Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: _____ B. WING _____	10/21/2015

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BRIDGEPOINT SUBACUTE AND	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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L 000	Initial Comments The Annual Licensure Survey was conducted on October 15, 2015 through October 21, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 30 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	L 000		12/31/15

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L 000	Continued From page 1 MDS - Minimum Data Set MRR - Medication Regimen Reviews Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;	L 051	1. Resident # 58 was not affected by the deficient practice of no respiratory care plan in the clinical record. The respiratory care plan was put into the chart immediately upon identification of the omission. Other residents on the unit charts were assessed and care plans were found to be compliant.	12/31/15

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L 051	Continued From page 2 (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: A. Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that the charge nurse failed to develop a comprehensive care plan with goals and approaches to address one (1) resident ' s respiratory needs for ventilator services. Resident #58. The findings include: A review of Resident #58 ' s clinical record revealed diagnoses that included " Respiratory Failure; Vent [Ventilator] Dependent. " Review of the October 2015 physician ' s orders revealed the following ventilator settings: "AC [Assist Control -ventilator mode of the way a breath is delivered], RR [Respiratory Set Rate - breaths per minute] 12, TV [tidal volume- The amount of volume inhaled in the lungs] 400, FIO2 [fraction of inspired oxygen- percent of oxygen a patient is inhaling] 40%,	L 051	2. Other resident with the potential to be affected by the deficient practice will be identified upon admission and/or with change in status for ventilator services (i.e. settings, etc.) All residents on ventilators charts were reviewed and showed respiratory care plans were in place appropriately with goals and approaches. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Upon admission physician orders will be reviewed for specific vent settings and other interventions to be rendered by the care team. • Manager will activate a comprehensive care plan with goals and approaches for residents with respiratory needs for ventilator/ respiratory services. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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L 051	Continued From page 3 PEEP [Positive End Expiratory Pressure -maintains lung expansion to help get oxygen from the lungs into the bloodstream.] 5. " Under Respiratory Treatments of Section O- Special Treatments, Procedures, and Programs of Resident #58 ' s Significant Change Minimum Data Set dated August 2, 2015, the resident was coded as having a " ventilator or respirator. " Review of the nursing notes dated October 17-21, 2015 revealed that the resident was receiving ventilator services. The clinical record lacked evidence of a care plan to address the resident ' s respiratory needs and/or ventilator services. On October 20, 2015 at approximately 2:35 PM, a face-to-face interview was conducted with Employee #3, who was asked to provide the care plan that addressed the resident ' s respiratory needs. He/she reviewed the record and acknowledged that there was no care plan to address the respiratory needs of the resident. The record was reviewed on October 20, 2015. B. Based on record review and staff interview for three (3) of 30 sampled residents, it was determined that the charge nurse failed to obtain a physician's order to flush intravenous access sites for two (2) residents and failed follow physician orders to obtain a dietary consult and laboratory test for one (1) resident. Residents #13, 74, and 82. The findings include: Lippincott, Williams & Wilkins, 2010 stipulate, "	L 051	1. Resident's, 13 and 82, were not affected by the deficient practice of not having a flush order for IV medications. Other residents on the unit MARs were checked for compliancy with S.AS.H (saline, administration, saline, heparin) IV process. 2. Other residents having the potential to be affected by the same deficient practice of not having flush orders will be identified by reviewing the physician orders upon admission or any subsequent IV medication orders or changes. All residents receiving IV medications MARs and charts were reviewed to ensure S.A.S.H orders were received and IV form was utilized. No other deficits noted. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Infusion medication administration record will be utilized by the nursing staff. • Audit tool developed for random audits will be done by nurse manager to	12/31/15

