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	095036	A. BUILDING _____ B. WING _____	03/07/2008

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L 000	Initial Comments An annual licensure survey was conducted March 4 through 7, 2008. The following deficiencies were based on observations, record reviews and staff interviews. The sample included 29 residents based on a census of 191 residents on the first day of the survey and six (6) supplemental residents.	L 000		
L 012	3203.2 Nursing Facilities A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that facility staff failed to ensure that the dietician was licensed in the District of Columbia. The findings include: A review of the facility's licenses revealed that the dietician did not have a license from the District of Columbia. A face-to-face interview was conducted with the dietician on March 7, 2008 at 11:30 AM. He/she stated, "I am registered with the Commission on Dietetic Registration of the American Dietetic Association. I did not know that I needed a license from the District of Columbia."	L 012	1. The Dietician is licensed by the Commission on Dietetic Registration. All paperwork was submitted to the District of Columbia Licensing Body and she has received a DC license. Facility staff reheated food items prior to serving. Facility cannot retrospectively correct the varying temperature on test tray. 2. All licenses were checked and no other staff was employed without DC license. A review of the meal schedule was done to ensure residents trays are passed in a timely manner. No other residents were affected by this practice 3. The Dietary Staff were notified that license must be maintained with both Dietetic Registration and The District of Columbia. Nursing personnel will be in-serviced on the meal schedule and passing food trays. 4. Monitoring of Licenses are completed by the Human Resources Department monthly and reported to Quality Assurance. Monthly audits of meal schedule and passing trays will be reported at the Quality Improvement meeting.	3/31/08
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	L 051		

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L 051	Continued From page 1 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 record review and staff interview for three (3) of 29 sampled residents and one (1) supplemental resident, it was determined that the facility staff failed to initiate and/or update care plans for two (2) residents after falls, one (1) resident for the management of Diabetes Mellitus and one (1) resident for physical aggression. Residents # 8, 17, 12 and S2. The findings include: 1. Facility failed to update Resident #8's care plan after a fall. A review of the resident's record revealed the following nurse's note: February 25, 2008 at 11:00 AM, " ...Resident stated [I was trying to get my shoe but I was unable to get it]. No injury noted ".	L 051	1. A review of the clinical record for resident #8 and #17 was completed, while both have care plans on falls it was necessary to update both care plans. The comprehensive care plan for resident #12's diagnosis of diabetes was reviewed and diabetes was addressed on the "at risk for weight loss care plan". An additional care plan has been written to address diabetes separately which includes goals and approaches. A review of resident # S2's care plan was completed and while the resident has a detailed care plan addressing verbal aggression. It was necessary to update the care plan to include physical aggression. 2. A review of all resident's charts with diabetes and physical aggression was done. No other residents were found to be affected by this practice. A review of all charts with falls was done. No other residents were found to be affected by this practice. 3. Nursing personnel will be re-educated on updating care plans to reflect diabetes and physical aggression. Interdisciplinary team will be re-educated on care plan updates 4. Monthly audits of care plans will be reported at Quality Improvement monthly meeting	4/25/08

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L 051	Continued From page 2 The care plan was last updated on October 26, 2007. A face-to-face interview was conducted with Employee # 24 on March 6, 2008 at 2:15 PM. He/she acknowledged that the care plan was not updated with new goals and approaches after the above cited fall. The record was reviewed on March 6, 2008. 2. Facility staff failed to update Resident #17's care plan after a fall. A review of Resident #17's record revealed that the resident fell on September 10, 2007. The nurses note dated September 10, 2007 at 6:45 PM, "...Resident was sitting beneath the clock (in the nurses station) leaning to his/her left side and falling over the side of the wheel chair hitting his/her head..." The care plan "#11 Resident has history of falling" documented the aforementioned fall dated September 10, 2007. There was no evidence in the record that new goals and approaches were initiated after the September 10, 2007 fall. A face-to-face interview was conducted with Employee #20 on March 7, 2008 at 10:00 AM. He/she acknowledged that new goals and approaches were not documented in the care plan after the fall on September 10, 2007. The record was reviewed on March 6, 2008. 3. Facility staff failed to develop a care plan for Resident #12 for the management of Diabetes Mellitus.	L 051		

