Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	A. BUILDING: _____ B. WING _____	C 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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L 000	Initial Comments An unannounced Annual Licensure survey was conducted at Forest Hills of DC on the following dates: February 17- 18, 2022 and February 22-25, 2022. Survey activities consisted of a review of 26 sampled residents. The facility's census during the survey was 45. The following complaint was investigated during this survey: DC00010523. The following facility reported incidences were investigated during this survey: DC00010109, DC00010124, DC00010123, DC00010121, DC00010144, DC00010168, DC00010219, DC00010222, DC00010262, DC00010309, DC00010320, DC00010344, DC00010409, DC00010423, DC00010507, DC00010523, DC00010521, DC00010535. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 for Nursing Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utlized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters	L 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	

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L 000	Continued From page 1	L 000		

CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological

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L 000	Continued From page 2 NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	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 records review on February 24, 2022, at approximately 3:00 PM, it was determined that facility staff failed to ensure that one (1) of three (3) persons in charge, who is a certified food protection manager, obtained a District of Columbia Food Protection Manager Identification Card.	L 012	1. Dining Service employee enrolled in a Food Protection Manager program on 2/28/2022 to get an updated District- Issued Food Protection Manager Identification card upon completion. 2. The remaining 2 dining managers had current certifications. 3. The Director of Dining Services in-serviced staff on completing Food Protection Manager Certifications to remain current. The director of Dining services and designee will ensure certification compliance by conducting on-going quarterly audits.	4/1/2022 2/25/2022 2/25/2022

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L 012	Continued From page 3 The findings include: During a review of dietary records on February 25, 2022, at approximately 3:00 PM, one (1) of three (3) persons in charge did not have an updated, District-issued Food Protection Manager Identification Card. The 2012 District of Columbia Food Code, section 203.3 of Chapter 2 states the following: 2012 District of Columbia Food Code 203 Certification and District -Issued ID Requirements Food Protection Manager, Person in Charge 203.3 A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. These observations were acknowledged by Employee #6 during a face-to-face interview on February 25, 2022, at approximately 2:45 PM.	L 012	4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by The Director of Dining Services or designee.	On-going
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	L 051	1. Resident #139 health record was updated to include diagnosis of Macular Degeneration. 2. A review of all baseline care plan reports within the last 30 days was completed by the Nursing Leadership to determine if a baseline care plan was completed upon admission. All missing diagnosis were updated. 3. IDT have been in-serviced on the process of completing baseline care plan within 48 hours of admission to include focus, goal, intervention and reviewing diagnosis both history and current with resident/family	2/24/2022 2/25/2022 2/28/2022

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L 051	Continued From page 4 physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 32 sampled residents, the charge nurse failed to: (1) develop a baseline care plan and delegate nursing staff to assess edema of the resident's left arm for one resident; and (2) delegate nursing staff to spoon-feed one (1) resident at all times. (Residents' #36 and #139) The findings included: 1. The charge nurse failed to a develop a baseline care plan for Resident #139. Resident #139 was re-admitted to the facility on 02/16/22 with multiple diagnoses including Nonexudative Age Related Macular Degeneration Right Eye Stage Unspecified. During a face-to-face interview on 02/23/22 at 11:22 AM, Resident #139 stated "I have Macular Degeneration. I can't hardly see. I'm afraid I'm going to knock my glass of water over."	L 051	• Medical Record personnel have been in-serviced to bring old records of previously admitted resident for review by the IDT upon admission • Nursing team will review baseline care plan with resident and family and will be given copy of their baseline care plan • Nursing leadership team including the supervisor will review hospital admissions within 48 hours and monitor the process to ensure compliance. • Any findings of non-compliance will be reported to the Director of Nursing 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	On-going

