educate all licensed staff on assessment of post falls and post hospitalization, will review all falls during daily stand-up meeting to assure proper assessment and documentation has occurred. 4. Administrator/DON or designee will conduct random audits monthly. Findings from daily review of falls will be reported to the facility Quality Improvement/Risk Management committee monthly.	04/30/07 04/30/07 04/30/07 05/02/07

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *4-24-07*

STATE FORM 32TP11 If continuation sheet 1 of 30

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L 051	<p>Continued From page 1</p> <p>provide the necessary care and services as evidenced by failing to perform an assessment on one (1) resident after returning from the hospital who was subsequently diagnosed with a fracture, update one (1) resident's care plan for falls and alcohol consumption and consistently monitor and document an indication for the continued use of medications for two (2) residents. Resident #6, 15, 20 and 25.</p> <p>The findings include:</p> <p>1. The charge nurse failed to re-assess Resident #6's right knee after returning from a hospitalization post fall. The resident was subsequently diagnosed with a fractured tibia.</p> <p>According to the facility's policy, " Fall Risk Reduction & Management ", number 3.5, revised date July 2006, " Procedure (after a resident has fallen): 1. Provide immediate care and services to the resident to treat any injuries ... 2. Evaluate resident for any additional injury which would require medical intervention. Evaluation includes but is not limit to: vital signs, assessment of visible head trauma, condition of skin ...condition of trunk and extremities to assess joints for change in normal range of motion ..."</p> <p>According to a nurse's note dated November 10, 2006 at 9:00 PM, "At 1600 (4:00 PM) writer called and informed resident fell in front of elevator on side. Writer went to assess resident sitting in wheelchair. Upon assessment noted swelling to R (right) knee. Resident complained of pain to right knee ...order to transfer resident to nearest ER in evaluation of R knee swelling with pain ..."</p> <p>There was no evidence in the record that facility staff assessed the resident when the resident fell</p>	L 051	<p>L 051 #2</p> <ol style="list-style-type: none"> 1. Resident #15 had a physician's order written on 4/3/07 PRN Haldol and Ativan discontinued on 4/3/07. Psychological evaluation order. 2. All residents receiving psychotropic medications will be reviewed from March 1, 2007 to assure a reason for medication is noted, proper MAR documentation is noted when a PRN medication is ordered and a behavior monitoring record is present and complete. 3. Unit managers/designee will complete random weekly audits of all residents on psychotropic medications to assure the appropriateness and use of the medication. Re-education of all licensed nurse on facility protocol on continued use of psychotropic medications and behavioral monitoring records. 4. Findings from audit will be reported to the Quality Improvement Committee monthly. <p>#3</p> <ol style="list-style-type: none"> 1. Resident #20 was offered an alcohol treatment program but resident refused. Resident's fall was alcohol abuse related. 2. All residents with ETOH abuse as a problem /diagnosis will be offered treatment. 3. All licensed staff will reeducated on proper documentation, notification of physician and family when resident is observed to be intoxicated. All residents identified as intoxicated will be placed on facility 24-hour report for appropriate follow-up. Facility Administrator/DON or designee will review 24-hour report as part of facility morning meeting to ensure that appropriate treatment options are offered residents who have been identified as alcohol abusers. 4. DON/Administrator will report findings from morning review to facility Quality Improvement committee monthly. 	<p>04/03/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p> <p>04/09/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p>

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L 051	<p>Continued From page 2</p> <p>at 4:00 PM. The initial assessment documented in the record was completed by the supervisor at 9:00 PM, five (5) hours after the fall.</p> <p>A nurse practitioner's order dated November 10, 2006 at 6:00 PM directed, "Transfer resident to ER for stat x-ray and evaluation of R knee injury s/p [status post] fall with pain and swelling ..."</p> <p>On November 11, 2006 at 4:40 AM, a nurse's note documented, "Resident back to unit from [hospital] via stretcherUpon assessment resident alert, verbally responsive. Skin warm and dry to touch. No sign of distress noted. Denies any pain at this time. No new order. Resident to follow up with primary care physician within 1-2 days. Supervisor notified. Resident made comfortable in bed. Vital signs 98.6 (temperature in degrees Fahrenheit), 18 (respirations), 70 (pulse), 120/80 (blood pressure)."</p> <p>Discharge instructions from the hospital dated November 11, 2006 at 12:00 AM, that accompanied the resident back to the facility included the following: " Follow up by your primary care physician. Your diagnosis: DJD (Degenerative Joint Disease). " There was no evidence that an evaluation of the right knee was done or x-rays taken.</p> <p>There was no evidence that the right knee was re-assessed after the resident returned to the facility or that the physician was notified of the resident's return.</p> <p>There was no evidence in the record that facility staff attempted to contact the hospital at the time the resident returned to the facility to request information regarding the evaluation of the right knee and the x-ray results, as directed by the</p>	L 051	<p>L 051 #4</p> <ol style="list-style-type: none"> 1. Resident # 25 continues to receive Ambien for insomnia. A psychological consult has been ordered. 2. Facility will review all residents receiving Ambien to ensure that there is appropriate documentation for continued use and that a behavioral monitoring record is present and complete. 3. All licensed nurses will be reeducated on appropriate documentation for residents receiving psycho-tropic medications and its continued use. 4. The DON, Unit Managers or designee will complete weekly audits X 4 audits then monthly audits to ensure that behavior monitoring records are present and complete and that there is documentation in record to demonstrate need for continued use. Findings from monthly audits will be presented to facility Quality Improvement committee monthly. 	<p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p>

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L 051	<p>Continued From page 3</p> <p>nurse practitioner's order.</p> <p>Nurses' notes were dated November 11, 2006 at 6:00 AM, 3:00 PM and 10:45 PM and November 12, 2006 at 6:00 AM and 12:30 PM and included no assessment of the resident's right knee. The resident was described as having no pain or distress in the above cited notes.</p> <p>A nurse's note dated November 12, 2006 at 2:45 PM documented, " Resident's right knee was checked by supervisor and charge (nurse). Found color normal but still swollen. [Physician] was paged." There was no evidence that the physician contacted the facility or that nursing staff attempted to contact the physician/medical director after this initial attempt.</p> <p>A nurse ' s note dated November 13, 2006 at 1:40 PM documented, "...Rt knee still swollen. [Physician] notified and x-ray ordered ..."</p> <p>A nurse's note dated November 13, 2006 at 3:00 PM documented, "Fall Action Team: Resident alert ...admits to remembering falling but when describing it somewhat different from what happened ...Did not hit head or suffered any body trauma ..."</p> <p>The Fall Action Team member #1, who wrote the above entry, stated in a telephone interview on April 4, 2007 at 12:10 PM that he/she interviewed the resident but did not do a physical assessment of the resident.</p> <p>An x-ray was done on November 14, 2006 with the following results, "Osteoporosis. Acute fracture of the proximal tibial metaphysis ..." The resident was sent to the emergency room for evaluation and treatment of the fracture on</p>	L 051		