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L 051	Continued From page 3 A review of the record revealed that Resident #12 was admitted to the facility on August 3, 2007. A physician's order written on August 23, 2007 and signed on September 6, 2007 stated, " Start Glipizide XL 5mg PO (by mouth) q (every) day. Add Diabetic to the dx. (diagnosis)." The care plan last reviewed on February 5, 2008, lacked evidence that there was a problem identified with appropriate goals and approaches for the management of Diabetes Mellitus. A face-to-face interview was conducted with Employee #7 at approximately 2:30PM on March 6, 2008. He/she acknowledged that the care plan lacked goals and approaches for the management of Diabetes Mellitus. The record was reviewed on March 6, 2008. 4. Facility staff failed to develop a care plan for Resident S2's physical aggression. A review of Resident S2's record revealed the following nurses' notes: December 28, 2007 at 11:40 PM, "[Resident S2] blocking passage way and another male in a wheelchair attempted to pass ...[Resident S2] got up from wheelchair and hit the other resident and the other resident hit [Resident S2] back. " March 3, 2008 at 12:00 PM, "... Identified by another resident as the [man/woman] who kicked [another resident] yesterday ..." The resident's care plan was reviewed by the interdisciplinary team on February 14, 2008. There was no evidence that a care plan with appropriate goals and approaches for physical aggression was initiated.	L 051		

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L 051	Continued From page 4 A face-to-face interview was conducted with Employee #19 on March 7, 2008 at 10:00 AM. He/she acknowledged that the resident did not have a care plan for physical aggression. The record was reviewed March 7, 2008.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and	L 052	1. Resident #5's colonoscopy was rescheduled on 3/6/08. Resident #22 was reassessed by the primary physician and the pacemaker check was completed on 3/18/08. Facility cannot retrospectively correct resident #26's neuro checks. 2. A review of all charts with pacemakers, colonoscopies, and neuro checks has been done. No other residents were found to be affected by this practice. 3. Nursing personnel will be re-educated on consultations and follow-up appointments. Staff will also be in-serviced on protocol on neuro checks and pacemaker procedure 4. Monthly audits of appointments neuro checks and pacemakers will be reported at Quality Improvement meetings.	4/25/08

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L 052	Continued From page 5 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 observation, staff interview and record review for three (3) of 29 sampled residents, it was determined that nursing staff failed to: follow-up on a colonoscopy for one (1) resident, perform pacemaker checks as per physician's orders for one (1) resident and accurately perform neurological checks for one (1) resident. Residents #5, 22 and 26. The findings include: 1. Facility staff failed to reschedule a colonoscopy procedure for Resident #5. A review of the resident's record revealed the following nursing notes: October 30, 2007 at 7:00 AM, "At 6:30AM, Writer was called by CNA [Certified Nursing Assistant] to take a look at resident's ****. It was very black in color. Writer tested it for occult blood and it was positive ...Resident appeared weak but stable ..."	L 052		

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L 052	Continued From page 6 December 12, 2007 at 3:00 PM, " ...Colonoscopy scheduled for January 15, 2008 at 8:00 AM ..." January 14, 2008, "Colonoscopy [preparation] not done because consent form was not signed by responsible party. Will reschedule appointment and [follow-up with responsible party] ..." A doctor's telephone order of October 30, 2007 directed, "G.I. consult for positive stool guaiac." A "Gastrointestinal Consultation Report," signed by the physician and dated December 12, 2007 and January 16, 2008 directed "Colonoscopy ...see instruction and consent form ..." A face-to-face interview was conducted with Employee #8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the facility failed to reschedule the resident for the colonoscopy that was first ordered on December 12, 2007. The record was reviewed on March 7, 2008. 2. Facility staff failed to perform a pacemaker evaluation/assessment as ordered by the physician. A review of Resident # 22's record revealed a physician's order form signed and dated January 9, 2008 that directed, "Pacemaker check every 3 months: January, April. July, October". A pacemaker's clinic consultation report in the resident's record revealed that the pacemaker was last evaluated on October 29, 2007. There was no evidence in the record that the resident had a pacemaker check in January as per the physician's order.	L 052		