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L 051	Continued From page 4 Performance phase: 1.Clean the port of the saline lock with alcohol. Insert a normal saline syringe need into the port and aspirate slightly. 2. Inject normal saline solution slowly to flush the reservoir of saline or heparin solution and blood ...5. Insert medication tubing, administer the drug, and infuse at the prescribed rate. 6. After drug or solution administration, insert the saline syringe and flush the reservoir slowly. Remove the syringe while still pushing the plunger of the syringe to ensure positive pressure. " (p. 91). 1. The charge nurse failed to obtain a physician ' s order to flush an intravenous access sites Resident #13 who received medication intravenously. A review of the physician ' s orders revealed the following: " Meropenem [antibacterial medication] 250 mg intravenous q (every) 12 hours [until] 10/21/15 for UTI (urinary tract infection) " A review of the October 2015 Medication Administration Record revealed that the resident received nine (9) doses of Meropenem, as evidenced by the staff signatures in the allotted signature boxes, from October 16 - 20, 2015 which indicated the medication was given as prescribed. A face-to-face interview was conducted on October 20, 2015 at approximately 4:00 PM with Employee #11. He/she stated, " I flush with 10 milliliters (mls) of normal saline before and after I administer the medication. " He/she further acknowledged that there was no order written to flush and he/she didn't document that it was done.	L 051	S.A.S.H (saline, administration, saline, heparin) orders are in place. • Staff will be re-educated on the importance of obtaining flush orders for any IV medication order that is written but does not have a flush order. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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L 051	Continued From page 5 There was no evidence that facility staff obtained an order to flush the intravenous line of Resident #13. The record was reviewed on October 20, 2015. 2. The charge nurse failed to follow a physician ' s orders to obtain a dietary consult and laboratory test for Resident #74. A review of the resident ' s clinical record revealed the following Physician ' s orders: " (1) Weigh pt. (patient) every 2 weeks x 4 weeks due to weight loss = 9lb in one month. Dietician consult for weight loss. (3) TSH (Thyroid Stimulating Hormone), Prealb (Pre-albumin) & albumin [levels] in am. " A review of the resident ' s clinical record failed to reveal any evidence of a dietary consult and/or reports of the requested laboratory tests (TSH, Pre-albumin and albumin). A face-to-face interview was conducted with Employee #2 at approximately 11:30 AM on October 20, 2015. After reviewing the record the employee acknowledged the Physician 's orders had not been carried out. The record was reviewed on October 20, 2015. 3. The charge nurse failed to obtain a physician ' s order to flush an intravenous access site for Resident #82 who received medication intravenously. A review of the physician ' s orders revealed the following: " Meropenem 500 mg intravenous q (every) 8	L 051	1. Resident #74 was not affected by the deficient practice. There were no further incidence of lab work and dietary consults not carried out per physician orders for other residents on the unit. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission and/or physician orders. All residents with dietary and lab orders were checked and carried out, as ordered. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Nursing staff to notify dietician that an order for consultation has been written. • Dietary consults will be carried out within 72 hours to prevent delay in treatment. • Lab values will be checked daily to monitor for compliance with physician notification, whether normal or abnormal.	12/31/15

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L 051	Continued From page 6 hours until 10/18/15 last dose ...for Pneumonitis " A review of the October 2015 Medication Administration Record revealed that the resident received 11 doses of Meropenem as evidenced by the staff signatures in the allotted signature boxes from October 15 - 18, 2015 which indicated the medication was given to the resident. A face-to-face interview was conducted on October 19, 2015 at approximately 2:58 PM with Employee # 8. He/she stated, " [Resident name] has a peripheral IV (intravenous line) in the left hand. I flush with normal saline 10mls. I give the medication and I flush again with ns 10mls and that was it. It [an order to flush] should have been here [on the medication administration record]. I did not document the SAS (saline, antibiotic, saline). " There was no evidence that facility staff obtained an order to flush the intravenous line of Resident #82. The record was reviewed on October 19, 2015.	L 051	•Audit tool developed to monitor physician lab notification compliance. • The 24 hour chart check process will be re-inserviced to track if orders are complete and accurate. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
L 071	3214.5 Nursing Facilities Each nursing employee shall be encouraged to attend education and training programs conducted in the community that relate to nursing practice. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the facility failed to provide 4.1 [four and one tenth] hours for Direct Nursing Care on one (1) of the seven (7) days reviewed, in accordance with Title 22 DCMR	L 071	1. No resident was affected by the deficient practice where the direct hours of nursing care was 3.9 instead of 4.1. All residents on the unit received all nursing care services. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon direct admission to the unit. Director of Nursing ,	12/31/15

