

COPY

PRINTED: 07/07/2006
FORM APPROVED

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 04/14/2006
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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 10 through 14, 2006. The following deficiencies were based on observations, record reviews and interviews with the facility staff and residents. The sample included 30 records based on a census of 283 residents on the first day of survey and 15 supplementals 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 observation, interview and record review for two (2) of 30 sampled residents, it was determined that the facility failed to maintain credentials and privileges for one (1) physician and a license for one (1) social worker. Residents #2 and 27. The findings include: 1. Facility staff failed to maintain credentials for Physician #1 who reviewed Resident 2's x-rays at the facility. A review of Resident 2's record revealed an attending physician's order dated January 16, 2006 at 12:20 PM, "Ortho consult for right ankle fracture with [Physician 1]." There was no evidence in the record that an office visit had been scheduled for Resident #2. A face-to-face interview was conducted with the charge nurse on April 10, 2006 at 1:15 PM. He/she stated, "I got the x-rays films for [Physician # 1] and [he/she] came to the unit one night and	L 012	3203.2 Nursing Facilities 1. Physician will not be permitted privileges at facility until credentialed. Social Workers will have current license on file. 2. Review of physician credentialing files will be conducted for physicians with privileges having credentials as required. Review of SS employee files for SS license on file. 3. Staff in serviced on credentialing requirements for physicians seeing resident's. SS director re-educated on licensure requirements. 4. Administrator/designee to QI monitor physician files monthly for required credentials. HR designee to QI monitor SS employee files monthly for current license.	7/31/06

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Exec Dir (X6) DATE: 7-21-06

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L 012	<p>Continued From page 1</p> <p>looked at the films. [Physician #1] did not see [Resident 2] and did not write in the record."</p> <p>Review of the clinical record confirmed that Physician #1 did not write a progress note concerning his/her visit to the facility.</p> <p>A face-to-face interview was conducted with the administrative assistant on April 13, 2006 at 3:30 PM. He/she stated, "[Physician #1] does not have privileges to practice in the facility." The record was reviewed April 10, 2006.</p> <p>2. Facility staff failed to maintain a license for Social Worker #1 who saw Resident #27.</p> <p>A review of Resident #27's record revealed social worker progress notes dated March 23 and 27, 2006, written by Social Worker #1. The facility did not have a current copy of the social worker's license on file.</p> <p>A face-to-face interview was conducted with the Director of Social Services on April 13, 2006 at 10:00 AM. He/she stated, "[Social Worker #1] worked with [organization] that contracted with the facility for mood disorders and substance abuse counseling. The contract ended and they no longer come here. We are working with another group to contract for those same services."</p> <p>The Director of Social Services was asked if he/she had a copy of Social Worker #1's current license. The Director stated, "I don't have it now, but I can call and get it."</p> <p>The license was not presented to the survey team by the end of the exit conference on April 14, 2006.</p>	L 012		

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L 051	<p>3210.4 Nursing Facilities</p> <p>A charge nurse shall be responsible for the following:</p> <p>(a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;</p> <p>(b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;</p> <p>(c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;</p> <p>(d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e) Supervising and evaluating each nursing employee on the unit; and</p> <p>(f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, for three (3) of 30 sampled residents, it was determined that the charge nurse failed to revise the interventions on the care plan with goals and approaches for three (3) residents with multiple falls and consistently provide fall mats for two (2) residents. Residents #8, 21, 23 and 26.</p> <p>The findings include:</p> <p>1. The charge nurse failed to revise or update interventions on Resident 8's care plan with goals and approaches after multiple falls.</p>	L 051		

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L 051	<p>Continued From page 3</p> <p>A review of Resident #8's clinical record revealed a nurse's note dated November 28, 2005 at 11:30 AM, " Resident found on the floor next to his/her bed by Certified Nurse Aide (CNA), body assessment done to all extremities no pain, no signs/symptoms of injury. "</p> <p>A nurse's note dated January 25, 2006 indicated, " Resident observed sitting on the floor beside his /her bed at 2:40 AM. He/she was helped back in bed by two staff members and checked for injuries none visible.</p> <p>A review of the care plan dated January 16, 2006 revealed, "Actual fall, potential for injury related to falls due to limited mobility; Goal and target date the resident will have decrease number of falls by 4/17/06; Interventions: answer call light promptly, keep bed close to the floor except with providing direct care, keep frequently used items within reach, fall risk assessment quarterly and PRN"</p> <p>After the surveyor asked for a copy of the care plan, the following was added: "Remind resident not to attempt to get out without assistant 1/26/06 "</p> <p>There was no evidence in the record that interventions were in place to prevent future falls after January 25, 2006.</p> <p>A face-to-face interview was conducted on April 10, 2006 at 11:00 AM with the Assistant Unit Manager. He/she admitted that alternative interventions should have been implemented after the resident fell on January 25, 2006.</p> <p>2. The charge nurse failed to revise and update interventions on Resident 21's care plan with</p>	L 051	<p>3210.4 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Resident #8, 21, 23 has had care plan revised and updated with fall interventions. Resident's #21 and 26 has floor fall mat in place. 2. Review of resident's with fall within last 30 days will be conducted for revisions and updating interventions for fall management. 3. Nursing staff in serviced on fall management clinical program. 4. UM/designee to QI monitor care plans for revision and updating s/p fall w/ly x4 then monthly. Appropriate action on findings. Findings reported to FLC. 	7/31/06

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L 051	<p>Continued From page 4</p> <p>goals and approaches after multiple falls and consistently provide a bedside fall mat.</p> <p>A. According to Resident #21's care plan, the resident was observed on the floor on March 9 and March 24, 2006. There were no new interventions initiated for the resident after the March 9, 2006 fall. On March 25, 2006, a pad at the bedside was initiated. The resident was observed on April 13, 2006 at 9:30 AM. The resident was in a geri chair and there was no pad in the room.</p> <p>A face-to-face interview with the Unit Manager (UM) was conducted at that time. He/she stated, "We clean the bedside pads and store them in the storage room during the day when [resident] is not in bed."</p> <p>The UM checked the resident's closet and the storage room. There were no bedside pads in either location. The UM spoke with staff members and stated, " [Resident #21's] pads were used last night for another resident. "</p> <p>The charge nurse failed to initiate new interventions for Resident #21 after a fall on March 9, 2006 and failed to consistently implement the intervention of a bedside pad initiated after a fall on March 25, 2006. The record was reviewed April 13, 2006.</p> <p>3. The charge nurse failed to revise and update interventions with goals and approaches for Resident 23 after multiple falls.</p> <p>According to Resident #23's clinical record, he/ she was observed on the floor November 12, 2005 and January 14, 28 and 31; February 1 and 26; March 9, 12 and 24; and April 6, 2006.</p>	L 051		

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L 051	<p>Continued From page 5</p> <p>A care plan problem identified, " Potential for fall related to periodic unsteady gait." The care plan recorded the falls for November 12, 2005, March 12, 2006 and April 6, 2006. The goal initiated for November 12, 2005 and March 12, 2006 was, " Resident is instructed to call for assistance whenever the need arises. " The goal initiated for the fall that occurred on April 6, 2006 was, " Ensure use of assistive devices (cane)." There was no evidence that facility staff initiated any additional interventions to prevent the resident from falling.</p> <p>A face-to-face interview was conducted with the UM on April 12, 2006 at 11:30 AM. After reviewing the resident ' s record, he/she acknowledged that no other interventions were initiated after falls on January 14, 28 and 31, February 1 and 26 and March 24, 2006, to prevent the resident from falling. The record was reviewed April 12, 2006.</p> <p>4. The charge nurse failed to provide a fall mat for Resident #26 who had a history of multiple falls.</p> <p>During the review of the clinical record for Resident #26 it was observed that the resident had falls without injuries on March 22 and 27, 2006. A physician's orders dated March 29, 2006 indicated, "Fall mat at beside when resident is in bed."</p> <p>The care plan was updated on March 27, 2006 for; "Fall mattress at bedside." However on April 13, 2006 at approximately 7:40 AM, the resident was observed in bed without a fall mat at the bedside.</p>	L 051		