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L 052	Continued From page 7 A face-to-face interview was conducted with Employee # 8 on March 7, 2008 at approximately 11:00 AM. He/she acknowledged that the resident did not have a pacemaker check in January 2008 as per the physician's order. The record was reviewed March 7, 2008. 3. Facility staff failed to accurately perform neurological checks for Resident #26. A review of Resident #26 revealed the following nursing note dated December 5, 2007 at 10:35 PM, " Approx. 10:00 PM charge nurse reports hearing a noise. Upon investigation [charge nurse] found [Resident #26] with head and upper body on floor ... " A physician ' s telephone order dated December 5, 2007 at 10:00 PM directed, " Neuro checks (neurological) ... " A review of the " Neuro Flow Sheet " revealed that the resident ' s pupils were checked at 10:00 PM and 10:15 PM. Both pupils were assessed as being equal and reactive to light and measured 2 millimeters (MM). According to a " Report of Consultation " from the ophthalmologist dated September 6, 2007, " Pupil O/S (left eye) 5 MM, nonreactive to light. Blind O/S with old retinal detachment... " A face-to-face interview was conducted with Employee #9 on March 6, 2008 at 2:30 PM. He/she acknowledged that the resident was not assessed accurately. The record was reviewed March 6, 2008	L 052		

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L 108	Continued From page 8	L 108		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on the observation of a test tray conducted on March 4, 2008, it was determined that facility staff failed to ensure that cold food did not exceed 45 degrees Fahrenheit (F) and hot foods were served above 140 F at the point of delivery to the resident. The temperatures were measured in the presence of Employee #9. The findings include: On March 4, 2008, trays were delivered to unit 4 North at 8:50 AM. The last tray was passed to the residents at 9:50 AM. The test tray was checked and the following food temperatures were recorded in the presence of Employee #9: 2% Milk - 61.6 F Apple Juice - 58.6 F Scrambled Eggs - 88.1 F Bacon - 80.4 F Toast - 81.0 F Employee #9 acknowledged the findings at the time of the observations.	L 108	1.Facility staff reheated food items prior to serving. Facility cannot retrospectively correct the varying temperature on test tray. 2. A review of the meal schedule was done to ensure residents trays are passed in a timely manner. No other residents were affected by this practice. 3. Nursing personnel will be in-serviced on the meal schedule and passing food trays. 4. Monthly audits of meal schedule and passing trays will be reported at the Quality Improvement meeting.	4/15/08
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations on five (5) of six (6)	L 161		

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L 161	Continued From page 9 nursing units, it was determined that the facility staff failed to dispose of expired medications. The findings include: On Tuesday, March 4, 2008 at approximately 1:00 PM and Wednesday, March 20, 2008 at approximately 3:00 PM an inspection of the facility's medication storage areas was conducted. All medication was observed in the medication carts. The tablets were packaged in blister packs. The following expired medications were found: 1 North Unit Plavix 75mg tab - expiration date of 1/3/2008 2 North Unit Glucagon Emergency Kit-expiration date of 6/2007 Albuterol nebulizers, 25/box-expiration date of 1/2008 Ipratropium nebulizers, 25/box-expiration date of 12/2007 Acetaminophen 325 mg tablets-expiration date of 8/2007 2 South Unit Acetaminophen 325 mg tablets, (3) packs-expiration date of 3/2007 Acetaminophen 325 mg tablets-expiration date of 12/2006 Acetaminophen 325 mg tablets, (2) packs-expiration date of 9/2007 Acetaminophen 325 mg tablets,(2) packs-expiration date of 7/2007 Acetaminophen 500 mg tablets-expiration date of 5/2007 Ibuprofen 200 mg tablets-expiration date of 10/2007	L 161	1. All expired medications were disposed of immediately. 2. All medication carts were reviewed and no additional expired medications were observes. 3. A meeting was held with the clinical team and pharmacy, and the clinical team was re-educated regarding importance of disposal of expired medication. 4. The nursing manager will evaluate/ audit the medication carts and provide information to the Administration and /or Nursing Leadership. This will be presented in the QA meetings.	4/15/08