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L 051	Continued From page 5 Review of the Electronic Health Record (EHR) for Resident #139, who was re-admitted to the facility on 02/16/22 showed the resident had a diagnosis of Nonexudative Age-Related Macular Degeneration Right Eye Stage Unspecified listed on her face sheet, Medication Administrative Record, Treatment Administration Record and Comprehensive-Care Plans from previous stay at the facility (admitted on 06/16/21 and discharged on 09/22/21). Review of the "Nursing Admission Screening/History" dated 02/16/22, documented, "Eyes ... PERRLA (pupils, equal, round and reactive to light and accommodation)... and adequate vision" were marked with a check sign indicating the admitting nurse assessed the resident's pupils. Review of the Baseline Care Plan dated 02/16/22 listed the resident's of Nonexudative Age Related Macular Degeneration Right Eye. However, there was no evidence that the facility developed a person-centered baseline care plan that included instructions/interventions to address Resident #139's diagnosis. During a face-to-face interview on 02/24/22 at 2:35 PM, Employee #11 (Assistant Director of Nursing) stated, "This resident was here before in June (2021) when they put her back in the system it re-populates, I checked on the discharge summary in February (2022) and that diagnosis was not there, yes she has Macular Degeneration." 2. The charge nurse failed to delegate nursing staff to assess for edema that was present in Resident #139's left arm and spoon feed	L 051		

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L 051	Continued From page 6 Resident #36 at all meals. A. Resident #139 was re-admitted to the facility on 02/16/22, with multiple diagnoses including Acute Kidney Failure, Muscle Weakness, and Chronic Obstructive Pulmonary Disease. Review of the Quarterly Minimum Data Set (MDS) dated 09/21/21 revealed the following: In section C (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) summary score of "15" indicating intact cognition. In section G (Functional Status) G0110 Activities of Daily Living (ADL) Assistance, Bed Mobility facility staff coded "extensive assistance "and resident requires "one-person physical assist" Transfer, facility staff coded "extensive assistance" and resident requires "Two-person physical assist" Walk in room, facility staff coded "Activity did not occur" Toilet use, facility staff coded "Extensive assistance" and resident requires "Two-person physical assist" Personal Hygiene, facility staff coded "extensive assistance" and resident requires "Two-person physical assist" G0400 Functional limitation in range of motion, Upper extremity, facility staff coded "No impairment", Lower extremity is coded "Impairment on one side" Review of the nursing progress note dated	L 051		

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L 051	Continued From page 7 02/17/22 at 4:31 PM, revealed " ...resident has pitting edema in her bilateral lower extremities, and left arm, which [is] elevated on the pillows ..." Review of "Skilled Charting" notes from 02/17/22 through 02/23/22 lacked documented evidence that staff assessed resident's edema in her left arm. During multiple observation from 02/17/22 to 02/24/22 starting at approximately 10:30 AM to 4:00 PM, the surveyor noted the resident lying in bed with the head of the bed elevated. The resident's left arm appeared larger that her right arm. Resident #139 stated, "My arm was swollen even worse when I was in hospital." During a face-to-face interview on 02/24/22 at 11:42 AM, Employee #11 (Assistant Director of Nursing) acknowledged the finding and stated "I spoke to the Nurse Practitioner yesterday (02/23/22) and we have been elevating the [resident's] arm." B. Resident #36 was admitted to the facility on 11/22/19, with multiple diagnoses including Dysphagia, Oropharyngeal Phase, Unspecified Protein-Calorie Malnutrition, Abnormal Weight Loss, Unspecified Glaucoma, and Unspecified Dementia Without Behavioral Disturbance. During an observation of the second-floor resident dining area on 02/23/22 at 9:15 AM, Resident #36 was observed sitting at a table alone and feeding himself his breakfast. Review of Resident #36's medical record showed the following:	L 051		

