Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| L 000 | Initial Comments<br><br>A Licensure survey was conducted at your facility on January 5 through January 12, 2015. The following deficiencies are based on observations, record reviews, resident and staff interviews for 37 sampled residents. | L 000 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(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:<br><br>A. Based on staff interviews and record review for five (5) of 37 sampled residents, it was determined that the facility staff failed to provide the necessary care and services for the residents to attain or maintain the highest practicable | L 051 | Please begin typing your responses here: | |

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| L 051 | Continued From page 1<br>physical, mental, and psychosocial well- being as evidenced by failure to: clarify the route of administration for aspirin prescribed by the physician for three (3) residents; ensure that one (1) resident received hospice care as ordered by the physician and collaborate with hospice to coordinate the necessary care and services for one (1) the resident. Residents' #65, 103, 104, 146, and 159.<br><br>The findings include:<br><br>1. Facility staff failed to clarify the oral method (chew or swallow) of administration for aspirin prescribed by the physician for three (3) residents. Residents #65, 103, and 146.<br><br>On January 9, 2015 at approximately 10:00 AM, a review of resident clinical records revealed the following:<br><br>A. A review of the clinical record for Resident #65 revealed the following physician ' s order dated January 2, 2015: "aspirin oral tablet chewable 81mg 1 tablet po [by mouth] 1 time a day 10 am, special instructions: dx [diagnosis]: prophylaxis."<br><br>B. A review of the clinical record for Resident #103 revealed the following physician ' s order dated January 2, 2015: "aspirin oral tablet chewable 81mg 1 tablet po 1 time a day 10 am special instructions: dx: stroke."<br><br>C. A review of the clinical record for Resident #146 revealed the following physician ' s orders dated January 2, 2015: "aspirin oral tablet chewable 81mg 1 tablet po 1 time a day 10 am special instructions: dx: cva [cerebral vascular accident] prophylaxis." | L 051 | 1. Residents #65, #103 and #146 did not suffer any harm from this deficient practice.<br><br>2. All residents on chewable Asprin were identified and clarification of orders to administer the medication chewed or swallowed was established.<br><br>3a.All licensed nurses were in-serviced on 1/31/15 on the administration of chewable medication.<br><br>3b.QA/Designee will conduct weekly audits for ninety days to ensure that all medications are administered per order.<br><br>4 Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months. | 2/16/15 |

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| L 051 | Continued From page 2<br><br>The clinical record lacked evidence that facility staff clarified the aspirin orders to provide unequivocal direction on whether to administer the aspirin to be chewed or swallowed.<br><br>A face-to-face interview was conducted on January 9, 2015 at approximately 11:30 AM with Employee #13 and Employee #3 regarding the above mentioned orders for aspirin. When queried regarding how the aspirin was to be administered, Employee #13 stated he/she would administer the medication by mouth to be swallowed by the resident. Employee #3 stated he/she would administer the medication by mouth to be chewed by the resident. Both acknowledged the aforementioned findings.<br><br>Facility staff failed to clarify the oral method of administration for aspirin prescribed for the residents. The clinical record was reviewed on January 9, 2015.<br><br>2. Facility staff failed to ensure that Resident #104 received hospice care as ordered by the physician.<br><br>According to the documentation in the clinical record, the physician ordered the following treatment for the resident on February 11, 2013: "Admit Resident to Hospice Care (Name of Agency). Dx. [Diagnosis] COPD [Chronic Obstructive Pulmonary Disease]." Current physician ' s orders dated January 2, 2015 includes an order for continued Hospice services.<br><br>A review of Resident #104 ' s clinical record lacked evidence of hospice nursing assessments and/or progress notes. Further review of a | L 051 | | |