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L 071	Continued From page 7 Section 3211. Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on October 20, 2015 at approximately 11:30 AM. According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. Of the seven (7) days reviewed, one (1) of the days failed to meet the Direct Nursing Care Hours 4.1 [four and one tenth] as follows: On October 11, 2015 it was determined that the facility provided direct nursing care at a rate of 3.9 hours. The findings were determined on October 20, 2015 at approximately 3:30 PM during a concurrent review of records with Employee #2 who acknowledged the findings.	L 071	Staffing Coordinator, and/or designee will monitor hours of care for compliance, each shift. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Director of Nursing/ Staffing Coordinator will review the daily schedule to ensure appropriate skill mix number and case mix of residents to meet the 4.1 hours of care. • Nurse Manager/ other nursing staff not on duty will be incorporated into resident care, as needed, to maintain 4.1 hours per patient day. • Nursing agency will be utilized as a last result to meet 4.1 hours of care upon proof of all requirements and checklist are received. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing	L 088		12/31/15

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L 088	Continued From page 8 infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on observations and interviews during the initial tour of the kitchen on October 20, 2015 it was determined that the facility failed to help prevent the spread of infection as evidenced by failure to ensure that eye wash solution was not stored beyond the expiration date in four (4) of four (4) bottles observed; and one (1) nurse failed to sanitize his/her hands prior to the administration of antibiotic eye ointment for one (1) resident. Resident # 53. The findings include: 1. Facility staff failed to ensure that eye wash solution was not stored beyond the expiration date in the main kitchen.	L 088	1. The four bottles of Salinaax eye wash flush that were observed stored for use with an expired date were removed and discarded at the time of the survey. 2. No resident was affected by this deficient practice. No other expired eye wash flush was found. 3. The Director of Food Services or designee will audit the eye wash stations monthly for expired eye wash flush to assure compliance. 4. Results of these audits will be reported at the Quality Assurance meetings quarterly by the Director of Food Services or designee. 1. Resident # 53 was not affected by the deficient practice of not sanitizing hands before the administration of eye antibiotic ointment. No other observations of improper hand sanitizing noted.	12/31/15

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L 088	Continued From page 9 During the initial tour of the kitchen on October 20, 2015 at approximately 8:30 AM, it was determined that the facility failed to help prevent the spread of infection. Four (4) of four (4) bottles of Salinaax 16 fl oz (eye wash flush) were observed stored for use with an expiration date of June 2015. These observations were made in the presence of Employee #13 who acknowledged these findings during the survey. 2. During medication pass observations Employee # 8 failed to sanitize his/her hands prior to administering eye ointment to Resident # 53. A review of the Physician ' s order dated October 7, 2015 directed, " Erythromycin ophthalmic 5mg/1gm ointment bid [twice a day] [times] 7 days for left red eye. On October 15, 2015 at approximately 10:00 AM, Employee #8 was observed administering medications to Resident #53 via a gastrostomy tube with gloved hands. Employee #8 then proceed to administer an eye ointment medication to the resident ' s left eye, touching and holding the resident ' s lower lid without first sanitizing his/her hands. There was no evidence that facility staff sanitized his/her hands before administering eye ointment to the residents left eye to help prevent the spread of infection.	L 088	2. Other residents having the potential to be affected by the deficient practice will be identified upon personal care or medication administration. Licensed staff was immediately re-educated on the infection control policy. Random observation of medication pass revealed no infection control deficits. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Audit tool has been generated to randomly monitor hand hygiene (secret shoppers). • Nursing staff will be re-educated on the importance of glove usage, hand washing/sanitizing before, during, and after resident care/medication administration. • Infection control policy will be reviewed at staff meetings. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free	L 099		12/31/15