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L 051	Continued From page 8 01/05/22 [physician order] directed, "Spoon feed at all meals" 01/21/22 [Quarterly Minimum Data Set] documented the following: In Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) the resident had a summary score of "03" indicating severe cognitive impairment. In section G (Functional Status) facility staff coded the resident required "extensive assistance" and "one-person physical assist" with eating. In section I (Active Diagnoses)- the resident was coded for Non-Alzheimer's Dementia, Glaucoma, and Generalized Muscle Weakness. In Section K (Swallowing/Nutritional Status) Swallowing Disorder, facility staff coded "None of the above" indicating the resident did not display any sign/symptoms of possible swallowing disorder during this assessment period. The resident was also coded for receiving a "mechanically altered diet" while a resident. In section O (Special Treatments, Procedures, and Programs) - lacked documented evidence Resident #36 was receiving speech therapy services. Review of certified nurse aide check list titled; "Documentation Survey Report" dated from 02/01/22 to 02/23/22 recorded that Resident #36 was totally dependent on one-person (staff) physical assist for eating meals on multiple dates. During a face-to-face interview on 02/23/22 at	L 051		

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L 051	Continued From page 9 11:40 AM, Employee #11 (Assistant Director of Nursing) stated "I'm not sure what happened normally someone helps him (Resident #36) to eat."	L 051		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, for five (5) of 32 sampled residents, the facility's staff failed to maintain Infection Control Practices to minimize or prevent the potential spread of infection as evidenced by: (1) staff not performing hand hygiene before serving a lunch tray for one (1) resident; (2) staff not performing hand hygiene between care (hygiene) for two (2) residents; (3) staff not providing a barrier during wound care for one (1) resident; and (4) not wearing clean gloves when changing bed linen for one (1) resident. (Residents' #1, #2, #9, #17 and #239). The findings included: 1. The facility's staff failed to perform hand hygiene before serving Resident #9 her lunch tray. Review of a policy titled, "Assisting the Impaired Resident with In Room Meals, instructed staff to, "wash their hands before serving food to residents ..."	L 091	1. There was no adverse effect to this deficient practice to resident #1, #2, #9, #17 and #239. The affected staff were immediately in serviced and redirected to practice appropriate infection control practice. 2. The nursing leadership conducted infection control round on the unit to ensure that staff are practicing appropriate infection control protocol, while serving meals and during wound care, no other findings was observed. 3. Employees have been in-service on infection control practices as it relates to hand hygiene. License Nurses were also in-serviced on infection control practice during wound care. Nursing leadership team will monitor for compliance on a weekly basis to ensure compliance. The results of the monitoring will be reported to the Director of Nursing. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/25/2022 2/18/2022 2/28/2022 On-going

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L 091	Continued From page 10 Resident #9 was admitted to the facility on 06/11/18 with multiple diagnoses including Dementia without Behavioral Disturbances and Dysphagia. During an observation on 02/18/22 starting at 12:30 PM, the following was observed: -Employee #10 (Certified Nurse Aide) was observed walking in the dining room, not wearing gloves, and rubbing her hands on her uniform multiple times. -The employee then collected Resident #9's lunch tray and placed it on the table in front of the resident. -Employee #10 sat beside the resident, removed the plastic covering from the plastic spoon, and dipped the spoon in the cream spinach. -The employee then attempted to feed Resident #9 but was stopped by the surveyor. When asked if she washed her hands after touching her uniform multiple times, serving the resident lunch tray, opening the resident's feeding utensil, and dipping the spoon in the cream spinach? Employee #10 stated that she did not wash her hands, but she should have washed her hands or used hand sanitizer before serving the resident her lunch. Employee #10 discarded Resident #9's lunch tray and washed her hands. Review of physician order dated 10/06/21, instructed, "NAS (No Added Salt) diet pureed texture, thin consistency ..." Review of the Quarterly Minimum Data Set dated 12/07/21 revealed the following:	L 091		