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| L 051 | Continued From page 3<br>"Hospice Visit Frequency Grid" in the clinical record also failed to reveal any consistent documentation of the hospice nurses' visits.<br><br>A face-to-face interview was conducted with Employee #2 at approximately 10:00AM on January 12, 2015. The employee was queried regarding the lack of hospice nursing documentation in the clinical record. He/she responded that hospice had its own chart and that I should look in the hospice chart for their nursing documentation.<br><br>A review of the hospice chart [a binder stored on the residential unit with records of residents receiving hospice services] failed to reveal nursing documentation or evidence of nurse visits for Resident #104. When queried about the absence of documentation in the hospice record, Employee #2 stated, "They keep their notes in their office [at another location]. Would you like me to have them faxed over here?" I responded, " No " and informed the employee that the aforementioned information needed to be readily available and accessible. The employee was also unable to determine the frequency of hospice nurse visits based on an assessment of the resident ' s needs. The record was reviewed on January 9, 2015.<br><br>Facility staff failed to ensure that Resident #104 received hospice care as ordered by the physician.<br><br>3. Facility staff failed to collaborate with hospice to coordinate the necessary care and services for Resident #159.<br><br>The Annual Minimum Data Set dated October 20, 2014 revealed that Resident #159 was admitted | L 051 | 1. Resident #104 and #159 did not suffer any harm from this deficient practice.<br><br>2. Review of all medical records of hospice residents was conducted and none was noted with this deficient practice.<br><br>3a An in-service was conducted on 1/31/15 with facility and hospice staff on coordination and collaboration of care.<br><br>3b QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. | 2/16/15 |

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| L 051 | Continued From page 4<br><br>to the facility on October 14, 2013 with diagnoses including Anemia, Deep Venous Thrombosis, Hearth Failure, Hypertension, and Non-Alzheimer 's Dementia. Additional diagnoses included Speech Disturbance, Vitamin B deficiency, and Encounter for Palliative Care.<br><br>Review of the October 14, 2013 Interim Order Form, timed 10:00 PM, revealed an order that directed the following: " Patient admitted to [company name] Hospice with a dx of Dementia ..."<br><br>Review of the November 13, 2014 physician progress notes revealed the following: "Continue supportive hospice care."<br><br>On January 8, 2014, at approximately 12:18 PM, a face-to-face interview was conducted with Employee #13 who was asked to explain how the facility coordinates care with the hospice provider to care for Resident #159. Employee #13 stated that hospice attendants come to assist with ADL's [Activities of Daily Living] and care; hospice provides music therapy and a pastor visits the resident. When asked how the facility staff and the hospice nurse coordinate care, Employee #13 provided no answer. When asked to provide the hospice notes, he/she stated, "The hospice care plans and notes are not in the resident's chart." He/she admitted that he/she didn't know where they were.<br><br>On January 8, 2014, at approximately 12:30 PM, a face-to-face interview was conducted with Employee #4 who was asked to provide the hospice care plans and notes for review. Employee #4 communicated that he/she would call the hospice manager to assist. At approximately 2:30 PM, Employee #4 provided | L 051 | | |

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| L 051 | Continued From page 5<br>the hospice binder for review.<br><br>Review of the hospice "Visit Frequency Grid," indicated the following:<br><br>November 11, 2014 - The resident was to receive planned visits by the nurse once a week. December 3, 2014 - The resident was to receive planned visits by the nurse twice a week. December 23, 2014 - The resident was to receive planned visits by the nurse once a week.<br><br>Review of the hospice sign in sheet revealed the following:<br><br>November 2014- no printed name with credentials or signed names with credentials of the hospice nurse.<br>December 2014-December 20, 2014, there was one printed and signed name with credentials of hospice nurse.<br><br>Review of the clinical record lacked documented evidence of hospice nursing assessments and notes from November 12, 2014 to January8, 2014.<br><br>January 2014- no printed name with credentials or signed names with credentials of the hospice nurse.<br><br>The clinical record lacked documented evidence that the facility staff collaborated with hospice to provide the necessary care and services to the resident.<br><br>On January 8, 2014, at approximately 2:40 PM, a face-to-face interview was conducted with the hospice representative who acknowledged the above mentioned findings. When asked if visits | L 051 | | |