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L 161	Continued From page 10 Prochlorperazine 10 mg tablets-expiration date of 12/2007 Diphenhydramine 25mg capsule-expiration date of 2/2008 4 North Unit Carbidopa/Levodopa 25/100 mg tablet-expiration date of 3/1/2008 Carbidopa/Levodopa 25/100 mg tablet-expiration date of 3/1/2008 Docusate Sodium 100 mg capsules, (3) packs-expiration date of 1/2008 Docusate Sodium 100 mg capsules-expiration date of 11/2007 Fexofenadine 180 mg tablets-expiration date of 3/1/2008 4 South Unit Ferrous Sulfate 325 mg tablets-expiration date of 10/2007 Oyster Shell tablets-expiration date of 12/2007 Bisacodyl 5mg tablets-expiration date of 9/2007 Acetaminophen 325 mg tablet, (3) packs-expiration date of 10/2007 Acetaminophen 325 mg tablet-expiration date of 8/2007	L 161		
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 survey period, it was determined that facility staff failed to maintain a hazard free environment as evidenced by: missing skid strips on stairs, an extension cord in a resident's room, excessive items in	L 214		

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L 214	Continued From page 11 residents' rooms and a electrical multi-plug on the floor in a resident's room. These observations were made on March 7, 2008 in the presence of Employees #1, 2 and 3 from 8:30 AM through 11:00 AM. The findings include: 1. The center stairs were observed with damaged skid strips. Residents were observed walking up and/or down the stairs on the following days: March 7, 2008 at 10:00 AM, March 8, 2008 at 12:30 PM and March 9, 2008 at 2:30 PM. 2. An extension cord in room 228 was observed connected to the resident's personal entertainment equipment. 3. Excessive personal items were observed in rooms 103, 110, 119, and 214. 4. A multi-plug was identified as being used for a resident's electric wheel chair in room 423 and was observed on the floor. Employees #1, 2 and 3 acknowledged these findings at the time of the observations	L 214	1. The skid strips identified on the center stairs were replaced. The extension cord was removed and replaced with a facility approved multi-plug unit which was secured to the wall. The multi-plug unit in room 423 was secured to the wall. The excessive items in the room identified have been secured. A meeting with the residents with excessive items was conducted by the Director of Social Work. All meetings were completed by 3/25/08. 2. All of the stair wells have been checked and no others were noted to not have skid strips. All room were rechecked for extension cords and /or multi-plug outlet not mounted and no others were identified. All rooms were checked for excessive items and no other rooms were found to be affected by this practice. 3. An inspection of skid strips will be added to engineer inspection sheet and replacement/repair will be made as indicated. Additionally, daily inspections are done of extension cords and excessive items. The Engineering Director met with the Admissions Department to coordinate efforts to ensure that new residents/families are aware that extension cords are prohibited, and excessive personal items must be secured. The nursing staff have been re-in-serviced to notify the Administration team when extension cords or excessive items are identified by the Engineering Director and is present in the monthly QA meeting. 4. The Engineering Director and Supervisors monitors the facility for safety issues. Any concern is corrected And reported to the Quality Assurance Meeting.	4/25/08
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations during the environmental tour, it was determined that facility staff failed to maintain a sanitary facility as evidenced by: soiled baseboards, bed frames, corners, Heating	L 410	1. All baseboards, bed frames, corners and lower portion of window sills identified in report will be corrected by 4/25/08 Additionally interior surface of HVAC and caulking of shower rooms, and TV room will be completed by 4/25/08. The walls surfaces in the rooms and ceiling tiles identified in the survey will be corrected by 4/25/08. Shower room doors on 4North and 4 South have been reviewed by outside contractors and will be repaired or replaced. No residents were affected by this practice.	