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L 051	Continued From page 6 On April 13, 2006 at approximately 11:30 AM, a licensed nurse reported that fall mats were obtained to place at the resident's bedside. The record was reviewed on April 12, 2006.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating;	L 052	3211.1 Nursing Facilities 1. Stairwells have monitors. Resident #21 has had no further falls in stairway. Resident #1 receives finger sticks to monitor blood sugar as ordered and receives eye ointment as ordered. Resident #2 had orthopedic consult scheduled and attending physician notified of appointment. Resident #4 receives meds as ordered and resident's attending physician is notified of dialysis physician orders. Resident #4 receives insulin as ordered. Resident JK1 has had IV's d/c and receives meds as ordered. Resident JK2 IV's d/c and resident receives meds as ordered. Resident JK3 receives meds as ordered. Resident JK4 receives meds as ordered. Resident JK5 receives meds as ordered 2. Review of MAR's will be conducted for resident's receiving meds as ordered. 3. Nursing staff re-educated on med administration and documentation of meds. 4. UM/designee to QI monitor MAR's daily for administration of meds as ordered. Findings reported to FLC.	7/31/06

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L 052	<p>Continued From page 7</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, record review, and staff interview for three (3) of 30 sampled residents and five (5) supplemental residents, it was determined that sufficient nursing time was not given as evidenced by failure to: adequately supervise one (1) resident who fell in the stairwell; monitor one (1) resident's blood sugar and administer eye ointment as ordered; follow up with an orthopedic consult for one (1) resident; clarify an Ativan order timely and follow physician's orders for the administration of insulin for one (1) resident; and administer medications to five (5) supplemental residents per physician's order. Residents #1, 2, 4, JK1, JK2, JK3, JK4 and JK5.</p> <p>The findings include:</p> <p>1. Facility staff failed to adequately supervise Resident #21 who fell in the stairwell.</p> <p>A review of Resident #21's record revealed an annual Minimum Data Set assessment completed March 2, 2006 coded the resident in Section D, "Vision" as impaired. In Section I, "Disease Diagnoses", the resident was coded for</p>	L 052		

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L 052	<p>Continued From page 8</p> <p>Glaucoma and profound blindness of one (1) eye.</p> <p>According to a nurse's note dated September 30, 2005 at 4:30 PM, "Resident found with wheelchair at north side 3rd floor stairway by treatment nurse. Reported to AM charge nurse. Writer called to treatment nurse in the stairway for staff to help resident back to the floor and assess resident. Resident complaining of pain on left side head and swollen right hand abrasion. ... transfer resident to ER for evaluation ..."</p> <p>According to a nurse's note dated October 1, 2005 at 2:45 PM, "...Resident lying in bed. Alert and verbally responsive ...small bruise noted on nose. Small hematoma noted on left side of forehead ..."</p> <p>A face-to-face interview with the Assistant Unit Manager was conducted on April 13, 2006 at 9:30 AM. He/she stated, "I don't know how he got into the stairwell. [Resident] is very active. [He/she] rolls around the unit in the wheelchair and doesn't see very well. We put up stop signs on the door after [resident] got into the stairwell. Now when [resident] gets agitated, [he/she] is usually hungry and we give him/her a snack and put [him/her] in a gerichair to rest."</p> <p>The record was reviewed on April 13, 2006.</p> <p>2. A review of Resident #1's record revealed that facility staff failed to monitor the resident's blood sugar by finger stick and administer eye ointment as ordered.</p> <p>A. A review of the physician's order dated January 1, 2006 indicated, " Glucose finger stick two times daily. " The Medication Administration Record (MAR) for February 2006 revealed that the resident's blood sugar was to be monitored by</p>	L 052		

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L 052	<p>Continued From page 9</p> <p>finger stick at 7:00 AM and 4:00 PM According to the MAR, the fingersticks were not performed at 7:00 AM on February 7, 13, 18, and 27, 2006.</p> <p>A face-to-face interview was conducted on April 10, 2006 at 11:00 AM with the Assistant Unit Manager. He/she acknowledged that finger sticks were not done and should have been done. There was no evidence of hypoglycemic or hyperglycemic symptoms. The record was reviewed April 10, 2006.</p> <p>B. A review of the physician's order dated February 8, 2006 indicated, " Artificial Tears Ointment apply into both eyes twice daily for Glaucoma. " A review of the April 2006 MAR revealed that the eye ointment was to be administered at 6:00 AM and 6:00 PM. According to the April 2006 MAR the eye ointment was not administered on April 1, 2, 3, 4, 5, 6, 7 and 9, 2006 at 6:00 AM.</p> <p>A face-to-face interview was conducted on April 10, 2006 at 11:00 AM with the Assistant Unit Manager. He/she acknowledged that the eye ointment should have been administered as ordered. The record was reviewed on April 10, 2006.</p> <p>3. Facility staff failed to follow-up on an orthopedic consult for Resident #2.</p> <p>According to a nurse's note dated December 23, 2005 at 8:00 AM, "Resident stated "I fell from bed" No bruises or injury noted. Range of motion done to all extremities. Resident complained of right leg pain ...[attending physician] gave order for right leg and hip x-ray ... " The x-ray was negative for a right leg and hip fracture.</p>	L 052		

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L 052	<p>Continued From page 10</p> <p>The resident complained of pain in the right leg on December 25 and 26, 2005. Resident #2 was medicated for pain; however, the physician was not notified of the resident's status.</p> <p>On December 28, 2005 at 6:00 AM the nurse observed the resident's foot as slightly swollen. The attending physician was notified and ordered an x-ray of the right foot and ankle.</p> <p>The x-ray showed a fracture of the distal fibula which was in good alignment. The resident was sent to the hospital via 911 for further treatment and evaluation. The resident returned from the hospital on December 29, 2005 at 7:00 AM with the right foot and ankle wrapped in an ace bandage.</p> <p>The attending physician wrote an order dated December 29, 2005 at 10:00 AM, " Call [orthopedic physician] to come and see patient. "</p> <p>A nurse's note dated December 30, 2005 at 10:30 AM documented, " Call was placed to [orthopedic physician]. The writer was informed that [physician] was out of town and would be back on 1/6/06. The receptionist ...would notify the MD."</p> <p>There was no evidence in the record that the attending physician was notified of the delay for Resident #2 to see the orthopedic physician.</p> <p>According to the nurses' notes, on January 3 and 4, 2006 the resident's right ankle was observed as slightly swollen. On January 9, 2006 the resident was observed on his/her knees by the bed. The resident was transferred to the hospital via 911 for further evaluation and treatment.</p>	L 052		

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L 052	<p>Continued From page 11</p> <p>The resident returned to the facility on January 10, 2006 with the right leg in a splint and ace bandage. The orthopedic physician was called on January 10 and 12, 2006. The resident was directed to come to the physician's clinic on Mondays and Thursdays. The resident never saw the orthopedic physician.</p> <p>The attending physician saw the resident on January 16, 2006 and ordered that another orthopedic physician see the resident.</p> <p>Through interview with the charge nurse on April 10, 2006 at 1:15 PM, the second orthopedic physician came into the facility, saw the x-rays but did not see the resident and did not write progress notes or orders in the record. This physician's credentials were not maintained at the facility and he/she had no privileges to practice at the facility.</p> <p>The attending physician saw the resident and wrote progress notes for December 29, 2005, January 19, February 10 and March 9, 2006. The right ankle fracture was reviewed in each progress note.</p> <p>The resident was observed on the floor on February 1, 7 and 19, 2006. No further injuries were noted. Follow-up x-rays were ordered by the attending physician on March 10, 2006. The x-ray showed, " Ankle Rt: There is a fracture involving lateral malleolus with modest healing. The joint alignment is maintained. There is associated soft tissue swelling ... " The record was reviewed April 10, 2006.</p> <p>4. Facility staff failed to notify the attending physician of the dialysis physician's order for</p>	L 052		

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L 052	<p>Continued From page 12</p> <p>Ativan timely and follow physician's orders for the administration of insulin to Resident #4.</p> <p>A. A review of Resident #4's record revealed an order written by the dialysis physician, on a dialysis physician's order sheet, maintained in the resident's clinical record dated February 3, 2006, " Give Ativan 2 mg po (orally) prior to coming to dialysis." The order was noted on February 3, 2006. However, in a face-to-face interview with the Unit Manager on April 11, 2006 at 2:30 PM, the signature could not be identified.</p> <p>There was no evidence that the attending physician had been notified of the order, that the order had been transcribed onto the February or March 2006 MAR or that the resident had received the medication prior to dialysis. The resident received dialysis every Monday, Wednesday and Friday.</p> <p>One (1) line below the above cited order on the same sheet of paper was, ".5 BID PRN ordered 2/10/06 & D/C .25 q d." This was signed by the attending physician no date indicated. On the next order sheet dated 2/10/06 at 9:30 AM was the following order, " D/C Ativan .25 mg. Ativan 0.5 mg po BID PRN - agitation." This order was signed by the attending physician and transcribed onto the resident's MAR. The record was reviewed April 11, 2006.</p> <p>B. Facility staff failed to follow physician's orders for the administration of insulin for Resident #4.</p> <p>A review of Resident #4's record revealed a physician's order dated January 31, 2006 directing additional insulin to be administered based on the results of a blood glucose test at 6:00 AM and 4:00 PM. The order directed, "[for</p>	L 052		