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| L 051 | Continued From page 6<br>were made by the hospice nurse during the above mentioned dates, he/she stated although they did not sign in, he/she knew they made visits. When asked to provide the hospice nursing assessments and notes for the resident from November 12, 2014 to January 8, 2014, he/she could not provide the information. He/she communicated that the assessments and notes were in the hospice office.<br><br>On January 8, 2014, at approximately 3:00 PM, a face-to -face interview was conducted with Employee #3 who acknowledged the aforementioned findings.<br><br>Facility staff failed to collaborate with hospice to coordinate the necessary care and services for the resident. The clinical record was reviewed on January 8, 2015.<br><br>B. Based on clinical record review and staff interviews for 1 (one) of 37 sampled residents it was determined that the facility staff failed to clarify a medication order to include an accurate indication for the use of Benzotropine (Cogentin) [an Anticholinergic medication used to treat symptoms of involuntary movement]. Resident #110.<br><br>The findings include:<br><br>Mosby ' s Nursing Drug Reference 2014 Cogentin - an Anticholinergic /Antiparkinsonian medication to control extrapyramidal [neurological network that causes involuntary reflexes and movements] disorders.<br><br>Facility staff failed to clarify a medication order to | L 051 | | |

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| L 051 | Continued From page 7<br>include an accurate indication for the use of Cogentin (Benzotropine) for Resident #110.<br><br>Initial physician ' s order: July 22, 2014, 10:27 AM, " Start Cogentin 0.5 mg [milligrams] po [by mouth] BID [twice a day] for psychosis/agitation. "<br><br>Current physician ' s order: January 2, 2015, Cogentin (Benztropine) Oral Tablet 0.5mg 1 Tablet PO 2 [two] Times a day 9am, 5pm special instructions: for psychosis/agitation. "<br><br>The clinical record lacked documented evidence that the facility staff clarified the medication order to include the accurate indication for the use of Cogentin (Benzotrophine).<br><br>On January 9, 2015 at approximately 2:30 PM, a face-to-face interview was conducted with Employee #4 who acknowledged the findings.<br><br>Facility staff failed to clarify a medication order to include an accurate indication for the use of Cogentin (Benzotropine). The clinical record was reviewed on January 9, 2015. | L 051 | 1a. Resident #10 did not suffer any harm from this deficient practice.<br><br>1b. Clarification of Cogentin was done to Include its indication of use.<br><br>2. All other residents on Cogentin (Benzo Tropine) were reviewed and none was noted with this deficient practice.<br><br>3a All nurse managers and charge nurses were in-serviced on 1/31/15 to include appropriate indication of medication use.<br><br>3b QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance.<br><br>4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. | 2/16/15 |
| L 099 | 3219.1 Nursing Facilities<br><br>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:<br>Based on observations made on January 8, 2015, it was determined that the facility failed to store, prepare and distribute food under sanitary conditions as evidenced by dented food service equipment such as one (1) of one (1) round pan | L 099 | 1. All dented pans were immediately identified, removed and discarded on 1/30/15.<br><br>2. Director of Food Service checked all pots and pans and none was noted with this deficient practice.<br><br>3a All Food Services staff were in-serviced on 1/31/15 on the identification and disposal of dented pans. | |

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| L 099 | Continued From page 8<br><br>and one (1) of one (1) half-size deep pan, five (5) of five (5) one-quarter size pans that were stored wet and dented and low final rinse temperatures from the dishwashing machine that were sporadically documented and not acted upon for nine (9) of 13 months in 2014 and 2015.<br><br>The findings include:<br><br>1. One of one round pan was dented.<br><br>2. Five of five one-quarter size pans were stored wet and dented.<br><br>3. One of one half-size deep pan was dented.<br><br>4. Final rinse temperatures for the dishwashing machine were documented at less than 180 degrees Fahrenheit on numerous occasions for 9 of 13 months in 2014 and 2015. A review of the dishwashing machine logs revealed that final rinse temperatures, which are recorded once in the morning and once in the afternoon, were below the expected minimum temperature of 180 degrees Fahrenheit during the following instances.<br><br>Three (3) times in January 2015<br>Twenty-two (22) times in December 2014<br>Six (6) times in November 2014<br>Twice (2) in October 2014<br>Fourteen (14) times in August 2014<br>Three (3) times in July 2014<br>Three (3) times in June 2014<br>Seven (7) times in May 2014<br>Three (3) times in February 2014.<br><br>There was no evidence that the low temperatures noted above were acted upon. | L 099 | 3b Food Service Director/Designee will conduct random audits bi-weekly for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meeting six months.<br><br>1. All five one quarter size pans were identified and immediately rewashed and air dried.<br><br>2. Dietary department checked all pans on 1/15/15 and none was noted with this deficient practice.<br><br>3a Director of Food Services in-serviced all dietary staff on 1/31/15 on proper air drying and storage of pans.<br><br>3b Director of Food Service / Designee will conduct weekly audits for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly monthly and quarterly QA meetings for six months.<br><br>1. No resident was harmed by this deficient practice.<br><br>2. The dish machine temperature log book was immediately checked and no other deficient practice was noted. | 2/16/15<br><br>2/16/15 |