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L 099	Continued From page 10 from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations that were made during a tour of the dietary services on October 16 and 20, 2015, it was determined that the facility failed to prepare and serve food under sanitary conditions: one (1) pan of improperly stored raw chicken and beef, and one (1) expired pan of tuna fish. The findings include: 1. One (1) of one (1) pan of raw chicken was stored above pan that contained a package of beef. 2. One (1) of one (1) half pan of tuna fish was stored for use beyond the expiration date. These observations were made in the presence of Employee # 9 who acknowledged these findings.	L 099	1. The one pan of raw chicken that was stored above a package of beef was removed at the time of survey. The one and one half pans of tuna fish that was stored for use beyond the expiration date was removed at the time of survey. 2. No resident was affected by this deficient practice. All other food items were checked for proper storage, preparation, distribution and being served under sanitary conditions. No other issues were found. 3. The Director of Food Services or designee will reeducate staff on the preparing and serving food under sanitary conditions. The Director of Food Services or designee audit daily to assure compliance. 4. The Director of Food Services or designee will report the finding these daily audits at the Quality Assurance Committee meeting quarterly.	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees,	L 128	1. Resident #39 was not affected by the deficient practice of facility not acting upon pharmacy recommendation for gradual reduction of anti-psychotic medication. Nurse Practitioner immediately corrected the irregularity on identified residents.	12/31/15

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L 128	Continued From page 11 including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review, and staff interview for two (2) of 30 sampled residents, it was determined that the facility staff failed to act upon reported recommendations from the Medication Regimen Reviews (MRR) by the pharmacist for Resident # ' s 39 and 80. The findings include: 1.The facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #39. A " Physician ' s Order " signed and dated October 1, 2015 directed, " Citalopram HBR 10 mg Tablet (RP: Celexa)1 tab[tablet] via G-Tube [gastrostomy tube] every day for depression" A review of the August 11, 2015 pharmacy consultation report revealed " Resident #39 has received citalopram 10 mg for management of depressive symptoms since 7/20/13. Please consider gradual dose reduction, perhaps decreasing to 5mg daily while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms. "	L 128	2. Other residents with the potential to be affected by the same deficient practice will be identified upon presentation of report by consultant pharmacist. Nurse Practitioner addresses all consultation reports to accept and/or decline recommendations in collaboration with the physician and psychiatrist. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Behavioral monitoring tool will continue to be utilized with shift to shift completion by nursing staff, as warranted. • DON/Nurse Managers will review monthly pharmacy consultation reports, immediately upon receipt. • Nurse practitioner/Primary Physician/Psychiatrist will address all pharmacy recommendations by indicating if the recommendation irregularities were declined or accepted. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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	HFD02-0023	A. BUILDING: _____ B. WING _____	10/21/2015

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L 128	Continued From page 12 There was no evidence that the pharmacist's August 11, 2015 recommendations were acted upon by the physician. A face-to-face interview was conducted with Employee #4 on October 21, 2015 at approximately 11:15 AM. He/she acknowledged the aforementioned findings. The record was reviewed on October 21, 2015. 2. The facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #80. A "Physician ' s Order" signed and dated October 2, 2015 directed: " Geodon 20mg /gt [by gastrostomy tube] BID [twice a day] for psychosis; and Haldol 10mg /gt [by gastrostomy tube] q12 hrs. [Every 12 hours] for psychosis. " A review of the Pharmacy consultation report revealed, " [Resident #80] receives two antipsychotic medications Haloperidol, Ziprasidone HCL [Geodon] concomitantly. Please consider gradual dose reduction of haloperidol with eventual discontinuation while monitoring for re- emergence of target and or withdrawal symptoms. The combined use of two or more antipsychotic medications complicates the drug regimen and increases the potential adverse for adverse events. " There was no evidence that the pharmacist's October 13, 2015 report of irregularity recommendations were acted upon by the physician.	L 128	1. Resident # 80 was not affected by the deficient practice of non-monitoring of anti-psychotic medication usage. The behavior monitoring flow record was implemented upon recognition of omission. 2. Other residents with the potential to be affected by the same deficient practice will be identified upon presentation of report by consultant pharmacist. Nurse Practitioner will continue to review consultation reports to accept and/or decline recommendations in collaboration with the physician and psychiatrist. Nurse practitioner reviewed all pharmacy recommendations and corrected all irregularities to meet the need of all residents on psychotics. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The admission nurse will review physician orders for the presence of antipsychotic medication and immediately implement the Behavior Monitoring Flow Record to track behaviors.	12/31/15