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L 051	<p>Continued From page 4</p> <p>November 14, 2006 at 11:00 AM.</p> <p>A face-to-face interview was conducted with the Director of Nursing on April 4, 2006 at 11:00 AM. He/she acknowledged that there was no assessment conducted of the right knee after the resident returned from the hospital and that the physician had not been notified of the resident's continued right swollen knee after the resident returned from the hospital. The record was reviewed April 3, 2007.</p> <p>2. The charge nurse failed to consistently monitor and document an indication for the continued use of Haldol and Ativan for Resident #15.</p> <p>A review of Resident #15's record revealed a physician's order dated January 13, 2007, renewed March 2, 2007, directed, "Ativan 0.5 mg po (orally) daily at bedtime PRN (as needed) for agitation" and "Haldol 2 mg 1 tab po every 8 hours PRN (as needed) for agitation."</p> <p>According to the history and physical examination completed by the physician on December 21, 2006, the resident had a history of agitation and periods of confusion.</p> <p>The Medication Administration Records (MARs) for January, February and March 2007 were reviewed. Resident #15 received no Haldol and three (3) doses of Ativan in January, no Ativan and 23 doses of Haldol in February and 15 doses of Ativan and 16 doses of Haldol in March 2007.</p> <p>There was no explanation on the reverse side of the above referenced MARs as to the date, time, reason medication was given or effectiveness of the medication with the exception of one (1) entry for February 24, 2007.</p>	L 051		

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L 051	<p>Continued From page 5</p> <p>The "Behavior Monitoring Record" for January and March 2007 were reviewed. Ativan was administered on January 14, 18 and 19, 2007. There was no indication on the " Behavior Monitoring Record " or in the nurses ' notes that the resident exhibited agitated behavior.</p> <p>The February 2007 " Behavior Monitoring Record " for February 2007 was requested but could not be located by facility staff during the survey period. The nurse ' s note dated February 18, 2007 described the resident having an altercation with another resident. There was no evidence in the nurses ' notes that additional episodes of agitated behavior occurred in February 2007.</p> <p>The March 2007 " Behavior Monitoring Record " had documentation for 13 days in which the resident exhibited agitated behavior. Ativan was administered 15 times and Haldol was administered 16 times during March 2007. There was no consistency between the administration of Haldol and the days the resident was identified as exhibiting agitated behaviors. There were no episodes of agitated behaviors documented on the " Behavior Monitoring Record " for the evening shift (3:00 PM to 11:30 PM) to explain why Ativan was administered 15 times at bedtime.</p> <p>A face-to-face interview was conducted with Assistant Unit Manager #2 on April 3, 2007 at 8:30 AM. After reviewing the record, he/she acknowledged that the reason, time and effectiveness of PRN medications should have been charted on the back of the MARs. Additionally, he/she acknowledged that behavior monitoring was required for residents using Ativan and Haldol and that there was inconsistent</p>	L 051		
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L 051	<p>Continued From page 6</p> <p>documentation to support the administration of those medications. The record was reviewed April 3, 2007.</p> <p>3. The charge nurse failed to update Resident #20's care plan for falls and alcohol consumption.</p> <p>A review of the nurses' notes for Resident #20's record revealed the following:</p> <p>August 22, 2006 at 2:00 PM - "...observed floor..." [No injury, MD (medical doctor) not notified.]</p> <p>September 13, 2006 at 10:50 AM - "...observed on the bathroom floor by the rail..." [No injury, MD notified.]</p> <p>September 13, 2006 at 2:15 PM - " Resident has been drinking beer. Resident was removed from his/her w/c [wheelchair] and placed in bed ... " [No injury, MD not notified.]</p> <p>September 18, 2006 at 12:15 AM - " Resident returned to the unit at 12:15 ... has a very strong smell of alcohol on his/her breath. " [No injury, MD not notified.]</p> <p>September 19, 2006 at 11:00 PM - "...Resident's breath also smell of alcohol." [No injury, MD not notified.]</p> <p>November 5, 2006 at 12:00 AM - "...Resident was observed with strong smell of alcohol. Responsible party stated: " He/she had a couple of beers at the party ..." [No injury, MD not notified.]</p> <p>November 18, 2006 at 5:15 PM - "... Resident observed with hematoma on frontal aspect of forehead, sustained from fall on floor in his/her</p>	L 051		

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L 051	<p>Continued From page 7</p> <p>room..." [Injury, MD notified.]</p> <p>January 10, 2007 at 11:30 PM - "...Resident was observed on the floor lying by CNA while making rounds on his/her back by the side of the [his/her] bed...Observed alcohol smell on his/her breath ..." [No injury, MD notified .]</p> <p>January 11, 2007 at 11:00 PM -" Resident was observed sitting out in pitch darkness on front patio. He/she appears to be intoxicated with alcohol (He/she smelled of alcohol). He/she appeared helpless and almost falling out of the chair. He/she appeared so intoxicated he/she could not answer any questions." [No injury, MD not notified.]</p> <p>February 1, 2007 at 8:00 AM - "Resident was observed on the unit very drunk. He/she was brought up by a staff from downstairs where he/she was drinking. All his/her clothes and pants were saturated with urine. He/she refuse to be undressed and be assisted. He/she was combative and scratched one of the CNA [Certified Nurse Aide] while attempting to wash him/her and keep clean clothes on him/her." [No injury, MD not notified.]</p> <p>February 28, 2007 at 1:15 AM - "...Observed on the floor ... He/she is smelling very strong of alcohol." [No injury, MD notified.]</p> <p>April 4, 2007 at 9:50 PM- "Called stat to parking lot by security. Resident found lying on ground with wheelchair on side. Nose bruised and bleeding. Rt (right) wrist scraped ... Resident was asked what he/she had been drinking and response was " Beer" [Injury, MD notified.]</p> <p>The review of Resident #20's care plan revealed</p>	L 051		