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| L 099 | Continued From page 9<br><br>During a face to face interview with Employee # 10 on January 8, 2015 at approximately 9:30 AM, he/she confirmed the findings and stated that some of the newer staff members needed to be re-educated about the dishwashing machine logs. He/she stated that the dishwashing machine had been operating normally and the low temperatures that were sporadically documented above were incorrect.<br><br>These observations were made in the presence of Employee #10 who acknowledged the findings. | L 099 | 3a Director of Food Services in-serviced all dietary staff on 1/31/15 on the accuracy of proper temperature range and documentation in the temperature log book.<br><br>3b. The food service director will conduct daily audit of the temperature log book for ninety days to ensure accuracy and compliance.<br><br>4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months. | 2/16/15 |
| L 201 | 3231.12 Nursing Facilities<br><br>Each medical record shall include the following information:<br><br>(a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion;<br><br>(b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;<br><br>(c)Medicaid, Medicare and health insurance numbers;<br><br>(d)Social security and other entitlement numbers;<br><br>(e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;<br><br>(f)Date of discharge, and condition on discharge;<br><br>(g)Hospital discharge summaries or a transfer form from the attending physician; | L 201 | | |

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| L 201 | Continued From page 10<br><br>(h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation;<br><br>(i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease;<br><br>(j)Current status of resident's condition;<br><br>(k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition;<br><br>(l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;<br><br>(m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service;<br><br>(n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;<br><br>(o)The plan of care; | L 201 | | |

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| L 201 | Continued From page 11<br><br>(p)Consent forms and advance directives; and<br><br>(q)A current inventory of the resident's personal clothing, belongings and valuables.<br><br>This Statute is not met as evidenced by:<br>A. Based on record review, and staff interview for three (3) of 37 sampled residents, it was determined that the facility's staff failed to maintain complete, accurate, and organized clinical records in accordance with accepted professional standards and practices as evidenced by failure to ensure that documentation related to Advanced Beneficiary Notice of Non-coverage was incorporated into the closed clinical records for three (3) residents. Residents #42, #51, and #61.<br><br>The findings include:<br><br>1. The facility's staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #42.<br><br>A review of Resident #42' s clinical record revealed that the resident was admitted to the facility on August 29, 2014 with diagnoses which included End Stage Renal Disease, Hemiparesis, Generalized Muscle Weakness Diabetes Mellitus, and Depression.<br><br>Additional review of the clinical record revealed that Resident #42 was discharged from the facility on September 11, 2014.<br><br>Resident #42 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider | L 201 | 1. Resident 42, 51 and61 ABN/denial letters were placed in their charts.<br><br>2. All other resident charts were checked and none noted with this deficient practice<br><br>3a. All social workers were in-serviced on 1/15/14 on the placement of ABN forms/denial letters in residents charts.<br><br>3b.QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. | 2/16/15 |

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| | HFD02-0001 | A. BUILDING: _____ B. WING _____ | 01/12/2015 |