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L 128	Continued From page 13 A face-to-face interview was conducted with Employee #4 on October 21, 2015 at approximately 11:15 AM. A query was made regarding whether the pharmacist ' s MRR was addressed. Employee #4 acknowledged the aforementioned findings. The record was reviewed on October 21, 2015.	L 128	• The QA nurse/designee will re-inservice nursing staff on the importance of monitoring for episodes of psychotic behaviors and/or noted changes (better or worsening we are in compliance. • Monthly audit tool will be implemented to ensure that we are in compliance. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
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 and staff interview, it was determined that facility staff failed to discard expired medications stored in the medication cart on four (4) of two (2) nursing units observed (Unit 3 East). The findings include: The medication storage observations were done on October 16, 2015 at approximately 1:00 PM and revealed the following: 1. Resident #1 had three (3) tablets of Lorazepam 1mg stored for use. The expiration date on the package was 9/30/2015. 2. Resident #26 ' s Lyrica dosage was increased from 75 to100mg on October 2, 2015. Upon inspection of the 3 East medication cart 28 capsules of Lyrica 75mg were observed stored for use. These observations were made in the presence of Employee #4. He/she acknowledged the findings.	L 161	1. Resident #1 was not affected by deficient practice of expired medications on cart. There was no documentation of resident utilization of the expired medications and medications were removed from the cart immediately once noted. Other residents' medications were not expired. 2. Other residents having the potential to be affected by the same deficient practice of expired medications will have all medications checked for expiration dates prior to medication administration. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Nurses will be re-educated on importance of utilizing all medications in a timely manner to prevent expired meds in cart. • Nursing staff will be re-educated to monitor for expiration dates of all medications prior to administering to the resident.	12/31/15

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L 190	Continued From page 14	L 190	• Audit tool developed to monitor medication/narcotic expiration dates compliance. • Expired medications will be removed in the appropriate manner. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings. 1. Resident # 51 was not affected by the deficient practice inaccurate transcribing of tube feeding order. Other residents with tube feeding orders were transcribed accurately. 2. Other residents having the potential to be affected by the deficient practice of not having accurately transcribed tube feeding orders will be identified when the MAR and the physician tube feeding orders are reconciled. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Dietician and nursing staff work collaboratively to endure orders are infused correctly. • Nursing staff were re-inserviced on the importance of carrying out the 24 hour chart check to capture potential errors. • Random check of the 24 hour chart check will be done to check for compliance.	
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 sampled residents, it was determined that the facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: the facility staff ' s failure to accurately transcribe one (1) resident's tube feeding orders onto the Medication Administration Record [MAR] and failed to document an accurate acquired date of a pressure ulcer for one (1) resident. Resident #51. The findings include: 1. A. Facility staff failed to accurately transcribe Resident #51 ' s tube feeding orders onto the Medication Administration Record [MAR] as written by the physician. On October 20, 2015 at approximately 10:10 AM, a review of the clinical record revealed that Resident #51 was re-admitted to the facility on October 19, 2015 with diagnoses that included Gastrointestinal Bleeding, Respiratory Failure, and Heparin Induced Thrombocytopenia, after being transferred to the emergency room for vomiting on October 7, 2015. Review of the physician ' s orders revealed an order dated October 19, 2015 that directed the following, " Enteral feeding: Formula Nutren 1.5 continuous rate 50 cc [cubic centiliters]/hr [hour] via feeding pump ... " Review of the October 2015 Medication	L 190		12/31/15