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L 052	<p>Continued From page 13</p> <p>blood glucose] 250 - 300 [G/dl] give 3 units [of insulin]; 301-350 = 6 units; 351-400 = 9 units; > 400 = 10 units and call MD ... "</p> <p>On February 24, 2006 at 4:00 PM, Resident #4's blood glucose was recorded as 226. It was documented on the February MAR that six (6) units of insulin was administered to the resident.</p> <p>According to the physician's orders dated January 31, 2006, no insulin should have been administered. There was no evidence that the resident experienced any untoward effects as a result of receiving the additional insulin.</p> <p>A face-to-face interview with the Unit Manager was conducted on April 11, 2006 at 2:30 PM. He/she acknowledged that the insulin should not have been administered. The record was reviewed April 11, 2006.</p> <p>5. Facility staff failed to administer Ancef 1 gram intravenously (IV) to resident JK1 as prescribed by the physician.</p> <p>A review of Resident JK1's record revealed a physician's order dated March 25, 2006, " Ancef 1 gram IV every 8 hours until April 20, 2006. " A review of the resident's Medication Administration Record (MAR) for March and April 2006 revealed that the resident was to receive Ancef at 2:00 PM, 10:00 PM and 6:00 AM. The resident did not receive Ancef, 1 gram IV at 2:00 PM on March 30, April 7 and April 12, 2006. The record was reviewed April 10, 2006.</p> <p>6. Facility staff failed to administer Cefepime 1 gram IV to Resident JK2 as prescribed by the physician.</p>	L 052		

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L 052	<p>Continued From page 14</p> <p>A review of Resident JK2's record revealed a physician's order dated March 15, 2006, " Cefepime 1 gram IV daily for three months starting 2/27/06 for sepsis. " A review of the March and April 2006 MARs revealed that the resident did not receive the medication on March 20, 23, 24, 26, 27 and April 1, 2, 7 and 8, 2006. The record was reviewed April 10, 2006.</p> <p>7. Facility staff failed to administer Levaquin 500 mg to Resident JK3 as per physician's orders.</p> <p>A review of Resident JK3's record revealed a physician's order dated April 7, 2006, " Levaquin 500mg via G-tube [gastrostomy] tube q d [daily] for 5 more days for sepsis. " A review of the resident's April 2006 MAR revealed that the medication was administered for four (4) days, April 8, 9, 10 and 11, 2006. No documentation was available to indicate that additional doses of Levaquin were administered. The record was reviewed April 13, 2006.</p> <p>8. Facility staff failed to administer a Duragesic patch for pain management to Resident JK4 as per physician orders.</p> <p>A review of Resident JK4's record revealed a physician's order dated March 23, 2006, " Duragesic patch 25 mcg to chest every 72 hours for pain. " The resident's Controlled Substance Record and March and April 2006 MARs were reviewed. The Controlled Substance Record indicated that a patch was signed out as being administered to the resident on March 24, 31, April 6 and 9, 2006. The controlled substance shift count log was correct for the days and times in question. The above mentioned record and log were reviewed April 10, 2006.</p>	L 052		

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L 052	<p>Continued From page 15</p> <p>It was documented on the March and April 2006 MAR that a patch was applied on March 24, 27, 31, April 3 and 6, 2006. However, there was no Duragesic patch signed out on the Controlled Substance Record for March 27, 2006 or April 3, 2006. No alternate source for the Duragesic patch was identified. The record was reviewed April 13, 2006.</p> <p>9. Facility staff failed to administer Tobramycin Ophthalmic Solution to Resident JK5 as per physician's orders.</p> <p>A review of Resident JK5's medical record revealed a physician's order, dated April 6, 2006, "Tobramycin eye drops, 1 drop to both eyes three times daily for 7 days." A review of the resident's April 2006 MAR, revealed that drops were scheduled to be administered at 6:00 AM, 2:00 PM and 6:00 PM. The eye drops were not administered at 6:00 PM on April 6, 7, 8, 9 and 10, 2006. The record was reviewed April 12, 2006.</p>	L 052		
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 the review of the facility's "Nursing Daily Staffing Sheet" for the week of the survey, it was determined that the facility failed to provide sufficient nursing staff at a minimum daily average of 3.5 nursing hours per resident day.</p> <p>The findings include:</p>	L 054	<p>3211.3 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Facility staff's at 3.5 nursing hours per resident day. 2. Daily review of nursing staffing will be conducted for 3.5 nursing hours per resident day. 3. Nursing staff educated on staffing requirement. 4. DON/designee to QI staffing hours daily x4 then monthly. Findings reported to FLC. 	7/31/06

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L 054	<p>Continued From page 16</p> <p>According to 22 DCMR 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 were requested for April 10 through April 14, 2006 during the entrance interview with the Administrator and the Director of Nurses (DON) on April 10, 2006. The staffing sheets revealed the following daily average of nursing hours per day (actual staffing April 10, 11, and 12, 2006; April 13, 14, and 15, 2006 was planned staffing.</p> <table border="1"> <thead> <tr> <th>Dates</th> <th>Nursing hours</th> </tr> </thead> <tbody> <tr> <td>April 10, 2006</td> <td>2.7</td> </tr> <tr> <td>April 11, 2006</td> <td>2.8</td> </tr> <tr> <td>April 12, 2006</td> <td>2.7</td> </tr> <tr> <td>April 13, 2006</td> <td>2.8</td> </tr> <tr> <td>April 14, 2006</td> <td>2.8</td> </tr> <tr> <td>April 15, 2006</td> <td>2.7</td> </tr> </tbody> </table> <p>April 2, 2006 staffing was randomly chosen for review. The nursing hours for April 2, 2006 were 2.8, the week prior to the survey.</p> <p>April 10, 11, and 12, 2006, 2006 staffing hours were calculated in the presence of the DON and the staffing coordinator.</p>	Dates	Nursing hours	April 10, 2006	2.7	April 11, 2006	2.8	April 12, 2006	2.7	April 13, 2006	2.8	April 14, 2006	2.8	April 15, 2006	2.7	L 054		
Dates	Nursing hours																	
April 10, 2006	2.7																	
April 11, 2006	2.8																	
April 12, 2006	2.7																	
April 13, 2006	2.8																	
April 14, 2006	2.8																	
April 15, 2006	2.7																	
L 145	<p>3226.5 Nursing Facilities</p> <p>The medication for self-administration shall be securely stored and accessible only to the appropriate resident and staff. This Statute is not met as evidenced by: Based on observations, it was determined that facility staff failed to secure one (1) self-medicating resident's medication. Resident H1.</p>	L 145																

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L 145	Continued From page 17 The findings include: Facility staff failed to ensure that Resident H1's medication was secured. On April 13, 2006 at approximately 6:35 AM, three (3) inhalants were observed in an unlocked drawer at Resident H1's bedside and a cup with two(2) pills was observed on the resident's over bed table. The resident was in bed and appeared to be asleep. The night staff nurse was called to the resident's room and she/he indicated that the resident had a physician's order for self medication of his/her inhaler. The night staff nurse stated that the pills left on the bedside table were the 6:00 AM dose of Motrin and Claritin.	L 145	3226.5 Nursing Facilities 1. Resident H1 no longer self medicates. Medications are not left at bedside. 2. Room observations will be conducted for meds at bedside unsecured. Appropriate action taken on findings. 3. Nursing staff re-educated on self administration of meds and medication administration. 4. UM/designee to QI monitor for unsecured meds and bedside appropriate action taken on findings. Findings reported to FLC.	7/31/06
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws, regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on observations, it was determined that facility staff failed to lock the medication cart on unit 5 South. The findings include: On April 12, 2006 at 5:10 PM the medication cart on unit 5 South was observed unlocked. There was no staff in the immediate area. The surveyor was told that the nurse was moving his/her car.	L 167	3227.18 Nursing Facilities 1. Med carts are locked when unattended. 2. Review of med carts will be conducted for being locked when unattended. 3. Nurses re-educated on locking med carts. 4. UM/designee to QI monitor med carts for being locked when unattended. Appropriate action taken on findings. Findings reported to FLC.	7/31/06