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| L 201 | Continued From page 12<br>determined that skilled nursing or rehabilitation services may be denied.<br><br>A face-to-face interview was conducted with Employee #9 on January 12, 2015, at approximately 11:40 AM. He/she acknowledged the findings and stated that copies of the Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the residents' closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015.<br><br>Facility staff failed to ensure that documentation related to Advanced Beneficiary Notice was incorporated into the closed clinical record for Resident #42.<br><br>2. Facility staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #51.<br><br>A review of Resident #51's clinical record on January 12, 2015, revealed that he/she was admitted to the facility on July 10, 2014.<br><br>Further review of the clinical record revealed the resident was discharged from the facility on August 29, 2014.<br><br>Resident #51 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider determined that skilled nursing or rehabilitation services may be denied.<br><br>A face-to-face interview was conducted with Employee #9 on January 12, 2015 at approximately 10:29 AM. He/she acknowledged the findings and stated that copies of the | L 201 | | |

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| L 201 | Continued From page 13<br><br>Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the resident's closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015.<br><br>Facility staff failed to ensure that documentation related to Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #51.<br><br>3. Facility staff failed to ensure that Advanced Beneficiary Notices were incorporated into the closed clinical record for Resident #61.<br><br>A review of Resident #61's clinical record on January 12, 2015, revealed that he/she was admitted to the facility on July 28, 2014 and was discharged from the facility on September 9, 2014.<br><br>Resident #61 ' s closed clinical record lacked documented evidence that he/she received notice of his/her appeal rights once the provider determined that skilled nursing or rehabilitation services may be denied.<br><br>A face-to-face interview was conducted with Employee #9 on January 12, 2015 at approximately 10:29 AM. He/she acknowledged the findings stating that copies of the Advanced Beneficiary Notices/ Notice of Medicare Non-coverage forms were not kept in the resident's closed records but were kept in a binder in the Social Service's office. The record was reviewed on January 12, 2015.<br><br>Facility staff failed to ensure that documentation related to Advanced Beneficiary Notices were incorporated into the closed clinical record for | L 201 | | |

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| L 201 | Continued From page 14<br>Resident #61.<br><br>B. Based on record review and staff interview for five (5) of 37 sampled residents, it was determined that the facility staff failed to ensure that Residents' Personal Property Inventory forms were revised quarterly in accordance with Title 22 DCMR 3231.12 (s). Residents #56, #68, #86, #99, and #191.<br><br>The findings include:<br><br>According to Chapter 32, Title 22B Long Term Care Licensure Regulations, the District of Columbia Municipal Regulations (DCMR), section 3231.12 stipulates: "Each facility shall ensure that each medical record shall include the following information:...(s) A quarterly inventory of the resident's personal clothing, belongings, and valuables".<br><br>1. The facility staff failed to ensure that Resident # 56's Personal Property Inventory was revised quarterly.<br><br>A review of Resident #56's clinical record on January 9, 2015, revealed that he/she was admitted to the facility on July 31, 2012.<br><br>Additional review of the clinical record revealed Resident #56's Personal Property Inventory was last revised on August 7, 2013.<br><br>Additionally, the clinical record contained Resident Personal Property forms dated November 27, 2014 and November 28, 2014, which detailed specific items and did not contain updated comprehensive itemizations of the | L 201 | 1. Residents #56, #68, #86, #99 and #191 did not suffer any harm from this deficient practice.<br><br>2. All other residents were personal property Inventory forms were reviewed and none noted with the deficient practice.<br><br>3a An in-service was conducted for nursing staff on 2/3/15 on updating personal property inventory forms and honoring of residents preferences in general and handling of laundry in particular.<br><br>3b QA/Designee will conduct bi-weekly rounds for ninety days to ensure compliance.<br><br>4. Further findings of this matter will be discussed in the weekly, monthly and quarterly QA meeting for six months. | 2/16/15 |

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| L 201 | Continued From page 15<br>resident's personal clothing, belongings, and valuables.<br><br>The clinical record lacked documented evidence that the facility conducted a quarterly inventory of all Resident #56's personal clothing, belongings, and valuables.<br><br>The facility staff failed to ensure that Resident 56's Personal Property Inventory was revised quarterly.<br><br>2. The facility staff failed to ensure that Resident # 68's Personal Property Inventory was revised quarterly.<br><br>A review of Resident #68's clinical record on January 9, 2015, revealed that he/she was admitted to the facility on January 21, 2012.<br><br>Additional review of the clinical record revealed Resident #68's Personal Property Inventory was last revised on April 27, 2013.<br><br>The clinical record lacked documented evidence that the facility conducted a quarterly inventory of Resident #68's personal clothing, belongings, and valuables.<br>A face-to-face interview was conducted with Employee #4 on January 8, 2015, at approximately 3:30 PM. He/she acknowledged the findings.<br><br>The record was reviewed on January 9, 2015.<br><br>The facility staff failed to ensure that Resident #68's Personal Property Inventory was revised quarterly. | L 201 | | |