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L 190	Continued From page 15 Administration Record [MAR] revealed that licensed staff transcribed the order as follows: " GT [Gastrointestinal] feeding: Nutren 1.5 @ 50 mls [milliliters]/hr via GT x [for] 24 hrs [hours]. " The transcribed order was recorded as " 24-hours as opposed to the physician ' s order that read " continuous. " On October 20, 2015 at approximately 10:20 AM, a face-to-face interview was conducted with Employee #8, regarding the aforementioned findings. He/she reviewed the clinical record and acknowledged the findings. The record was reviewed on October 20, 2015. 1B. Facility staff failed to document an accurate acquired date of a pressure ulcer. Review of the nursing note dated September 17, 2015 at 8:00 AM revealed the following: " ... 3.2 x 8 cm [pressure ulcer] on sacral area. Area cleaned with dry dsg [dressing]. [Doctor named] notified with orders for skin consult ... " Review of the 'Wound Care Rounds ' sheet dated September 30, 2015 revealed the following: " Wound Type-Pressure, Location of Wound-Sacrum, Stage of Wound - Unstageble, Acquired September 23, 2015, Measurements - 3x3 cm ... " The clinical record revealed inconsistencies in the date that the pressure ulcer was acquired. The nursing note recorded a date of September 17th and the " Wound sheet revealed an acquired date of September 23rd. On October 20, 2015 at approximately 10:20 AM, a face-to-face interview was conducted with Employee #3 who was asked to explain when the	L 190	• The nurse will contact physician to clarify tube feeding orders to ensure correct feeding amounts. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings. 1. Resident # 51 was not affected by the deficient practice of lack of date of an acquired pressure ulcer. No other resident records were without appropriate date of pressure ulcer acquirement. 2. Other residents having the potential to be affected by the deficient practice of not having a date of pressure ulcer acquirement will be identified on wound and skin assessment rounding. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The nurse will immediately document in the clinical record the date in which the pressure ulcer was identified with accurate measurements.	12/31/15

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L 190	Continued From page 16 sacral wound was acquired. He/she reviewed the clinical record and explained that the acquired date was on September 17, 2015. The record was reviewed on October 20, 2015.	L 190	• The Quality Nurse will re-educate the nursing staff on the importance of correct wound care documentation to prevent inconsistencies. • Audit tool generated to do random audits for compliance with wound acquirement date. • The wound nurse will monitor the wound rounding sheet for documentation of wound acquirement dates and • Measurements and incorporate in the clinical record. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
L 359	3250.1 Nursing Facilities 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 and interviews, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: (4) of six (6) burners failure to ignite on the stove in the main kitchen. The findings include: During observational rounds in main kitchen on October 20, 2015 at approximately 10:00 AM four (4) of six (6) burners failed to ignite. These observations were made on October 20, 2015 at approximately 10:00 AM in the presence of Employee #9 who acknowledged the findings.	L 359	1. Employee acknowledged that four out of six burners failed to ignite on the stove during the time of survey. The vendor was called to repair the stove. 2. No resident was affected by this deficient issue. All other essential equipment was checked for safe operating conditions. No other issues were found 3. Upon inspection by the vendor, it was determined that the stove in its present condition needed to be replaced. The Director of Food Services has ordered a new stove and it will be delivered within the next 60 days. 4. The Director of Food Services or designee will audit the essential equipment in the kitchen for safe operating conditions weekly. The result of this audit will be reported at the Quality Assurance Committee meeting by the Director of Food Services or designee quarterly.	12/31/15