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L 204	Continued From page 18	L 204		
L 204	<p>3232.2 Nursing Facilities</p> <p>A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:</p> <p>(a)The date, time, and description of the incident;</p> <p>(b)The name of the witnesses;</p> <p>(c)The statement of the victim;</p> <p>(d)A statement indicating whether there is a pattern of occurrence; and</p> <p>(e)A description of the corrective action taken.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, it was determined that the facility staff failed to complete a summary of all incidents that occurred in the facility. Residents #2, 8, 14 and 21.</p> <p>The findings include:</p> <p>During the survey period, a summary of the incidents reports for January, February and March 2006 was received from the Director of Nursing (DON) and reviewed by the survey team. After the initial review of the incidents on April 11, 2006, the DON was asked if all the incidents were contained in the report. A supplemental report was given to the surveyors on April 13, 2006 and the DON assured the survey team that the summary of incident reports was complete. After review of the supplemental report, the following incidents were not included in the report</p>	L 204	<p>3232.2 Nursing Facilities</p> <ol style="list-style-type: none"> Summary of incidents is maintained which includes all incidents. Incidents for 2, 8, 14 and 21 have been added to summary. DON/designee will conduct review of incidents for last 30 days for being contained in summary. Incident reports to be logged into system and maintained by DON/designee. Administrator /designee to QI monitor summary of incidents for completeness monthly and report findings at FLC. 	7/31/06

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L 204	Continued From page 19 Resident 2 - found on the floor on February 1 and 19, 2006. Resident 8 - found on the floor on January 25, 2006. Resident 14 - found on the floor on February 24, 2006. Resident 21 - found on the floor on January 3 and March 9, 2006.	L 204		
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 the facility failed to maintain a functional, safe, supportive, comfortable and sanitary environment as evidenced by: two (2) of three (3) inoperable elevators which impacted the movement of residents, staff and visitors; 3" screws found on one (1) resident's bedside dresser; a broken brake on one (1) resident's wheelchair; an unlocked treatment cart; unsecured horizontal lamps over residents' beds; chemicals stored on the floor in a resident's room; soiled isolation carts, a hopper hose, hydraulic lift straps, a mattress, linen carts and ice machine chutes; particles in the Barbisol solution and items stored under the sink in the Beauty shop; and hot water temperatures below 160 degrees Fahrenheit (F) in the washing machine. The findings include:	L 214		

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L 214	<p>Continued From page 20</p> <p>1. Two (2) of three (3) elevators were not on line during the survey period. Based on the review of contracts with two (2) vendors, the facility had two (2) of three (3) elevators out of service, since or before August 31, 2005 impacting the movement of residents, staff and visitors in the facility.</p> <p>During the group meeting on April 12, 2006 at 10:30 AM, residents reported difficulty in attending activities, going to the patio or outside because of the long wait for elevator service.</p> <p>On April 10, 2006 at 11:30 AM, Resident #23 was observed walking down the steps with a cane from the second floor. The surveyor asked the second floor charge nurse if he/she was aware that Resident #23 was walking down the steps. The charge nurse was not aware the resident had started walking down the steps, remained on the second floor landing and called to the resident to return. The resident stated, "I'm not waiting for the elevator."</p> <p>A face-to-face interview was conducted with Resident #10 on April 12, 2006 at 9:15 AM. Resident #10 returned from the hospital on April 7, 2006 after an amputation of the toes on the right foot. Resident #10 used a cane while walking. Resident #10 stated that he/she walked down the stairs at least three (3) times a day to smoke on the patio. Resident #10 stated that there was only one (1) elevator that worked and he/she had waited at least 15 minutes since returning from the hospital for the elevator. Resident #10 stated, "It can't be doing my foot any good to walk down the steps, but it's ridiculous to wait that long for the elevator."</p> <p>A face-to-face interview was conducted with Resident #15 on April 14, 2006 at 11:45 AM.</p>	L 214	<p>234.1 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Stairwell monitors in place in stairwells. Elevators 1&2 are on line and in service. 2. Screws removed from resident #17's room immediately. 3. Resident 15's wheelchair in proper working condition. 4. Treatment carts are locked when unattended. 5. Horizontal lamps over resident beds have been secured in rooms 307, 325, 234 and 536. 6. Lysol disinfectant and isopropyl alcohol and pine sol removed from room 329. 7. Isolation carts cleaned. Betadine and peroxide removed. 8. Hopper hoses replaced. 9. Hydraulic lifts strap replaced. 10. SR's and mattresses cleaned. 11. Linen carts cleaned. 12. Ice machine chutes cleaned and drains unclogged. 13. Barbisol solution changed out. 14. Supplies in beauty shop kept behind locked cabinet when unattended. Door under sink cabinet secured shut. 15. Hot water to washers maintain 160(F) for minimum of 25 minutes. <p>2. Environmental rounds conducted for stairwell monitors, screws in room, wheelchair repairs, treatment carts being locked when unattended, over bed lights being secured, biologicals, isolation cart cleanliness, cleanliness of hopper hose, hydraulic lifts straps, SR and mattresses cleanliness, cleanliness of isolation carts and linen carts and cleanliness of pantry ice machines. Appropriate action taken on findings.</p> <p>3. Staff in serviced on requirement of maintaining a functional, safe, healthful, comfortable and supportive environment.</p> <p>4. Admin./designee to conduct facility environmental rounds daily x4 then monthly. Appropriate action based on findings. Findings reported to FLC.</p>	7/31/06

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L 214	<p>Continued From page 21</p> <p>Resident #15 stated that he frequently walked down the steps with a cane because he had missed prior appointments due to waiting for the elevator because there was only one (1) elevator in service. Resident #15 had an amputation of the great toe of his/her foot and was admitted on September 5, 2005 for rehabilitation services and extensive antibiotic therapy. A physician's order dated March 30, 2006 directed, "...only heel touch weight bearing for short distances ..."</p> <p>Resident #15 stated that it was difficult to take the stairs but the only way to ensure that he/she could be on time for transportation and to keep the appointments.</p> <p>On April 13, 2006 at 7:20 AM a resident was observed walking down the stairs. On April 12, 2006 the facility's plan was to have continuous monitoring on the stairwells. There were no monitors on either stairwell (north and south) at the time of this observation.</p> <p>On April 13, 2006 at 2:50 PM it was observed that five (5) residents in wheelchairs were waiting for elevator service. Dietary staff reported that seven (7) of eight (8) food carts had not been returned to the kitchen area for cleaning and preparation for the evening meal. The facility's plan was to provide an elevator operator to assist in elevator services. Prior to the time of this observation, it was reported to the surveyors that the elevator operator was not present for an unknown period of time.</p> <p>Multiple observations during the survey period revealed that residents in wheelchairs had difficulty maneuvering in the elevator to accommodate space for others trying to board or exit on their requested floors.</p>	L 214		

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L 214	<p>Continued From page 22</p> <p>On April 11, 2006 at approximately 8:30 AM, it was observed that a large bin of trash and three (3) residents in wheelchairs were transported in the same elevator and exited on the first floor.</p> <p>An interview was conducted on April 12, 2006 at 2:30 PM with Resident #S4 and his/her family member. The family member stated that he/she had limited time to visit with the resident because of arranging transportation to and from the facility. The family member stated that he/she had waited as long as 30 minutes for an elevator which limited the time the family member had available to visit the resident.</p> <p>2. Two (2) 3" screws were observed on Resident #17's bedside table.</p> <p>During a wound dressing change observation on April 13, 2006 at 1:40 PM, two (2) 3 " screws with toggle bolts were observed on Resident #17's bedside dresser. The resident stated, " The maintenance people left those when they put this (pointed to a wall guard behind the bed) on the wall. They did that a couple of days ago. "</p> <p>3. Facility staff failed to repair Resident S1's wheelchair brake.</p> <p>On April 11, 2006 at 10:00 AM, the physical therapist was escorting Resident S1 to the therapy department. The left hand brake was observed hanging down on the side of the chair. The therapist was asked if he/she was aware of the broken brake. The therapist stated, " It (the brake) has been broken for awhile and can't be fixed. [Resident S1] is being measured for a new chair. We don't have any more wheelchairs."</p> <p>4. Facility staff failed to lock the treatment cart on</p>	L 214		