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| L 235 | Continued From page 18<br>controlled and shall not exceed one-hundred and ten degrees Fahrenheit (110 F) nor be less than ninety-five degrees Fahrenheit (95 F).<br>This Statute is not met as evidenced by:<br>Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM and on January 9, 2015 at approximately 9:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by low water temperatures in five (5) of 44 resident's rooms.<br><br>The findings include:<br><br>1. Water temperatures in five (5) of 44 residents' rooms surveyed were less that 95 degrees Fahrenheit (F) as required by Title 22 DCMR. The water temperatures were as follows:<br><br>Room # 403 = 92.8 degrees F<br>Room # 402 = 84.0 degrees F<br>Room # 303 = 93.4 degrees F<br>Room # 302 = 90.3 degrees F<br>Room # 203 = 84.0 degrees F<br>These observations were made in the presence of Employee #11 and Employee #12. | L 235 | 1a Cold water temperatures in rooms 403, 402, 303, 302 and 203 were Immediately restored to compliance between 95-110 degrees by replacing the gas valve by American Boiler on 1/8/15<br><br>2. All other rooms in the facility were checked and none noted with this deficient practice.<br><br>3a. The Director of Maintenance in-serviced the staff on 1/31/15 on the accuracy of water temperature per regulation.<br><br>3b. Director of Maintenance/Designee will conduct daily rounds for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. | 2/16/15 |
| L 306 | 3245.10 Nursing Facilities<br><br>A call system that meets the following requirements shall be provided:<br><br>(a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents;<br><br>(b)In new facilities or when major renovations are | L 306 | | |

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| L 306 | Continued From page 19<br>made to existing facilities, be of type in which the call bell can be terminated only in the resident's room;<br><br>(c)Be of a quality which is, at the time of installation, consistent with current technology; and<br><br>(d)Be in good working order at all times.<br><br>This Statute is not met as evidenced by:<br><br>Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM, it was determined that the facility failed to maintain resident's call bell system in good working condition as evidenced by call bells in six (6) of 44 resident ' s rooms that did not emit an alarm when tested.<br><br>The findings include:<br><br>1. Resident call bells did not operate as intended in six (6) of 44 resident's rooms including rooms # 507, # 508, # 513B, # 518B, # 517A and # 207.<br><br>These observations were made in the presence of Employee #11 and/or Employee #12. | L 306 | 1. Call cords in rooms 507, 508, 513B, 517A and 207 were identified and immediately replaced and tested for proper operation on 1/8/15.<br><br>2. All call lights in the facility were checked and none was noted with this deficient practice.<br><br>3a. All maintenance staff were in-serviced on 1/12/15 on proper functioning of call bells.<br><br>3b. The Director of Maintenance//Designee will check call bell daily for ninety days to ensure proper functioning.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and daily QA meetings for six months. | 2/16/15 |
| L 410 | 3256.1 Nursing Facilities<br><br>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.<br>This Statute is not met as evidenced by:<br>Based on observations made on January 8, 2015 between 11:00 AM and 4:30 PM and on January | L 410 | | |

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| L 410 | Continued From page 20<br>9, 2015 at approximately 9:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled bathroom vents in five (5) of 44 residents' rooms surveyed and one (1) of two (2) damaged over-bed table in one (1) of 44 resident's room surveyed.<br><br>The findings include:<br><br>1. Bathroom vents were soiled with dust particles in five (5) of 44 residents' rooms Rooms #518, #505, # 405, # 319 and # 308.<br><br>2. One (1) of two (2) over-bed table in room #320 was worn at the seams and needed to be replaced in one (1) of 44 resident's room surveyed.<br><br>These observations were made in the presence of Employee #11 and Employee #12. | L 410 | | |
| L 426 | 3257.3 Nursing Facilities<br><br>Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by:<br><br>Based on observations made during the survey, it was determined that the facility failed to maintain an effective pest control program as evidenced by crawling and flying insects observed in the facility throughout the survey. | L 426 | 1. The chairs in room 420 was immediately Identified and removed from the resident's room and discarded.<br><br>2a All chairs located in residents rooms in the entire building were checked and none noted with this deficient practice. | |