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L 051	<p>Continued From page 8</p> <p>the following problem initiated July 6, 2006, "Resident is consuming alcoholic beverages regardless of prescribed medication interactions and medical conditions." An approach included, "Notify MD of alcohol consumption/ follow orders as given."</p> <p>There was no evidence that new approaches were implemented when the care plan was reviewed on August 10 and November 2, 2006 and January 25, 2007. Additionally, there was no evidence that the MD was consistently notified when the resident was observed to be intoxicated.</p> <p>A review of the "Potential for injury, risk for falls..." care plan revealed that the above cited falls with the exception of the fall on September 13, 2006 were documented. However, facility staff failed to initiate additional approaches after the resident fell on September 13, 2006. Subsequently, the resident fell on November 18, 2006 and on April 4, 2007 and sustained injury from both falls.</p> <p>A face-to-face interview was conducted with the Unit Manager #2 and the Director of Nursing on April 5, 2007 at approximately 3:00 PM. They acknowledged that after reviewing the record, the physician was not contacted as per the plan of care after each alcoholic incident. Additionally, no new interventions were initiated after September 13, 2006 to prevent the resident from falling and subsequently sustaining injuries. The record was reviewed April 5, 2007.</p> <p>4. The charge nurse failed to consistently monitor and document an adequate indication for the use of Ativan and Ambien for Resident #25.</p> <p>A. Resident #25 was admitted to the facility on</p>	L 051		

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L 051	<p>Continued From page 9</p> <p>February 1, 2007. According to the admission Minimum Data Set assessment completed February 6, 2007, the resident was coded for no behavior or mood problems in Section E.</p> <p>The history and physical examination completed by the physician on February 5, 2007, does not include reference to the resident having behavior problems.</p> <p>The admission orders signed by the physician on February 5, 2007 included, " Ativan 1 mg po at bedtime for agitation. "</p> <p>According to the February and March 2007 MARs, the resident received Ativan every night at 11:00 PM for both months.</p> <p>The " Behavior Monitoring Record " was requested for February 2007. Facility staff was unable to locate the monitoring record during the survey. There was no evidence in the nurses ' notes that the resident exhibited agitated behaviors during February 2007.</p> <p>The "Behavior Monitoring Record" for March 2007 indicated that the resident exhibited agitated behaviors during the evening shift (3:00 PM to 11:30 PM - bedtime) on March 31, 2007.</p> <p>The resident exhibited agitated behaviors during the night shift (11:00 PM to 7:30 AM) March 1 through 7, 2007. There were no other documented episodes of agitated behaviors exhibited by the resident during the month of March 2007 on the " Behavior Monitoring Record " and the nurses' notes.</p> <p>The physician saw the resident on February 5 and 12 and March 12, 2007. There was no</p>	L 051		

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L 051	<p>Continued From page 10</p> <p>evidence that the physician reviewed the resident's need for Ativan.</p> <p>B. Facility staff failed to consistently identify an adequate indication for the use of Ambien for Resident #25.</p> <p>A physician ' s telephone order dated February 5, 2007 and signed by the physician on February 9, 2007, directed, " Ambien CR 6.25 mg , 1 tab po q HS (bedtime) for insomnia. " The order was renewed April 4, 2007.</p> <p>The nurses ' notes were reviewed from February 1 through February 9, 2007. There was no evidence that the resident experienced episodes of insomnia.</p> <p>The physician saw the resident on February 5 and 12 and March 12, 2007. There was no evidence that the physician reviewed the resident ' s need for Ambien.</p> <p>A face-to-face interview was conducted with Unit Manager #3 on April 4, 2007 at 11:30 AM. He/she acknowledged that there was insufficient documentation for the administration of Ativan and Ambien for Resident #25. The record was reviewed April 3, 2007.</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 rehabilitative nursing care as needed;</p>	L 052		

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L 052	<p>Continued From page 11</p> <p>(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p> <p>(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;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e) Encouragement, assistance, and training in self-care and group activities;</p> <p>(f) Encouragement and assistance to:</p> <p>(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;</p> <p>(2) Use the dining room if he or she is able; and</p> <p>(3) Participate in meaningful social and recreational activities; with eating;</p> <p>(g) Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h) Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i) Assistance, if needed, with daily hygiene, including oral care; and</p> <p>(j) Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record</p>	L 052	<p>L 052 3211.1 Nursing Facilities</p> <p>#1</p> <p>1. Resident #20 is very independent and spends a majority of his/her day off the nursing unit. The facility staff monitors residents every two hour at a minimum. 04/30/07</p> <p>2. All facility residents are monitored at a minimum of every two hours. Residents that require more frequent monitoring is based on the individual resident needs. 04/30/07</p> <p>3. Staff will be re-educated on the importance of monitoring residents locations to ensure adequate supervisor is provided as needed. Safety staff will be re-educated on monitoring the residents that are outside the facility on the grounds of the facility. 04/30/07</p> <p>4. Administrator/DON designee will do random audits weekly X4, then monthly. Findings of these audits will be reported to the risk management monthly. 05/02/07</p> <p>#2</p> <p>1. Facility immediately obtained weights for resident # 7 and weekly weights X 4 weeks. 04/30/07</p> <p>2. On all admissions, all records will be reviewed to ensure that all weekly weights X 4 weeks have been completed. 04/30/07</p> <p>3. Facility educator will re-educate all licensed nursing staff on obtaining weekly weights X 4 weeks as ordered by the physician. 04/30/07</p> <p>4. DON/Designee will report findings from weekly audit will be presented to the facility quality improvement/risk management committee monthly. 05/02/07</p>	

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L 052	<p>Continued From page 12</p> <p>review for six (6) of 30 sampled residents, it was determined that sufficient nursing time was not given to each resident to provide the necessary care and services as evidenced by failing to: provide adequate supervision for one (1) resident with multiple falls and subsequent injuries, perform weekly weights as per physician's orders for two (2) residents, ensure that one (1) resident received fluids as ordered, assess one (1) resident for a chair alarm, discontinue the administration of a medication and administer medication as ordered by the physician for one (1) resident, and ensure that there was a physician's order prior to withholding medication for one (1) resident. Residents #20, 7, 8, 15, 23, and 29.</p> <p>The findings include:</p> <p>1. Sufficient nursing time was not given to provide adequate supervision for Resident #20, a resident with multiple falls and subsequent injury.</p> <p>The annual MDS (Minimum Data Set) dated January 25, 2007 coded the resident as having a short and long term memory problems and was moderately impaired for cognitive skills for daily decision making (Section B); required limited assistance with walking on the unit and required limited assistance with transfers (Section G). The resident was coded as above for the quarterly MDS assessments completed August 5, 2006 and November 1, 2006.</p> <p>A review of Resident #20's nurses' progress notes revealed the following:</p> <p>August 22, 2006 at 2:00 PM - "...observed floor..." [No injury, MD (medical doctor) not notified.]</p>	L 052	<p>L 052 #3</p> <ol style="list-style-type: none"> 1. The facility staff obtained a physician's order to perform intake and output X 2 weeks on resident # 8. 2. Review of all records of residents with physician's orders for hydration to ensure that all fluids are given as ordered by the physician. 3. Re-educate all licensed staff on the importance of accurately transcribing orders from month to month. 4. Units Managers or designee will complete random weekly audits to ensure compliance. Findings from weekly audit will be presented to the facility quality improvement/risk management committee monthly. <p>#4</p> <ol style="list-style-type: none"> 1. Resident #15 was assessed for bed/chair alarm. Bed/chair alarm was implemented immediately. 2. 100% audit of all residents with bed/chair alarms to ensure appropriate use. 3. Facility educator will re-educate all facility staff on the importance of fall prevention devices such as bed/chair alarms. 4. Unit manager/designee will complete random weekly audit on residents with bed/chair alarms to ensure compliance. Findings of weekly audit will be presented to the facility quality improvement/risk management committee monthly. 	<p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p>