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L 214	<p>Continued From page 23</p> <p>unit 3 South.</p> <p>On April 11, 2006 at 12:15 PM the treatment cart was observed unlocked on unit 3 South. There was no staff in the immediate area. When the nurse returned to the cart after completing a treatment, he/she stated, " I forgot to lock the cart. "</p> <p>5. Horizontal lamps located over residents' beds were not secured in the following areas:</p> <p>Second Floor Room 234 in one (1) of 18 observations at 11:35 AM on April 11, 2006.</p> <p>Third Floor Rooms 307 and 325 in two (2) of 11 observations between 2:50 PM and 4:14 PM on April 11, 2006.</p> <p>Fifth Floor Room 536 in one (1) of eight (8) observations on April 12, 2006.</p> <p>6. Chemicals such as Lysol disinfectant spray, isopropyl alcohol and Pine Sol, were stored on the floor in room 329 in one (1) of one (1) observation at 8:55 AM on April 12, 2006.</p> <p>7. Four (4) isolation carts were observed soiled with dust and debris on the top surface, drawer handles and the inside of the drawers.</p> <p>2nd floor, two (2) of two (2) isolation carts observed on April 10, 2006 between 8:45 AM and 9:10 AM.</p> <p>3rd floor, one (1) of one (1) isolation cart observed on April 10, 2006 between 8:30 AM and 8:35 AM.</p> <p>5th floor, one (1) of one (1) isolation cart</p>	L 214		

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L 214	<p>Continued From page 24</p> <p>observed on April 10, 2006 between 8:25 AM and 9:30 AM. The cart had a bottle of Betadine and peroxide stored in the bottom drawer. Neither product was currently being utilized by the resident assigned to the cart.</p> <p>8. An observation of the 2 South Soiled Utility Room was conducted on April 12, 2006 at 4:45 PM. The hose to the hopper was observed with a brown substance on the nozzle. The hose was lying in the water.</p> <p>9. Hydraulic lifts in the hallways were observed to have soiled straps in the following areas:</p> <p>3 North hallway in one (1) of one (1) observation at approximately 12:10 PM on April 11, 2006.</p> <p>4 South hallway in one (1) of one (1) observation at approximately 1:00 PM on April 12, 2006.</p> <p>5 South hallway in one (1) of one (1) observation at approximately 4:00 PM on April 12, 2006.</p> <p>10. A mattress and side rails on a resident's bed were soiled in one (1) of one (1) observation at 2:30 PM on April 11, 2006.</p> <p>11. The frame surfaces of clean linen carts were soiled and stained on the clean side of the laundry room in eight (8) of eight (8) observations at 9:45 AM on April 13, 2006.</p> <p>12. Ice machine chutes in the pantry rooms were soiled with debris on the inner surfaces and drains were clogged as evidenced by standing water in the bottom trays in the following areas:</p> <p>4 South Pantry in one (1) of one (1) observation at approximately 1:00 PM on April 12, 2006.</p>	L 214		

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L 214	<p>Continued From page 25</p> <p>5 South Pantry in one (1) of one (1) observation at approximately 4:20 PM on April 12, 2006.</p> <p>13. Particles were observed suspended in the Barbisol solution in the Beauty shop in one (1) of one (1) observation at 9:30 AM on April 13, 2006.</p> <p>14. Supplies were stored under the sink in the beauty shop such as Salon Care, No Rinse and shampoo in three (3) of three (3) observations at approximately 11:30 AM on April 13, 2006.</p> <p>15. Hot water supplied to washers in the laundry room was not at 160 degrees Fahrenheit (F) for a minimum of 25 minutes to the wash cycle. The observed temperature was 137 degrees F in two (2) of four (4) observations at 9:40 AM on April 13, 2006.</p>	L 214		
L 273	<p>3241.1 Nursing Facilities</p> <p>Each elevator shall be designed, constructed, maintained, and inspected in accordance with the 1996 NFPA National Elevator Code, and all other applicable District laws and regulations.</p> <p>This Statute is not met as evidenced by: Based on observations during the survey period of two (2) of three (3) elevators, it was determined that the facility failed to maintain the elevators in operating condition. This is a repeat deficiency.</p> <p>The findings include:</p>	L 273		

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L 273	<p>Continued From page 26</p> <p>The facility has three (3) elevators that serve five (5) resident floors. The facility's census on the first day of the survey was 283, with approximately 50 to 60 residents per resident floor.</p> <p>Two (2) of three (3) elevators were not on line during the survey period. Based on the review of contracts with two (2) vendors, the facility had two (2) of three (3) elevators out of service, since or before August 31, 2005 impacting the movement of residents, staff and visitors in the facility.</p> <p>During the group meeting on April 12, 2006 at 10:30 AM, residents reported difficulty in attending activities, going to the patio or outside because of the long wait for elevator service.</p> <p>On April 10, 2006 at 11:30 AM, Resident #23 was observed walking down the steps with a cane from the second floor. The surveyor asked the second floor charge nurse if he/she was aware that Resident #23 was walking down the steps. The charge nurse was not aware the resident had started walking down the steps, remained on the second floor landing and called to the resident to return. The resident stated, "I'm not waiting for the elevator."</p> <p>A face-to-face interview was conducted with Resident #10 on April 12, 2006 at 9:15 AM. Resident #10 returned from the hospital on April 7, 2006 after an amputation of the toes on the right foot. Resident #10 used a cane while walking. Resident #10 stated that he/she walked down the stairs at least three (3) times a day to smoke on the patio. Resident #10 stated that there was only one (1) elevator that worked and he/she had waited at least 15 minutes since returning from the hospital for the elevator.</p>	L 273		

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L 273	<p>Continued From page 27</p> <p>Resident #10 stated, "It can't be doing my foot any good to walk down the steps, but it's ridiculous to wait that long for the elevator. "</p> <p>A face-to-face interview was conducted with Resident #15 on April 14, 2006 at 11:45 AM. Resident #15 stated that he frequently walked down the steps with a cane because he had missed prior appointments due to waiting for the elevator because there was only one (1) elevator in service. Resident #15 had an amputation of the great toe of his/her foot and was admitted on September 5, 2005 for rehabilitation services and extensive antibiotic therapy. A physician's order dated March 30, 2006 directed, "...only heel touch weight bearing for short distances ..."</p> <p>Resident #15 stated that it was difficult to take the stairs but the only way to ensure that he/she could be on time for transportation and to keep the appointments.</p> <p>On April 13, 2006 at 7:20 AM a resident was observed walking down the stairs. On April 12, 2006 the facility's plan was to have continuous monitoring on the stairwells. There were no monitors on either stairwell (north and south) at the time of this observation.</p> <p>On April 13, 2006 at 2:50 PM it was observed that five (5) residents in wheelchairs were waiting for elevator service. Dietary staff reported that seven (7) of eight (8) food carts had not been returned to the kitchen area for cleaning and preparation for the evening meal. The facility's plan was to provide an elevator operator to assist in elevator services. Prior to the time of this observation, it was reported to the surveyors that the elevator operator was not present for an unknown period of time.</p>	L 273		

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L 273	<p>Continued From page 28</p> <p>Multiple observations during the survey period revealed that residents in wheelchairs had difficulty maneuvering in the elevator to accommodate space for others trying to board or exit on their requested floors.</p> <p>On April 11, 2006 at approximately 8:30 AM, it was observed that a large bin of trash and three (3) residents in wheelchairs were transported in the same elevator and exited on the first floor.</p> <p>An interview was conducted on April 12, 2006 at 2:30 PM with Resident #S4 and his/her family member. The family member stated that he/she had limited time to visit with the resident because of arranging transportation to and from the facility. The family member stated that he/she had waited as long as 30 minutes for an elevator which limited the time the family member had available to visit the resident.</p>	L 273		
L 359	<p>3250.1 Nursing Facilities</p> <p>Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. 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 in a safe and sanitary manner as evidenced by: an inoperative analog thermometer on the exterior of the walk in refrigerator, soiled shelf surfaces on a cart, plastic drain covers, mechanical can opener, hotel pans, plates in the plate warmer, rubber tray covers, cutting boards, sprinkler head covers, hood filters over cooking areas and floors and lower wall surfaces; and a drain was not constructed to direct food and water away from</p>	L 359		