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L 091	Continued From page 11 In section C (Brief Interview for Mental Status) was blank indicating the resident was severely cognitively impaired. In section G (Functional Status) Resident #9 was coded as totally dependent on the physical assistance of one person for eating. In section I (Active Diagnoses)- the resident was coded for Dementia and Dysphagia Review of the resident's care plan showed the following: -Focus area - Nutrition [resident's name] is noted ...with care & comfort measures due to Advanced dementia per family request (revision date 12/16/21). -Interventions included provide NAS (No Added Salt) Diet/Mech (mechanical) soft texture/thin liquids and spoon feed meals and snacks. During a face-to-face interview on 02/18/22 at approximately 12:00 PM, Employee #2 (Director of Nursing) stated that staff should wash their hands or use hand sanitizer before serving trays or feeding residents. 2. Facility staff failed to maintain infection control practices while assisting residents with care (hygiene) before a meal. A dining observation was performed on the 2nd floor dining area on 02/18/22 at 12:30 PM, the surveyor observed the following: -Facility's staff bringing residents into the common dining area and placing residents	L 091		

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L 091	Continued From page 12 Individually at separate tables. - Employee # 25 (Certified Nurse Aide) not wearing gloves and using a wipe to clean Resident #17 and Resident #1 face and hands. - However, the employee failed to sanitize her hands before and between providing care to the previously mentioned residents. During a face-to-face interview conducted at the time of observation, Employee # 25 (Certified Nurse Aide) stated "We sanitize all the residents before they eat". The employee said that she should have sanitized her hands before and between providing care to the residents. 3. The facility's staff failed to maintain Infection Control Practices when providing wound care for Resident #2. Resident #2 was admitted to the facility on 12/06/18. The resident had history of multiple diagnoses including Hemiplegia and Hemiparesis, CVA Dementia, Urinary/Fecal Incontinence, and Stage 4 Right Ischium Pressure Injury. During an observation on 02/25/22 at approximately 1:00 PM, Employee #11 (Assistant Director of Nursing/ Wound Nurse) provided wound care for Resident #2's Stage 4 right ischium pressure injury. While providing wound care, Employee #11 failed to maintain Infection Control Practices by not placing a barrier under the resident. Instead, the employee provided wound care on top of Resident #2's urine-soiled incontinent brief. Review of the resident's medical record showed	L 091		

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FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 091	Continued From page 13 the following: 02/18/22 [physician's order] - "Cleanse right ischium with Dankin's Solution, pat dry, apply Santyl ointment, then skin prep to peri wound, and cover with dry dressing every day." Review of the Wound-Weekly Observation Tool (Licensed Nurse) dated 02/24/22 documented the following: "Location- right ischium, inhouse-acquired on 05/13/21, type - pressure, pressure ulcer stage: original -Stage 2 , current - Stage 4, visible tissue: unchanged, unhealthy granulation tissue, and 100% necrotic tissue, drainage: type-serous, amount - scant, odor- none present, wound measurements: Length - 15 mm (millimeters), Width 14 mm, Depth- blank ... comments- seen by wound doctor. Bedside debridement done. Continue with POC (plan of care)." Review of the Quarterly Minimum Data Set dated 11/08/21 revealed the following: In section C (Brief Interview for Mental Status)- the resident was given a summary score of "5" indicating the resident was severely cognitively impaired. In section I (Active Diagnoses)- Resident #2 was coded for Hemiplegia and Hemiparesis. In section M (Skin Condition) - the resident was coded for having one Stage 4 pressure ulcer, using a pressure reducing bed and chair, ointments, and medication. Review of care plan showed the following: "Focus area- [Resident' s name] has a...pressure	L 091		