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L 052	Continued From page 13 September 13, 2006 at 10:50 AM - "...observed on the bathroom floor by the rail..." [No injury, MD notified.] September 13, 2006 at 2:15 PM- " Resident has been drinking beer. Resident was removed from his/her w/c [wheelchair] and placed in bed ... " [No injury, MD not notified.] September 18, 2006 at 12:15 AM - " Resident returned to the unit at 12:15 ... has a very strong smell of alcohol on his/her breath. " [No injury, MD not notified.] September 19, 2006 at 11:00 PM - "...Resident's breath also smell of alcohol." [No injury, MD not notified.] November 5, 2006 at 12:00 AM- "...Resident was observed with strong smell of alcohol. Responsible party stated: " He/she had a couple of beers at the party . ." [No injury, MD not notified.] November 18, 2006 at 5:15 PM - "... Resident observed with hematoma on frontal aspect of forehead, sustained from fall on floor in his/her room..." [Injury, MD notified.] January 10, 2007 at 11:30 PM - "...Resident was observed on the floor lying by CNA while making rounds on his/her back by the side of the [his/her] bed... Observed alcohol smell on his/her breath ..." [No injury, MD notified .] January 11, 2007 at 11:00 PM - " Resident was observed sitting out in pitch darkness on front patio. He/she appears to be intoxicated with alcohol (He/she smelled of alcohol). He/she appeared helpless and almost falling out of the	L 052	L 052 #5 (A) 1. The 2567 lists resident #23, however it is resident 25. Resident was not harmed by this deficient practice. 2. Facility Unit Manager or designee will complete 100% audit of pharmacy consult recommendations/orders beginning March 1, 2007 to ensure no other pharmacy recommendations or physician orders have been missed. 3. All licensed nurses will be re-educated on ensuring pharmacy consult/ recommendations are carried out in a timely manner. 4. Unit manager or designee will report findings from the weekly audits to the facility quality improvement/risk management committee monthly. (B) 1. The 2567 lists resident #23, however it is resident 25. The physician order has been corrected to reflect the correct administration of Aspirin. 2. Facility Unit Manager or designee will complete 100% audit of pharmacy consult recommendations/orders beginning March 1, 2007 to ensure no other pharmacy recommendations or physician orders have been missed. 3. All licensed nurses will be re-educated on ensuring pharmacy consult/ recommendations are carried out in a timely manner. 4. Unit manager or designee will complete weekly audits on pharmacy consultant recommendations. Findings from the weekly audit will be submitted to the facility quality improvement/risk management committee monthly.	04/30/07 04/30/07 04/30/07 05/02/07 04/30/07 04/30/07 05/02/07

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L 052	<p>Continued From page 14</p> <p>chair. He/she appeared so intoxicated he/she could not answer any questions." [No injury, MD not notified.]</p> <p>February 1, 2007 at 8:00 AM - "Resident was observed on the unit very drunk. He/she was brought up by a staff from downstairs where he/she was drinking. All his/her clothes and pants were saturated with urine. He/she refuse to be undressed and be assisted. He/she was combative and starched one of the CNA [Certified Nurse Aide] while attempting to wash him/her and keep clean clothes on him/her." [No injury, MD not notified.]</p> <p>February 28, 2007 at 1:15 AM - "...Observed on the floor ... He/she is smelling very strong of alcohol." [No injury, MD notified.]</p> <p>April 4, 2007 at 9:50 PM- "Called stat to parking lot by security. Resident found lying on ground with wheelchair on side. Nose bruised and bleeding. Rt (right) wrist scraped ... Resident was asked what he/she had been drinking and response was " Beer" [Injury, MD notified.]</p> <p>A review of the " Potential for injury/risk for falls ... " care plan revealed that the resident had multiple falls with subsequent injury on November 18, 2006 and April 4, 2007. The care plan lacked evidence that facility staff implemented any additional approaches to prevent the resident from falling.</p> <p>A review of the social service progress note dated January 25, 2007 at 12:50 PM revealed, " Social worker met with resident to discuss several issues educated resident on the mixing of alcohol and medication. The resident was offered outside service and support with regards</p>	L 052	<p>#6</p> <ol style="list-style-type: none"> 1. Resident #29 is no longer a resident at this facility. 2. 100% audit of all residents on blood pressure medication to ensure that appropriate parameters for administering and holding medication is in place. 3. Facility educator will re-educate all licensed nursing staff on appropriate protocol for withholding blood medication. 4. Unit manager will complete weekly random audits on all residents on blood pressure medication to ensure appropriate administration of blood pressure medication. Findings from the weekly audit will be submitted to the facility quality improvement/risk management committee monthly. 	<p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p>

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L 052	<p>Continued From page 15</p> <p>to alcoholism. SW (social worker) will make referral ASAP ...The resident agreed to continue with day care program. The goal is to attend at least two times per week. In addition, a second goal was to encourage resident to continue with weekly talk sessions. Social worker will f/u (follow up) as needed once services are in place.</p> <p>"</p> <p>A face-to-face interview was conducted with the social worker on April 5, 2007 at approximately 2:15 PM. He/she stated " The resident refused to attend the outside services. "</p> <p>The record lacked evidence that the outside services, talk sessions and/or addiction support programs were refused by the resident.</p> <p>The social worker acknowledged after reviewing the record, that there was no follow up with outside services and/or programs after January 25, 2007 to assist the resident with alcohol addiction.</p> <p>A face-to-face interview was conducted with the Recreational Therapy Director on April 5, 2007 at approximately 2:15 PM. He/she stated, " The resident is on the list to attend a talk therapy program for drug and alcohol addicted residents, however the last time he/she attended was November 29, 2006."</p> <p>A face-to-face interview was conducted with Unit Manager #2 and the Director of Nursing on April 5, 2007 at approximately 3:00 PM. They acknowledged after reviewing the record, that there were no interventions to prevent the resident from falling or to assist the resident with alcohol addiction. The record was reviewed April 5, 2007.</p>	L 052		