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L 359	<p>Continued From page 29</p> <p>the floor, and a small refrigerator was directly on the floor. These observations were made in the presence of Dietary Manager.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The analog thermometer on the exterior of the walk in refrigerator was inoperative during the dietary survey in one (1) of one (1) observation at 8:10 AM on April 10, 2006. 2. The shelf surfaces of a cart containing dome plate lids were soiled and stained in (1) of three (3) observations at approximately 7:30 AM on April 10, 2006. 3. Plastic drain covers under sinks near the tray line and food preparation areas were soiled with accumulated debris in two (2) of two (2) observations at 8:11 AM on April 10, 2006. 4. A manual can opener in the food preparation area was soiled with residual food and metal shavings on the cutting surfaces and holder in one (1) of one (1) observation at 7:55 AM on April 10, 2006. 5. Hotel pans (12 x 24 x 6 inches) washed in the pot and pan wash area stored on racks for reuse were not thoroughly cleaned as evidenced by residual food on the inner and outer surfaces in seven (7) of seven (7) observations at 7:00 AM on April 11, 2006. 6. Hotel Pans (10 x 12 x 10 inches) washed in the pot and pan wash area stored on racks for reuse were not thoroughly cleaned of food residue on the inner and outer surfaces in five (5) of five (5) observations at 7:10 AM on April 11, 2006. 	L 359	<p>3250.1 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Thermometer replaced. 2. Shelf surfaces cleaned. 3. Plastic drain covers under sinks replaced. 4. Manual can opener was <i>was replaced 4/12/06 MJD 5/11/06</i> 5. Hotel pans (12x24x6) re-washed and are maintained without food residue. 6. Hotel pans (10x12x10) re-washed and are without food residue. <ol style="list-style-type: none"> 2. Rounds made of kitchen for food service areas operating in a sanitary and safe manner. Appropriate action taken based on findings. 3. Dietary staff educated on maintaining kitchen and equipment in sanitary and safe condition. Dietary manager to conduct sanitation rounds. 4. Admin./designee to QI monitor kitchen weekly x4 then monthly for kitchen being maintained in a safe and sanitary condition. Findings reported at FLC. 	7/31/06 <i>P. T. Johnson</i>

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L 359	<p>Continued From page 30</p> <p>7. The top and bottom surfaces of chinaware (plates) stored in the plate warmer were not thoroughly cleaned as evidenced by food particles on the inner and outer surfaces in 32 of 72 observations at 12:45 PM on April 10, 2006.</p> <p>8. The rubber shelf tray covers on a cart in the pot and pan wash area were soiled and stained with debris in two (2) of two (2) observations at 8:02 AM on April 10, 2006.</p> <p>9. Yellow and green cutting boards stored on a rack in the pot and pan wash area were stained in two (2) of (2) observations at 7:10 AM on April 11, 2006.</p> <p>10. The outer surfaces of sprinkler head covers over cooking areas were soiled with dust and grease in five (5) of five (5) observations at approximately 8:00 AM on April 10, 2006.</p> <p>11. Metal framed filters under cooking hoods in the main kitchen were soiled and not in good condition to contain grease fires and two (2) filters were missing in two (2) of 12 observations at 8:15 AM on April 10, 2006</p> <p>12. Floors and the lower wall surfaces in the serving and food preparation areas of the main kitchen were soiled with debris in two ((2) of two (2) observations at 7:36 AM on April 10, 2006.</p> <p>13. A plastic drain under the disposal unit in the pot and pan wash area was not constructed to direct food and water away from floor surfaces in one (1) of two (2) observations 8:30 AM on April 10, 2006.</p> <p>14. A small refrigerator was directly on floor surfaces in the main kitchen and this refrigerator</p>	L 359		

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L 359	Continued From page 31 was used to store foods for the tray line during the breakfast and lunch meals in two (2) of two (2) observations at 8:10 AM on April 10, 2006.	L 359		
L 377	3252.2 Nursing Facilities Various services provided shall afford each resident an opportunity to purchase items such as magazines, candies, small gifts, postage stamps, stationery, writing implements, and other supplies. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility failed to provide adequate stationery supplies in the gift shop for residents of the facility to purchase. The findings include: Observations of the gift shop were conducted each day during the survey period (April 10 through 14, 2006). There was no evidence that the gift shop stocked stationery, postage, writing implements, magazines and small gifts that residents could purchase. A face-to-face interview was conducted with the administrator on April 12, 2006 at 4:45 PM. He/ she acknowledged that the gift shop lacked the above cited items.	L 377	3252.2 Nursing Facilities 1. Gift shop stocks stationery, postage, writing implements, magazines and small gifts. 2. Resident interviews conducted to ensure gift shop is providing items desired for purchase. 3. Administrator will meet with resident council president regarding gift shop items. 4. Social Service/designee to QI monitor gift shop for availability of items desired for purchase weekly x4 then monthly. Findings reported at FLC.	7/31/06
L 389	3254.5 Nursing Facilities The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy. This Statute is not met as evidenced by: Based on observation during the environmental tour, it was determined that the facility failed to	L 389		

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L 389	<p>Continued From page 32</p> <p>maintain the linen level at three (3) times the amount needed for licensed occupancy.</p> <p>The findings include:</p> <p>The facility is licensed for 296 beds.</p> <p>Through examination and observation of the linen supply bundles and boxes of towels, sheets and wash cloths, it was determined that the supply of linens was not adequate to ensure that three (3) times the resident occupancy was available in one (1) of one (1) observation in the basement storage room at 9:00 AM on April 13, 2006.</p>	L 389	<p>3254.5 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Facility has purchased linen in order to ensure three (3) times the resident occupancy linen levels maintained all 3 shifts. 2. Review conducted of linen carts for adequate linen. Linen discarded if in disrepair. 3. Housekeeping in serviced on maintaining required levels. PAR levels will be Maintained to meet the needs of occupancy. 4. Administrator/designee to QI monitor linen levels monthly. Appropriate action taken on findings. Findings reported at FLC. 	7/31/06
L 410	<p>3256.1 Nursing Facilities</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that housekeeping and maintenance services were not adequate to ensure that the facility was maintained in a safe and sanitary manner as evidenced by:</p> <p>Soiled floor surfaces, damaged and soiled baseboards, marred and damaged walls, weighted straps stored on the floor, soiled chairs, wheelchair parts stored on the floor and supplies stored under the sink in the Rehabilitation Department (Rehab);</p> <p>Soiled and missing ceiling tiles in the basement storage room, soiled concrete and floor surfaces at the entrance to the facility, lint accumulation on sprinkler heads and supply vents in the laundry</p>	L 410		

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L 410	<p>Continued From page 33</p> <p>room, soiled and damaged floors and wall surfaces in the laundry room, and blankets and towels stored on the floor in the laundry storage room;</p> <p>Stained privacy curtains, strong urine odors in resident rooms and bathrooms, excessive personal items stored in residents' rooms, soiled wheelchairs on the spoke and frame surfaces, open drains soiled on the interior in soiled linen rooms, call bell lamps recessed into consoles in residents' rooms, marred and damaged entrance, closet and bathroom doors, damaged geri chair armrests, soiled lower surfaces of IV poles in residents' rooms, marred table and chair legs in day rooms, soiled janitorial closet floors, baseboards and walls, soiled and stained floor surfaces and baseboards and baseboards separated from wall surfaces, marred and scarred furnishings in residents' rooms and draperies not attached to curtain rods. These findings were observed in the presence of the Housekeeping, Maintenance and Nursing Staff.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Floor surfaces were soiled and stained in treatment areas of the Rehab department in one (1) of one (1) observation at 12:25 PM on April 13, 2006. 2. Baseboards were soiled, marred and damaged in the Rehab department in one (1) of one observation at 12:27 PM on April 13, 2005. 3. Wall surfaces were marred and scarred in the Rehab department in one (1) of one (1) observation at 12:35 PM on April 13, 2005. 4. Weighted straps were observed stored on the 	L 410	<p>3256.1 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Floors have been cleaned and cleaning scheduled established . 2. Baseboards cleaned and/or replaced per a schedule. 3. Walls in Rehab. Unit repaired and repainted. 4. Rehab. Equipment, weighted straps stored off the floor. 5. Rehab. Furniture cleaned and/or replaced. 6. Wheelchair parts in box stored off the floor. 7. Cabinet under the sink secured closed and supplies/equipment stored off floor. 8. Ceiling tiles replaced. Entrance sidewalk sandblasted , debris and chewing gum removed. 9. Lobby area floor deep cleaned. 10. Laundry room sprinkler heads cleaned of lint and dust. 11. Floors and wall surfaces of laundry repaired and repainted. 12. Items stored off floor on pallites or shelves. 13. Privacy curtains cleaned or replaced. 14. Urine odors eliminated. 15. Rooms have been cleaned and personal items stored off floor or in resident storage. 	7/31/06