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| L 201 | Continued From page 16<br><br>3. The facility staff failed to ensure that Resident #86's Personal Property Inventory was revised quarterly.<br><br>A review of Resident #86's clinical record on January 8, 2015, revealed that he/she was admitted to the facility on June 29, 2011.<br><br>Additional review of the clinical record revealed Resident #86's Personal Property Inventory was last revised on "12/10"[date incomplete].<br><br>The clinical record lacked documented evidence that the facility conducted a quarterly inventory of Resident #86's personal clothing, belongings, and valuables.<br><br>A face-to-face interview was conducted with Employee #7 on January 8, 2015, at approximately 3:30 PM. He/she acknowledged the findings.<br><br>The record was reviewed on January 8, 2015.<br><br>The facility staff failed to ensure that Resident #86's Personal Property Inventory was revised quarterly.<br><br>4. The facility staff failed to ensure that Resident #99's Personal Property Inventory was revised quarterly.<br><br>A review of Resident #99's clinical record on January 9, 2015, revealed that he/she was admitted to the facility on September 26, 2008.<br><br>Additional review of the clinical record revealed Resident #99's Personal Property Inventory was | L 201 | | |

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| L 201 | Continued From page 17<br>last revised April 26, 2011.<br><br>The clinical record lacked documented evidence that the facility conducted a quarterly inventory of Resident #99's personal clothing, belongings, and valuables.<br>The record was reviewed on January 9, 2015.<br><br>The facility staff failed to ensure that Resident # #99's Personal Property Inventory was revised quarterly.<br><br>5. The facility staff failed to ensure that Resident #191's Personal Property Inventory was revised quarterly.<br><br>A review of Resident #191's clinical record on January 9, 2015, revealed that he/she was admitted to the facility on August 8, 2013.<br><br>Additional review of the clinical record revealed Resident #191's Personal Property Inventory was last revised on August 8, 2013.<br><br>The clinical record lacked documented evidence that the facility conducted a quarterly inventory of all Resident #191's personal clothing, belongings, and valuables.<br><br>The facility staff failed to ensure that Resident#191 ' s Personal Property Inventory was revised quarterly. | L 201 | | |
| L 235 | 3236.4 Nursing Facilities<br><br>The temperature of hot water of each fixture that is used by each resident shall be automatically | L 235 | | |

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| L 426 | Continued From page 21<br>The findings include:<br><br>1. On January 8, 2015, at approximately 3:00 PM, crawling insects were observed inside a chair located in room #420, one (1) of 44 resident ' s rooms surveyed. Food such as crackers was stored under the seat of the chair. The chair was immediately removed from the resident ' s room and according to Employee # 12, it was immediately discarded.<br><br>2. A large flying insect was observed in the area of rooms #415 A and B and #415 C and D on January 7, 2015 at approximately 1:00 PM.<br><br>3. A smaller flying insect was observed at the nursing station on the fourth (4th.) floor on January 8, 2015 at approximately 3:00 PM.<br><br>These observations were made in the presence of Employee #11 and/or Employee #12 during the tour. | L 426 | 2b All environmental service staff were in-serviced on 1/22/14 on pest control.<br><br>3 The Director of Environmental service or designee will conduct daily rounds for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.<br><br>1. Rooms 415A, 415B, 415C, 415D and the nursing station were treated for pest by Western Pest Control Company on 2/2/15<br><br>2a The entire building was treated and checked by Western Pest Control and none noted with this deficient practice.<br><br>3a. All Environmental Staff were in-serviced on 1/31/15 on Pest control and the login book located on all units.<br><br>3b. The Director of Environmental service or designee will conduct daily checks for ninety days to ensure compliance.<br><br>4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months. | 2/16/15<br><br>2/16/15 |