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L 052	<p>Continued From page 16</p> <p>2. Facility staff failed to follow physician's orders to obtain weekly weights for Resident #7.</p> <p>A review of the "Physician's Order Sheet" dated January 25, 2007 and signed by the physician (undated), revealed " ...WT [weight] Q [every] week times 4 ... "</p> <p>A review of the weight record dated January 25, 2007 lacked evidence that weekly weights were completed as ordered by the physician.</p> <p>According to the resident's record, the resident's weight in January 2007 was 86.2 pounds and March 2007 95.6 pounds. There was no evidence that the resident was weighed in February 2007.</p> <p>A face-to-face interview was conducted with Unit Manager #1 on April 3, 2007 at 3:30 PM. He/she acknowledged that the weekly weights were not done. The record was reviewed on April 3, 2007.</p> <p>3. Facility staff failed to weigh Resident #8 and ensure that the resident received fluid as per physician's orders.</p> <p>A. A review of the "Physician's Admission Orders and Plan of Care" dated and signed January 31, 2007 at 11:05 PM revealed the following order, " Wt. Q week x 4 week; wt Q month. (weigh every week for four weeks then every month) "</p> <p>A review of Resident #8's record lacked evidence that the resident was weighed every week for four (4) weeks as ordered.</p> <p>B. Facility staff failed to ensure that Resident #8 received fluid as ordered.</p>	L 052		

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L 052	<p>Continued From page 17</p> <p>A review of the "Physician's Admission Orders and Plan of Care" dated and signed January 31, 2007 at 11:05 PM revealed the following order, " Drink at least 400 mls Q shift. "</p> <p>A review of Resident #8's February 2007 Treatment Record (TR) revealed that the resident received 400 mls every shift as ordered, as evidenced by facility staff initials entered into the allotted areas. A review of the March and April 2007 TR lacked evidence that the order for fluid was continued. A review of the physician's orders for March and April 2007 lacked evidence that the order of January 31, 2007 to give fluid had been discontinued.</p> <p>A face-to-face interview was conducted with the Director of Nursing, Unit Manager #1 and Nutritionist on April 3, 2007, at 1:20 PM. They acknowledged that the resident was not weighed as ordered and did not receive fluid as ordered. This record was reviewed April 2, 2007.</p> <p>4. Facility staff failed to assess Resident #15 for a chair alarm as per physician's orders.</p> <p>A review of Resident #15's record revealed that the resident fell on December 26, 2006, February 10 and 19, 2007. The resident sustained no injuries from these falls. The intervention for February 10, 2007 was to have the resident assessed for a chair alarm.</p> <p>Physician's orders included: February 12, 2007, " Please assess resident for chair alarm". March 26, 2007, "Please evaluate resident for bed/chair alarm." There was no evidence in the resident ' s record that the resident had been</p>	L 052		

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L 052	<p>Continued From page 18</p> <p>assessed for a chair alarm.</p> <p>Resident #15 was observed on April 2, 2007 at 2:30 PM without a chair alarm. On April 3, at 10:30 AM the chair alarm was present. On April 3, 2007 at 3:50 PM, there was no chair alarm.</p> <p>A review of the Treatment Administration Records (TARs) for February, March and April 2007 revealed that an order to assess/evaluate the resident had been transcribed onto the above mentioned TARs. The March and April 2007 TARs had "FYI (for your information)" next to the order. There was no evidence that the resident had been assessed for the chair alarm.</p> <p>A face-to-face interview was conducted on April 3, 2007 at 8:30 AM with Unit Manager #3. He/she was asked when the chair alarm had been initiated. After reviewing the record, the Unit Manager stated, " I really don't know when the alarm was placed. No one signed that the alarm had been in place for February, March or April (2007). I know [Resident #15] has an alarm. It wasn't added to the care plan either. " The record was reviewed April 3, 2007.</p> <p>5. Facility staff failed to discontinue the use of Ativan and administer Aspirin to Resident #23 as per the nurse practitioner's orders.</p> <p>A. The review of Resident #23's record revealed a nurse practitioner's order dated March 12, 2007 that directed, " Discontinue Ativan. "</p> <p>According to the March and April 2007 Medication Administration Record (MAR), the Ativan was administered to the resident from March 13 through April 2, 2007. The resident received 19 doses after the order to discontinue</p>	L 052		

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L 052	<p>Continued From page 19</p> <p>Ativan was written.</p> <p>A face-to-face interview was conducted with Assistant Unit Manager #1 on April 4, 2007 at 11:30 AM. He/she stated that the Ativan should have been discontinued on March 12, 2007. The record was reviewed April 4, 2007.</p> <p>B. Facility staff failed to administer Aspirin for Resident #23 as ordered by the nurse practitioner.</p> <p>A pharmacy "Consultation Report" recommended, "Please consider initiating Aspirin 81 mg daily as a means of primary prevention." The report was signed by the nurse practitioner and included the order, "Aspirin 81 mg po q day." The order was written and signed on March 12, 2007.</p> <p>A review of the March and April 2007 Medication Administration Records revealed that the order was not initiated and the resident had not received Aspirin as directed by the nurse practitioner.</p> <p>A face-to-face interview was conducted with Assistant Unit Manager #1 on April 4, 2007 at 8:30 AM. He/she acknowledged that Aspirin was never administered to Resident #23. The record was reviewed April 4, 2007.</p> <p>6. Facility staff failed to ensure that there was a physician's order prior to withholding a blood pressure medication for Resident #29.</p> <p>During the review of the resident's clinical record, nurses' progress notes revealed the following: November 30, 2006 at 1545 (3:45 PM), "Resident is not responding well, his pulse (P) is 56,</p>	L 052		

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L 052	<p>Continued From page 20</p> <p>respirations (R) 18, blood pressure (B/P) 134/68. Called the doctor. MD ordered to hold the B/P medications till further notice ...Pass it on to 3-11 shift to keep monitoring."</p> <p>December 1, 2006 3:15 PM, "VS 97 (T), 55 (P), 20 @, 148/60 (B/P). Resident alert and oriented responds to verbal stimulus. Consumed 75-100% of both meals this shift. MD aware of abnormal B/P and pulse, stated to continue to hold B/P meds ..."</p> <p>The Medication Administration Record (MAR) was reviewed for December 2006. Documented on the MAR and dated November 30, 2006 was FYI (for your information) "Hold B/P Meds until pulse ox rate is WNL (within normal limits) and Pulse ox Q (every) shift until pulse ox rate is WNL."</p> <p>The review of the MAR revealed that Avapro and Lasix for blood pressure and a Nitrek patch was circled (to indicate not administered) on December 1, 2 and 3, 2007. It was also documented on the area of the MAR for Medication Exception and Hold Notes that the medications were not administered on December 1, 2 and 3, 2007.</p> <p>There were no physician's orders in the record with parameters directed to withhold the resident's blood pressure medication.</p> <p>On April 5, 2006 at approximately 11:00AM a face-to-face interview was conducted with the Assistant Nurse Manager #2 who acknowledged that there was not a physician's order to withhold the blood pressure medication. The record was reviewed on April 3, 2007</p>	L 052		