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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 410	Continued From page 34 floor in various areas of the Rehab department in one (1) of one (1) observation at 12:40 PM on April 13, 2005. 5. The seat surfaces of chairs in treatment areas of the Rehab department were soiled and worn in five (5) of five (5) observations at 12:45 PM on April 13, 2006. 6. A box of wheelchair parts were stored on the floor in the Rehab department storage room in one (1) of one (1) observation at 12:50 PM on April 13, 2006. 7. Supplies and equipment were stored in a cabinet under the sink in the Rehab department in one (1) of one (1) observation at 12:53 PM on April 13, 2005. 8. Ceiling tiles in the basement storage room were observed to be soiled and missing in one (1) of one (1) observation at 12:58 PM on April 13, 2006. 9. Concrete surfaces located at the entrance of the building were soiled with debris and chewing gum and floor surfaces in the lobby area were soiled with embedded debris in five (5) of five (5) observations between 8:00 AM and 5:30 PM on April 11, 2006 and April 14, 2006. 10. Lint and dust accumulation was observed on sprinkler heads and on the interior and exterior surfaces of supply vents in the laundry room in five (5) of five (5) observations at approximately 10:00 AM on April 13, 2006. 11. Floor and wall surfaces on the clean and soiled sides of the laundry room and in the rear of washers were soiled and damaged in two (2) of	L 410	3256.1 Nursing Facilities (Continued) 16. Wheelchairs have been power washed and routine cleaning schedule established. 17. Drains in soiled utility rooms cleaned and maintained. 18. Call bell system has been repaired to eliminate recessed lights. 19. Doors repaired and repainted or replaced. 20. Geri chairs with tears replaced. 21. IV poles have been power washed and cleaning schedule established. 22. New day room furnishings have been ordered. 23. Janitorial closet floors, baseboard and walls repaired, cleaned and repainted. 24. Floors have been stripped and waxed on schedule established for maintaining cleanliness. Baseboards have been cleaned and or on schedule to be replaced. 25. New furnishing to replace marred and scarred resident furnishings ordered. 26. Draperies repaired or replaced. 2. Environmental rounds conducted for cited items. Appropriate action taken. 3. Staff in serviced on maintaining and safe and clean environment and requirement to report needed repairs. 4. Administrator and/or Maintenance Director or Housekeeping to conduct walking rounds weekly for areas needing repair and/or replacement. Appropriate action taken on findings. Findings reported at FLC.	7/31/06

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L 410	<p>Continued From page 35</p> <p>two (2) observations at approximately 10:10 AM on April 13, 2006.</p> <p>12. Bundles of blankets and boxes of towels were stored on floor surfaces in the basement laundry room, in two (2) of two (2) observations at approximately 10:15 AM on April 13, 2006.</p> <p>13. Privacy curtains were soiled and stained with grease in residents' rooms in the following areas:</p> <p>Second Floor Rooms 210, 215, 221, 228 and 234 in five (5) of 14 observations between 10:15 AM and 4:30 PM on April 10, 2006 and 3:55 PM and 4:30 PM on April 11, 2006.</p> <p>Third Floor Rooms 307, 328, 329 and 334 in four (4) of 11 observations between 8:40 AM and 11:40 AM on April 11, 2006.</p> <p>Fourth Floor Rooms 402, 403, 410, 411, and 427 in five (5) of 12 observations between 10:30 AM and 12:00 PM on April 12, 2006.</p> <p>Fifth Floor Rooms 502, 524, and 532 in three (3) of seven (7) between 2:30 PM and 4:30 PM on April 12, 2006.</p> <p>14. Strong urine odors were detected in the following areas:</p> <p>2 North Shower room in one (1) of one (1) observation at 2:56 PM on April 10, 2006.</p> <p>Third Floor training toilet in one (1) of one (1) observation at 4:10 PM on April 12, 2006</p> <p>Fifth Floor room 536 in one (1) of one (1) observation at 4:20 PM on April 12, 2006.</p>	L 410		

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L 410	<p>Continued From page 36</p> <p>15. Excessive personal clothing, bags and boxes were observed on the floor, on top of closets and tables in the following areas:</p> <p>Second Floor Rooms 201 and 210 in two (2) of 14 observations between 10:15 AM and 4:30 PM on April 10, 2006.</p> <p>Third Floor Rooms 302, 321 and 329 in three (3) of 11 observations between 9:00 AM and 2:30 PM on April 12, 2006.</p> <p>Fifth Floor Rooms 508, 515, 517 and 528 in four (4) of seven (7) observations between 10:00 AM and 2:40 PM on April 12, 2006.</p> <p>16. Residents' wheelchairs were soiled with food, dust and had worn arm rests in the following areas:</p> <p>Second Floor Room 221 in one (1) of one (1) observation at 11:25 AM on April 11, 2006.</p> <p>3 North Day Room and Shower Room in two (2) of four (4) observations at 4:20 PM on April 11, 2006.</p> <p>Fourth Floor Rooms 407 and 420 in two (2) of 11 observations between 10:00 AM and 11:00 AM on April 12, 2006.</p> <p>Fifth Floor Rooms 501 and 513 in two (2) of nine (9) observations between 2:40 PM and 5:00 PM on April 12, 2006.</p> <p>17. Drains were soiled with dust and debris in the North side soiled utility rooms in four (4) of four (4) observations at 10:45 AM on April 10, 2006 (2 North), at 3:00 PM on April 11, 2006 (3 North), at 11:00 AM (4 North) and 3:00 PM (5 North) on</p>	L 410		

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L 410	<p>Continued From page 37</p> <p>April 12, 2006.</p> <p>18. Call bell lamps were recessed into the console and not visible when activated in Fourth Floor Rooms: 420, 430 and 434 in three (3) of 11 observations between 2:00 PM and 3:00 PM on April 12, 2006.</p> <p>19. Entrance, closet and bathroom doors were marred and damaged in the following areas:</p> <p>Second Floor Rooms 213, 230, 234 and 235 in four (4) of 18 observations between 10:15 AM and 4:30 PM on April 10, 2006.</p> <p>Third Floor Rooms 305, 307, 321, 329, 3 North Soiled Utility Room and 3 North Shower Room, in six (6) of 11 observations between 2:30 PM and 4 :30 on April 11, 2006 and 8:30 AM and 10:20 on April 12, 2006.</p> <p>4 South Shower Room in one (1) of one (1) observation at 11:20 AM on April 12 , 2006.</p> <p>Fifth Floor Rooms 501, 524 and 528 in three (3) of nine (9) observations between 2:40 PM and 5: 00 PM on April 12, 2006.</p> <p>20. Geri Chair armrests were damaged and worn on edges in the following areas:</p> <p>2 North Day Room in one (1) of one (1) observation at 10:15 AM on April 10, 2006.</p> <p>3 North Day Room in one (1) of one (1) observation at 3:20 PM on April 11, 2006.</p> <p>4 North Day Room in one (1) of one (1) observation at 11:30 AM on April 12, 2006.</p>	L 410		

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L 410	<p>Continued From page 38</p> <p>21. The base surfaces of IV poles were soiled in the following areas:</p> <p>Second Floor Rooms 221 and 225 in two (2) of two (2) observations between 10:30 AM and 11:30 AM on April 11, 2006.</p> <p>Third Floor Room 321 in one (1) of one (1) observation at 3:00 PM on April 11, 2006.</p> <p>Fourth Floor Room 402 in one (1) of one (1) observation at 10:30 AM on April 12, 2006.</p> <p>22. Day room furnishings such as tables and chairs were marred on frontal surfaces and straight back chairs were not sturdy in the following areas:</p> <p>2 North and 2 South Dayrooms in 11 of 17 chairs between 8:30 AM and 10:55 AM on April 11, 2006.</p> <p>3 North and 3 South Dayrooms in six (6) of 11 tables between 3:30 PM and 4:30 PM on April 11, 2006 and between 8:30 AM and 8:50 AM on April 12, 2006.</p> <p>4 North and 4 South Dayrooms in 18 of 18 chairs between 10:30 AM and 12:30 PM on April 12, 2006.</p> <p>5 South Dayroom in four (4) of four (4) tables and six (6) of eight (8) chairs at 4:10 PM on April 12, 2006.</p> <p>23. Janitorial closet floors, baseboards and walls were stained in the following areas:</p> <p>3 South in one (1) of two (2) observations at 9:30 AM on April 12, 2006.</p>	L 410		