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L 091	Continued From page 14 injury (right ischium) related to fragile skin [and] impaired mobility. Interventions included apply treatments per MD (medical doctor) order, follow facility protocols for treatment of injury, and report abnormalities ...to MD (medical doctor). " During a face-to-face interview on 02/25/22 at 1:30 PM, Employee #11 stated that she should have placed a barrier under the resident before providing wound care. 4. The facility's staff failed to wear clean gloves when changing Resident #239's bed linen. Resident #239 was admitted to the facility on 01/14/20 with the following diagnoses Cerebral Vascular Accident(CVA), Spastic Hemiplegia Affecting Unspecified Side, Cellulitis of Left Lower Limb, Non-Alzheimer's Dementia, and Stage 4 Pressure Ulcer of Right Buttock, Stage 4. Review of a Quarterly Minimum Data Set (MDS) dated 10/05/21 showed that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns)- Resident #239 had a Brief Interview of Mental Status (BIMS) summary score of "99," indicating that the resident was unable to complete the interview. In Section G (Functional Status)- the resident was coded as being totally dependent and required the physical assist of two or more people or bed mobility, transferring, and dressing. In Section H (Bowel and Bladder)- Resident #230 was coded as always incontinent of bowel and bladder. During an observation on 02/24/22 12:30 PM, the	L 091		

Health Regulation & Licensing Administration

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L 091	Continued From page 15 following was observed: -Resident #239 was laying in her bed while Employee #21 (Certified Nurse Aide - CNA) and Employee #22 (CNA) were providing Activities of Daily Living (ADL) care including grooming, bathing, perineal care, and changing the resident's bed linen. - After bathing the resident and providing perineal care, Employee #21 did not change her gloves. Instead she picked up the bed clean linen to make Resident #239's bed. - The surveyor then stopped Employee #21 and asked are you suppose to change your gloves? Employee #21 stated, "Oh, that's right." The employee then removed her gloves, washed her hands and left the room. In a few minutes, she returned with the clean bed linen. She then washed her hands, donned cleaned gloves and she continued to provide ADL care to the resident.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by four (4) of four (4) damaged cutting boards, one (1) of one (1) soiled salamander grill, one (1) of one (1) fire extinguisher that was past due its yearly	L 099	1. All damaged cutting boards were discarded immediately and replaced with brand new boards. Grill and nozzles were degreased immediately, Kitchen fire extinguisher was immediately replaced, and dish cart was relocated from that area, second- floor pantry dishwashing machine was immediately placed out of service. Dish repair vendor repaired second- floor pantry dishwashing machine. Sanitation cycle time was increased to help reach appropriate temperature on kitchen dish washer. 2. The Dining Services Department inspected all cutting boards, grill, nozzles, and equipment. No other deficiencies were identified. Second floor dishwashing machine is operable.	2/25/2022 2/25/2022

Health Regulation & Licensing Administration

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L 099	Continued From page 16 inspection date, four (4) of eight (8) soiled fire suppression nozzles, one (1) of three (3) dishwashing machine that leaked from the bottom when used, and one (1) of three (3) dishwashing machine that did not consistently reach a minimum final rinse temperature of 180 degrees Fahrenheit. The findings include: During a walkthrough of dietary services on February 17, 2022, at approximately 10:30 AM and on February 24, 2022, at approximately 9:45 AM, the following were observed: 1. Two (2) of two (2) red cutting boards and one (1) of one (1) white cutting board that were stored for use, and one (1) of one (1) green cutting board that was being used to slice carrots were damaged with deep grooves that could possibly inhibit bacteria and odor. 2. One (1) of one (1) salamander grill was soiled with grease deposits on the outside. 3. One (1) of two (2) fire extinguisher in the main kitchen had not been inspected since November 2020. 4. Four (4) of eight (8) fire suppression nozzles located above the grease fryer and the flat grill were soiled with grease deposits. 5. One (1) of one (1) dishwashing machine located on the second-floor pantry leaked from the bottom when used.	L 099	Main kitchen dishwasher service for preventive maintenance is scheduled for March 22, 2022. 3. The Director of Dining Services and Chef conducted an in-service to dining staff on proper cleaning of appliances, the avoidance of blocking the kitchen fire extinguishers, on dishwashing and sanitizing process and reporting any defective equipment to the maintenance department. The Dining Service Management team has added cutting board inspection to the weekly audit list on February 17, 2022. Cutting boards will be automatically replaced every three months to prevent deep grooves. Beginning March 17, 2022 the Director of Dining Services or designee will do an additional random audit weekly for four weeks and then monthly to ensure compliance. A checklist was created to inspect the grill and nozzles after each shift and an on- going audit will be conducted once a week by the Director of Dining Services or designee. 4.Performance will be monitored, and compliance reported quarterly to the QAPI committee by the Director of Dining Services or designee.	2/26/2022 On-going