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L 054	Continued From page 21	L 054																		
L 054	<p>3211.3 Nursing Facilities</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on a review of "Nursing Daily Staffing" sheets and staff interview for seven (7) of seven (7) days reviewed, it was determined that facility staff failed to maintain nurse staffing at 3.5 nursing hours per resident per day.</p> <p>The findings include:</p> <p>According to 22DCMR 3211.3, " Beginning no later than 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. "</p> <p>The "Nursing Daily Staffing" sheets for March 29, 30, 31, April 1, 2, 3 and 4, 2007 were reviewed with the Director of Nursing (DON) on April 5, 2007. The staffing sheets revealed the following:</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Nursing Hours</th> </tr> </thead> <tbody> <tr> <td>March 29, 2007</td> <td>3.4</td> </tr> <tr> <td>March 30, 2007</td> <td>3.2</td> </tr> <tr> <td>March 31, 2007</td> <td>2.9</td> </tr> <tr> <td>April 1, 2007</td> <td>2.7</td> </tr> <tr> <td>April 2, 2007</td> <td>2.83</td> </tr> <tr> <td>April 3, 2007</td> <td>3.4</td> </tr> <tr> <td>April 4, 2007</td> <td>3.4</td> </tr> </tbody> </table> <p>The DON acknowledged that staffing was below 3.5 nursing hours per resident per day. He/she stated, " Staff is offered overtime and bonuses for working extra. Everybody is trying. We even</p>	Date	Nursing Hours	March 29, 2007	3.4	March 30, 2007	3.2	March 31, 2007	2.9	April 1, 2007	2.7	April 2, 2007	2.83	April 3, 2007	3.4	April 4, 2007	3.4	L 054	<p>L 054 3211.3 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Facility has hired additional staff and continues to actively recruit and retain staff. Facility is currently holding weekly orientation classes for new hires. 04/30/07 2. Daily review of staffing levels is conducted to monitor staffing and to ensure that staffing levels meet the needs of residents. 04/30/07 3. Staffing coordinator, DON, ADON, Charge Nurses, Nursing Supervisors and Unit Managers will be reeducated on need to maintain staffing at 3.5 hours per patient day. Daily review of staffing by Administrator/ DON or designee will be completed to ensure compliance. Facility will continue to offer bonuses and overtime to staff to ensure compliance. 04/30/07 4. Administrator/DON will report findings of staffing level review to facility Quality Improvement Committee monthly. 05/02/07 	
Date	Nursing Hours																			
March 29, 2007	3.4																			
March 30, 2007	3.2																			
March 31, 2007	2.9																			
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L 054	Continued From page 22 have half shifts, where someone works four hours extra and the next shift comes in four hours early. " This was a repeat deficiency from the re-certification survey completed April 14, 2006 and the follow-up survey completed June 29, 2006.	L 054		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations 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 walls, baseboards, doors, floors, plate warmer, air compressor fan covers, convection and gas oven panels, a can opener, a deflector plate on the ice machine, coffee cups, knives, and hotel pans, and drain pipes not installed to prevent water overflow. These observations were made on April 4, 2007 between 7:15 AM and 2:30 PM in the presence of the Director of Food Service. The findings include: 1. Wall, floor and baseboard surfaces near the entrance to dietary and floor and door surfaces on the outside back loading dock area were soiled with accumulated debris in two (2) of two (2) entrance areas observed in the main kitchen. 2. The interior surfaces near the heating	L 099	L 099 3219.1 Nursing Facilities #1 1. Walls, floor and baseboard surfaces near the entrance to dietary and floor and door surfaces on outside back loading dock areas were cleaned immediately. 2. Food service staff/housekeeping staff is now monitoring these areas daily to ensure that they remain clean. 3. Food service and housekeeping staff were reeducated on importance of keeping these areas clean. 4. Food service manager/housekeeping manager will complete daily rounds through these areas to ensure that they remain clean. Findings from the daily rounds will be reported to facility Quality Improvement Committee monthly. #2 1. Plate warmer was dismantled and cleaned immediately. 2. Cleaning plate warmer assured that no other resident was affected by this deficient practice. 3. Food service staff was reeducated on the importance of keeping plate warmer clean. 4. Food service manager or designee will complete daily audit of plate warmer to ensure its cleanliness. Findings from this daily audit will be presented to facility Quality Improvement Committee monthly.	04/03/07 04/03/07 04/30/07 05/02/07 04/02/07 04/02/07 04/23/07 05/02/07

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L 099	<p>Continued From page 23</p> <p>elements of the plate warmer were soiled with accumulated debris in one (1) of one (1) plate warmer observed.</p> <p>3. The air compressor fan covers in the walk-in refrigerator were soiled with dust in one (1) of one (1) walk-in refrigerator observed.</p> <p>4. The front and side panels of the convection and gas ovens were soiled with debris in two (2) of two (2) ovens observed.</p> <p>5. The manual crank can opener in the cook's area was soiled with metal shavings on the gear and cutting surfaces and the holder was soiled with food debris in one (1) of one (1) can opener observed.</p> <p>6. The plastic deflector plate on the interior of the ice machine was soiled with debris in one (1) of one (1) ice machine observed.</p> <p>7. Coffee cups were stained on the interior with coffee residue after being washed and ready for reuse in 10 of 48 coffee cups observed.</p> <p>8. Knives were soiled with food after washing and ready for reuse in 16 of 47 knives observed.</p> <p>9. Hotel pans (12" x 24" x 10") were soiled with food residue after being washed and ready for reuse in five (5) of six (6) hotel pans observed.</p> <p>10. The ice machine drain pipes in the cook's and serving areas were not installed to prevent water from draining onto floor surfaces. Drain pipes were making contact with a plastic sleeve surrounding the pipes in two (2) of two (2) drain pipes observed.</p>	L 099	<p>#3</p> <ol style="list-style-type: none"> 1. The air compressor fan cover was cleaned immediately. 2. After cleaning fan cover, no other residents were affected by deficient practice. 3. Food service staff was reeducated on importance of monitoring and keeping fan covers clean. 4. Food service director or designee will perform weekly audits of fan covers to ensure continued cleanliness. Findings from weekly audits will be reported to facility Quality Improvement committee monthly. <p>#4</p> <ol style="list-style-type: none"> 1. The convection oven was dismantled and cleaned immediately. 2. Convection oven was cleaned immediately to ensure that no other residents were affected by this deficient practice. 3. Food service staff was reeducated on importance of keeping convection oven clean at all times. 4. Dietary manager will complete daily audits of convection oven to ensure continued cleanliness. Findings from weekly audits will be reported to facility Quality Improvement committee monthly. <p>#5</p> <ol style="list-style-type: none"> 1. Can opener was dismantled and cleaned immediately. 2. Facility food service staff cleaned can opener to ensure that no other residents were affected. 3. Food service staff was reeducated on importance of cleaning can opener after each use. 4. Food service manager or designee will complete daily audits of can opener to ensure its cleanliness. Findings from weekly audits will be reported to facility Quality Improvement committee monthly. 	<p>04/03/07</p> <p>04/03/07</p> <p>04/20/07</p> <p>05/02/07</p> <p>04/02/07</p> <p>04/02/07</p> <p>04/23/07</p> <p>05/02/07</p> <p>04/02/07</p> <p>04/02/07</p> <p>04/23/07</p> <p>05/02/07</p>