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L 410	Continued From page 12 Ventilation and Air Conditioning (HVAC) units, lower window sills, caulking; marred/scarred/ soiled/damaged walls and ceiling tiles and rusted shower room doors. These observations were made in the presence of Employees #1, 2 and 3 on March 7, 2008 from 8:30 AM through 11:00 AM. The findings include: The following items were observed soiled: 1. Baseboards in rooms: 103, 123, 1N by the water fountain, 1S TV lounge, 1N soiled utility room and 230 in six (6) of 24 rooms/areas observed. 2. Bed frames in rooms: 103, 104, 107, 110, 114, 119, 122, 123 and 207 in nine (9) of 24 rooms observed. 3. Corners in rooms: 105, 107, 110, 114, 122, 1N in the TV room, 1N clean utility room, 214, 215, 221, 230, 4N soiled utility room and 4N dining room in 13 of 36 rooms observed. 4. HVAC units soiled on the interior of the front panel: 104, 105, 122, 203, 207, 210, 215, 219, 221, 228, 234, 406, 407, 410, 411, 415, 416, 426, and 433 in 19 of 36 HVAC units observed. 5. Lower portion of window sills in rooms: 103, 104, 105, 112, 114, 123 and 214 in seven (7) of 24 window sills observed. 6. Caulking: 1N shower room, 2S and 2N shower rooms, 3N TV room by the windows and 3N shower room in five (5) of 30 rooms observed. The following were	L 410	2. Assessment was done of resident room and common areas including baseboards, bedframes, corners, HVAC, window sills and caulking. Additional review of wall surfaces, doors and ceiling tiles were conducted. A schedule has been completed to correct any areas of concern identified. 3. A room log has been developed by the Environmental Services Director and Supervisor. Staff has been in-serviced on the usage and resident room and common area requirements. This will be utilized for common area inspection. During monthly and quarterly filter changes the HVAC will be cleaned with a shop vac Additionally, the Engineering Director has re-educated Engineering staff and met with Environmental Services Director to coordinate inspection and repair of shower rooms, caulking, and walls and ceiling tiles. 4. The Directors of Engineering and Environmental Services will monitor and conduct audits of rooms and common areas. This inspection will be reported in the QA meeting.	4/25/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 13 soiled/marred/scarred/damaged: 1. Walls in rooms: 103, 105, 110, 111, 114, 216, 234, 407, 416, 426, and 4S by the TV room in 11 of 36 rooms observed. 2. Ceiling tiles in rooms: 112, 114, 203, 207, 211, 215, 216, 2S TV room, 2N shower room, 406, 4 N TV room, 4N janitorial closet, 4N shower room in 13 of 36 rooms observed. 3. The bottom of the 4N and 4S shower room doors were observed rusted in two (2) of two (2) shower room doors observed on the 4th floor. Employees #1, 2 and 3 acknowledged these findings at the time of the observations.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that facility staff failed to maintain a pest free environment as evidenced by crawling and/or flying insects observed throughout the facility. These observations were made in the presence of Employees #1 and 2. The findings include: On March 4, 2008, pests were observed as follows: A crawling insect at 9:00 AM near room 119. A crawling insect at 9:40 AM near room 419.	L 426	1. Western Pest Control was at the facility during the survey for their regularly schedule inspection. They immediately treated the areas that were reported on gnats and 2 crawling insect were observed. 2. The facility was checked and all rooms were found to be free of insects. 3. The facility has a detailed pest control program. Staff has been in-serviced. Additionally Contractors who are doing construction have been reminded not to leave windows open and replace screens if they need to remove them. 4. The Director of Environmental Services and Supervisors monitors the facility for insects. This information is logged and used by the Pest Control Contractor. The outcome is reported to the Quality Improvement Team quarterly.	4/11/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 426	Continued From page 14 A gnat at 12:25 PM in the 1 N soiled utility room. A gnat at 2:00 PM in room 215. A dead insect at 3:15 PM in room 221. A gnat at 3:30 PM in room 230. On March 5, 2008, pests were observed as follows: A gnat at 8:30 AM, 3N entrance way. A gnat at 10:00 AM in the doorway of room 407. A gnat at 12:30 PM in the basement hallway by the elevators. Employees #1 and 2 acknowledged these findings at the time of the observations.	L 426		