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L 410	<p>Continued From page 39</p> <p>4 South in one (1) of two (2) observations at 12:33 PM on April 12, 2006.</p> <p>24. Floor surfaces were soiled and stained and baseboards were soiled and separated from wall surfaces in the following areas:</p> <p>Second Floor Rooms 207, 215, 216, 217, 226, 228 and 234 in seven (7) of 18 observations between 3:55 PM and 4:30 PM on April 10, 2006 and between 10:15 AM and 11:15 AM on April 11, 2006.</p> <p>Third Floor Rooms 302, 325, 328, 329, 334, 3 North Dayroom, 3 North soiled linen room, 3 North clean linen room and 3 South clean utility room in nine (9) of 11 observations between 2:30 PM and 4:30 PM on April 11, 2006 and 8:30 AM and 10:20 AM on April 12, 2006.</p> <p>Fourth Floor Rooms 407, 410, 413, 417, 420, 427, 429, 430 and 434 in nine (9) of 12 observations between 10:30 and 2:00 PM on April 12, 2006.</p> <p>Fifth Floor Rooms 512, 519, 528, 532, 5 North soiled utility room and 5 South Dayroom, in six (6) of eight (8) observations between 2:40 PM and 4:30 PM on April 12, 2006.</p> <p>25. Furnishings in residents' rooms such as chairs and end tables were marred and scarred on the frontal surfaces in the following areas:</p> <p>Second Floor Rooms 206, 215, 217, 219, 220, 221, 225 and 235 in eight (8) of eight (8) observations between 10:15 AM and 4:30 PM on April 10, 2006 and 3:55 PM and 4:30 PM on April 11, 2006.</p>	L 410		

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L 410	<p>Continued From page 40</p> <p>Third Floor Rooms 307, 312, and 325 in three (3) of 11 observations between 2:30 PM and 4:30 on April 11, 2006 and 8:40 AM and 10:20 AM on April 12, 2006.</p> <p>Fourth Floor Rooms 410, 413, 417, 420, 429 and 434 in six (6) of 11 observations between 10:20 AM and 12:00 PM on April 13, 2006.</p> <p>Fifth Floor Rooms 512 and 524 in two (2) of nine (9) observations between 2:30 PM and 5:00 PM on April 13, 2006.</p> <p>26. Draperies were not attached to curtain rods and traverse rods were not in place to move the curtains in the following areas:</p> <p>Second Floor Rooms 202, 202, 216, 217, 219 and 225 in six (6) of 18 observations between 10:15 AM and 4:30 PM on April 10, 2006 and 3:55 PM and 4:30 PM on April 11, 2006.</p> <p>Third Floor Rooms 302, 317, 328 and 334 in four (4) of 11 observations between 8:40 AM and 11:40 AM on April 11, 2006.</p> <p>Fourth Floor Rooms 403, 410, and 413 in three (3) of 11 observations between 10:30 AM and 12:00 PM on April 12, 2006.</p> <p>Fifth Floor rooms 508, 528 and 532 in three (3) of nine (9) rooms between 2:40 PM and 5:00 PM on April 12, 2006.</p>	L 410		
L 426	<p>3257.3 Nursing Facilities</p> <p>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</p>	L 426		

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L 426	<p>Continued From page 41</p> <p>and rodents. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility failed to maintain an effective pest control program.</p> <p>The findings include:</p> <p>During the survey period, roaches were observed in the following areas:</p> <ol style="list-style-type: none"> 1. Room 420 on April 12, 2006 at 11:30 AM. 2. 5 South pantry on April 12, 2006 at 4:45 PM. <p>The contract for pest control was reviewed. Per the contract, the pest control company was to provide service to the facility twice monthly. Treatment sheets were reviewed from May 2005 through February 2006. The facility failed to provide treatment sheets for March and April 2006.</p>	L 426	<p>3257.3 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Pest control sighting logs in place. 2. Pest control provided treatments to deal with roaches. 3. Treatment sheets will be maintained by maintenance department to contact pest control company as indicated by Pest Sighting Log to ensure twice monthly visits. 2. Staff in serviced on documentation of pests in pest sighting log. Maintenance department to check Pest Sighting Log daily. 3. Environmental rounds conducted for pest sightings. Pest company contacted for treatment as needed. 4. Admin./designee to conduct weekly walking pest sighting rounds. Pest control company contacted as needed based on findings. Findings reported at PLC. 	7/31/06
L 438	<p>3258.9 Nursing Facilities</p> <p>Each container or cylinder of flammable and non-flammable gas shall be securely racked and fastened at all times. This Statute is not met as evidenced by: Based on observations, it was determined that facility staff failed to secure oxygen tanks.</p> <p>The findings include:</p> <p>During the environmental tour, four (4) oxygen tanks were observed in the Rehabilitation Department. The tanks were not secured to prevent accidental tip-over in four (4) of four (4) observations on April 13, 2006, at 12:35 PM.</p>	L 438		

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L 999	DC CODE	L 999		
	<p>This Statute is not met as evidenced by: Based on observation, interview and record review for two (2) of 30 sampled residents and two (2) supplemental residents, it was determined that the facility failed to: document specific reasons for residents' relocation within the facility. Residents #5, 18, H1 and S3.</p> <p>The findings include:</p> <p>DC Official Code 44-1003.02 included the following: "...(d) The written notice required by subsection (a) of this section shall be on a form prescribed by the Mayor and shall at a minimum contain: (1) The specific reason(s), stated in detail and not in conclusory language, for the proposed discharge, transfer, or relocation;..."</p> <p>The facility has a state license for 296 beds. All 269 beds are dually licensed as Medicare and Medicaid beds.</p> <p>1. A review of Resident #5, 18, H1 and S3 record revealed a " Notice of Discharge or Transfer from this Facility or Relocation within this Facility " for [relocation form] dated April 3, 2006. The residents were relocated from a room on the second floor to other rooms in the facility. The specific reason on each relocation form for the action taken was, " Essential to meet facility's reasonable administrative needs and no practicable alternative is available; or because the unit the resident is leaving is now a skilled level unit and the resident is not a skilled level resident."</p> <p>The relocation forms were sent to the</p>		<p>3258.9 Nursing Facilities</p> <ol style="list-style-type: none"> 1. Resident's 5, 18, H1 and S3 have been interviewed regarding satisfaction with transfer and SS Note made. 2. Anticipated transfers reviewed for appropriateness and required documentation and procedure. Actions taken based on findings. 3. Social Service department in serviced on procedure for Notice of Discharge or Transfer. 4. Admin./designee to QI monitor transfers and discharge process at morning meeting. Appropriate action taken. Finding reported at FLC. 	7/31/06

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L 999	<p>Continued From page 43</p> <p>Department of Health on April 3 and 4, 2006. A telephone interview was conducted with the Social Worker on April 4, 2006 at 10:30 AM. He/she stated, "Corporate wants to make the 2nd floor a skilled floor." The social worker was asked why residents were being relocated off the second floor if the all the facility's beds were dually licensed. He/she stated, "I don't know. That's what I was told to put on the form."</p> <p>A face-to-face interview was conducted with another Social Worker on April 11, 2006 at 10:15 AM. He/she was asked about Resident #18's relocation from the 2nd floor. The social worker stated, "The corporate office wants to make the 2nd floor a skilled unit."</p> <p>A face-to-face interview with the Administrator was conducted during the re-licensure survey on April 11, 2006 at 10:30 AM. He/she stated, "We are trying to bring the residents who are currently receiving rehab (rehabilitation) services and dialysis services to the 2nd floor. Since only one elevator is operating and two are not operating, we thought that bringing the residents who use rehab and dialysis services to the 2nd floor would make it easier for them to access those services."</p> <p>Rehabilitation services are located on the 2nd floor and the dialysis unit is located on the 1st floor of the facility. Residents requiring dialysis and transported in wheelchairs would still require elevator transportation to the dialysis unit on the first floor.</p> <p>Facility staff failed to consistently identify specific reasons for residents being relocated from the 2nd floor to other units within the facility.</p>	L 999		