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L 108	Continued From page 24	L 108		
L 108	<p>3220.2 Nursing Facilities</p> <p>The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.</p> <p>This Statute is not met as evidenced by: Based on two (2) test tray observations, it was determined that facility staff failed to ensure that hot foods were served above 140 degrees Fahrenheit (F) and cold foods did not exceed 45 degrees F.</p> <p>The findings include:</p> <p>A test tray for breakfast was observed on April 5, at 8:50 AM on 3 North. Food temperatures were as follows:</p> <p>Corn beef hash: 120 degrees Fahrenheit (F) Scrambled Eggs - 112 degrees F Grits - 128 degrees F French toast - 108 degrees F 2% Reduced fat mild - 48 degrees F</p> <p>A test tray for lunch was observed on April 5, 2007 at 1:05 PM on 5 North. Food temperatures were as follows:</p> <p>Green Beans - 129.2 degrees F Hot Water (for tea) - 95.5 degrees F Milk - 53.2 degrees F</p> <p>The food service supervisors acknowledged the above cited temperatures for the test trays.</p>	L 108	<p>L 108 3220.2 Nursing Facilities</p> <ol style="list-style-type: none"> 1. No residents were harmed by deficient practice. 2. Tray line temps were checked at beginning, middle and end of meal service to ensure safe temperatures. 3. Reeducated food service staff and nursing staff on importance of maintaining safe food temperatures and serving residents immediately to ensure safe temperatures. 4. Food service manager or designees will be performing random weekly audits of food temps in food service department and on nursing units to ensure acceptable temperatures. Findings from weekly audits will be presented to facility Quality Improvement Committee monthly. 	<p>04/05/07</p> <p>04/05/07</p> <p>04/23/07</p> <p>05/02/07</p>
L 205	3232.3 Nursing Facilities	L 205		

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L 205	<p>Continued From page 25</p> <p>Summaries and analysis of incidents shall be reviewed at least monthly by the Administrator or designee in order to identify and correct health and safety hazards and patterns of occurrence. This Statute is not met as evidenced by: Based on a review of incident reports for January, February and March 2007, it was determined that facility staff failed to identify and correct the pattern of resident-to-resident altercations.</p> <p>The findings include:</p> <p>A review of the incident reports for January, February and March 2007 revealed the following resident-to-resident altercations:</p> <p>Resident QA1 - January 18, 2007 - Physical fight with another resident.</p> <p>Resident QA2 - February 8, 2007 - Hit another resident in the dining room.</p> <p>Resident #10 - February 8, 2007 - Hit two (2) other residents in the dining room.</p> <p>Resident #15 - February 18, 2007 - Physical fight with another resident.</p> <p>Resident QA3 - February 20, 2007 - Hit another resident on left side of neck.</p> <p>Resident QA4 - February 22, 2007 - Argued with another resident then turned over table and two (2) chairs.</p> <p>Resident #10 - March 4, 2007 - Threw a shoe and hit resident on left leg.</p> <p>Resident QA5 - March 6, 2007 - Scratched by another resident.</p> <p>Resident QA6 - March 8, 2007 - Loud verbal argument with roommate.</p> <p>Resident QA7 - March 8, 2007 - Loud verbal argument with another resident.</p> <p>Resident QA1 - March 11, 2007 - Observed with</p>	L 205	<p>L 205 3232.3 Nursing Facilities #1</p> <ol style="list-style-type: none"> 1. Resident QA1 was observed with a steak knife in her hand. Facility staff immediately confiscated the knife. 2. Resident QA1's room was thoroughly searched to ensure that he/she had no other knives in the room. No other residents were harmed nor threatened by this incident. 3. Staff was re-educated on importance of observing their surroundings particularly when in resident's rooms with focus on items that could be used as weapons. 4. Unit Manager or designee will conduct random weekly rounds X 4 weeks then monthly throughout resident rooms in an effort to identify potentially dangerous items that could be used as weapons. 	<p>03/11/07</p> <p>03/11/07</p> <p>04/30/07</p> <p>05/02/07</p>

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L 205	Continued From page 26 steak knife and threatening staff. Resident QA8 - no date - Verbally abusive and hit another resident Resident QA9 - no date - Screaming at top of voice to roommate Resident QA10 -no date - Hit by roommate. A face-to-face interview was conducted with the QI Compliance Officer on April 5, 2007, at 11:30 AM. He/she acknowledged that there was an increase in resident-to-resident altercations and resident aggressive behaviors and no plan had been developed by the facility to address the issues.	L 205	L 205 #2 1. In all the incidents cited in survey report, the facility took immediate action to separate residents or temporarily locate residents. DO, OIG and in some instances the police was notified. Responsible parties and physicians were notified. None of the resident involved suffered any remarkable injuries as a result of these personal confrontations with each other. 2. All resident involved in these resident to resident altercations will be care planned as "behavioral" problems, referred to social services and activities for diversional activities. 3. Facility will re-educate the IDT team members on integration of care plans that reflect the residents' behavioral problems, redirection for aggressive behavior and diversional activities offered. Administrator or designee will conduct random monthly audits of care plans on residents who display aggressive behavior towards each other to ensure that facility has made every attempt to address this behavior.	04/30/07 04/30/07
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and staff interview during the environmental tour, it was determined that the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, and homelike environment for residents as evidenced by: marred and/or damaged doors, floors, baseboards, walls, vertical blinds, and straight back chairs, standing water in the laundry room, graffiti on elevator walls, accumulated cigarettes butts on the front sidewalk, cleaning equipment stored on the floor, soiled water/ice machines, toilet seats, a geri chair, an oxygen concentrator and a shower stretcher. These observations were made on April 2, 2007 between 2:30 PM and 7:30 PM in the presence of maintenance, housekeeping and	L 410	4. Findings from monthly audit will be submitted to facility Quality Improvement Committee monthly.	04/30/07 05/02/07

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L 410	Continued From page 27 nursing staff. The findings include: 1. The front and edge surfaces of shower, bath and resident room entrance doors were marred and/or damaged in rooms 201, 203, 210, 220, 231, 2S shower room, 301, 324, 4S clean utility room, basement and laundry room doors in 11 of 23 doors observed. 2. Floors and baseboards were soiled, marred and/or damaged in rooms 203, 212, 220, 329, 1st floor dining room, 2S pantry, 3S soiled utility room, 4S pantry, basement housekeeping and equipment storage areas in 10 of 28 floors and baseboards observed. 3. Walls were marred, scarred and/or damaged in rooms 201, 203, 231, 234, 2N shower room, 3S dayroom, 4S dayroom, 4S soiled utility room in eight (8) of 24 walls observed. 4. Vertical blinds in dayrooms were damaged with missing slats on 2S, 2N, 3S, 3N, and 4S in 5 of 5 dayroom windows observed. 5. Straight back chairs were damaged and/or marred in dayrooms: 2N nine (9) of 13 chairs observed; 2S eight (8) of 12 chairs observed; 3N six (6) of six (6) chairs observed; 3S five (5) of six (6) chairs observed; 4S seven (7) of 11 chairs observed. 6. Standing water was observed on the floor in the rear of washers in the laundry room in one (1) of one (1) observation of the laundry room. 7. Elevator door frames were marred and the interior walls of the elevators had graffiti on the	L 410	L 410 3256.1 Nursing Facilities #1 1. The front edges of the shower doors and resident bathroom doors to rooms 201, 203, 210, 220, 231, 2 South shower, 301, 324, 4 South's clean utility, basement and laundry doors have been repaired and painted. 2. The maintenance staff will check all doors throughout facility to ensure that no other doors are deficient. 3. Housekeeping and maintenance staff were in-serviced on regulations on maintaining sanitary, orderly and comfortable interior to provide residents with safe, clean and homelike environment. 4. Maintenance staff will perform random weekly inspections of doors to ensure compliance. Findings from the weekly audit will be reported to the facility Quality Improvement Committee monthly. #2 1. All floors and baseboards identified as being damaged in room 203, 212, 220, 329, 1 st Floor dining room, 2 South pantry, 3 South soil utility, 4 South pantry, basement housekeeping and equipment storage areas have been cleaned and repaired. 2. Maintenance staff will check all floors and baseboards throughout building to ensure that no other floors or baseboards are deficient. 3. Housekeeping and maintenance staff were in-serviced on regulations on maintaining sanitary, orderly and comfortable interior to provide residents with safe, clean and home-like environment. 4. Maintenance staff will complete random weekly inspections of floors and baseboards to ensure compliance. Findings from weekly audit will be reported to facility Quality Improvement Committee/Risk Management monthly.	04/30/07 04/30/07 04/30/07 04/30/07 04/30/07 04/30/07 05/02/07

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L 410	<p>Continued From page 28</p> <p>walls in three (3) of three (3) elevators observed.</p> <p>8. Cigarette butts were accumulated on the sidewalk near the main entrance on the first day of the survey in one (1) of one (1) observations of the front sidewalk.</p> <p>9. Cleaning equipment such as mops, brooms and dust pans were stored on the floor of the janitorial closets and in the hallway on 2N, 2S, 3N hallway and 4S in four (4) of eight (8) observations of cleaning equipment.</p> <p>10. The water and ice chutes in the 2N pantry were soiled with mineral deposits and accumulated debris in one (1) of seven (7) water/ice machines observed.</p> <p>11. Two (2) portable shower toilets in the 2N shower room and one (1) toilet seat in the 4S training toilet were soiled on the seat surfaces with a dark substance in three (3) of four (4) toilets observed.</p> <p>12. A geri chair in the shower room of 2S was soiled on the seat surface with a dark brown substance in one (1) of one (1) geri chair observed.</p> <p>13. An oxygen concentrator in room 307 lacked a filter and the internal parts were soiled with accumulated dust in one (1) of four (4) oxygen concentrators observed.</p> <p>14. A shower stretcher pad was soiled with dust and debris in the 3S shower room in one (1) of four (4) shower stretchers observed.</p> <p>Maintenance, housekeeping and nursing staff acknowledged the above cited items.</p>	L 410	<p>L 410 #3</p> <ol style="list-style-type: none"> 1. Marred, scarred and damaged walls identified in room 201, 203, 231, 234, 2 North shower room, 3 South day room, 4 South day room and 4 South soiled utility room were repaired. 2. Maintenance staff will check all walls throughout facility to ensure that no other walls are deficient. 3. Housekeeping and maintenance staff were in-serviced on regulations on maintaining sanitary, orderly and comfortable interior to provide residents with safe, clean and home-like environment. 4. Maintenance staff will complete random weekly inspections of walls throughout facility to ensure compliance. Findings from random weekly audit will be presented to facility Quality Improvement/Risk Management meeting. <p>#4</p> <ol style="list-style-type: none"> 1. Damaged vertical blinds on 2 South, 2 North, 3 South, 3 North and 4 South will be replaced. 2. Maintenance staff will check all vertical blinds in building to ensure compliance. Damaged blinds will be replaced. 3. Housekeeping and maintenance staff were in-serviced on regulations on maintaining sanitary, orderly and comfortable interior to provide residents with safe, clean and home-like environment. 4. Maintenance staff will complete weekly audit of all vertical blinds to ensure compliance. Findings from weekly audit will be reported to facility Quality Improvement/Risk Management Committee monthly. 	<p>04/30/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p> <p>05/11/07</p> <p>04/30/07</p> <p>04/30/07</p> <p>05/02/07</p>

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			L 099 #6 1. Plastic deflector plate was cleaned immediately. 2. Food service staff cleaned deflector cover to ensure that no other resident was affected. 3. Food service staff was reeducated on cleaning assignments and importance of keeping plastic deflector cover clean at all times. 4. Food service director will complete daily audit of plastic deflector to ensure continued cleanliness. Findings from daily audit will be presented to facility Quality Improvement Committee monthly.	04/02/07 04/02/07 04/23/07 05/02/07
			#7 1. Coffee cups were immediately removed and de-stained. 2. Food service completed 100 percent audit all coffee cups to ensure that no others were stained. 3. Food service staff was reeducated on importance of checking coffee cups prior to use and what to do when stained cups are found. 4. Food service manager or designee will complete daily audit of coffee cups to ensure compliance. Findings from daily audit will be presented to facility Quality Improvement Committee monthly.	04/02/07 04/19/07 04/23/07 05/02/07