Health Regulation & Licensing Administration

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L 099	Continued From page 17 6. One (1) of one (1) dishwashing machine in the main kitchen failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit on two (2) of three (3) observations. These observations were acknowledged by Employee #6 during a face-to-face interview on February 25, 2022, at approximately 2:45 PM.	L 099		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies;	L 201	1. Advance Directives for the affected residents (#20, #37, #38) were reviewed with residents and family, and their health records have been updated to reflect their wishes. 2. A review of all residents advance directives was conducted by the Social Services Director to identify 8 resident without advance directives. The advance directives for those 8 residents identified was reviewed with residents and family and their health records updated to reflect their wishes. 3. Social Service Director or designee have been in-serviced to ensure that all residents are offered the opportunity to formulate their advance directives, obtain order from the attending Physician, review code status with family and residents, and update resident's health record to reflect their code status wishes. Social Service Director or designee will monitor for compliance on a monthly basis to ensure compliance and report findings to the DON and Administrator immediately. 4. Social Service Director or designee will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	2/22/2022 2/22/2022 2/25/2022 On-going

Health Regulation & Licensing Administration

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L 201	Continued From page 18 (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)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; (n)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; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)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; (q)The plan of care;	L 201		

Health Regulation & Licensing Administration

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L 201	Continued From page 19 (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record reviews and staff interviews, the facility's staff failed ensure residents medical records included Advance Directives for three (3) of 32 sampled residents.(Residents' #20, #37 and #38). The findings included: 1.Resident #20 was admitted to the facility on 10/26/21 with multiple diagnoses including Parkinson's Disease, Alzheimer's Disease, and Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set dated 12/16/21 showed in Section C (Cognitive Patterns) Resident #20 had a Brief Interview for Mental Status (BIMS) summary score of "06," indicating severely impaired cognition. Review of Resident #20 's medical record revealed: 10/26/21 [physician's order] instructed, "CPR" (Cardiopulmonary Resuscitation). 11/04/21 [care plan] showed the following: -" Focus Area: Code status showed, "Full Code." - Goal: All staff will remain aware of [resident's name] wishes regarding code status and will	L 201		

Health Regulation & Licensing Administration

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L 201	Continued From page 20 ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of [resident's name] wishes and obtain corresponding order, and review code status wishes with resident and RR (resident representative) as needed and at quarterly care plan meetings." 12/10/21 [Psychosocial Progress Note] documented "...Resident continues to have Full Code status- CPR..." During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 (Director of Social Work) acknowledged that Resident #20 did not have an Advance Directive. Resident #20's medical record lacked documented evidence of an Advanced Directive. 2. Resident #37 was admitted to the facility on 01/24/22 with the following diagnoses Congestive Heart Failure, Atrial Fibrillation or Other Dysrhythmia, Atherosclerosis, Hypoxemia, Essential Hypertension, and Diabetes Mellitus Type 2. Review of the Admission Minimum Data Set dated 01/31/22 showed in Section C (Cognitive Patterns) that the Resident #37 had a Brief Interview for Mental Status (BIMS) summary score of "12," indicating mildly impaired cognition. Review of the resident's medical record showed the following: 01/31/22 [physician order] instructed "CPR." (Cardiopulmonary Resuscitation).	L 201		

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L 201	Continued From page 21 02/02/22 [care plan] revealed the following: - "Focus Area: Code status showed "CPR." - Goal: All staff will remain aware of Resident #37 's wishes regarding code status and will ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of [resident's name] wishes and obtain corresponding order, and review code status wishes with [resident's name and RR (resident representative) as needed and at quarterly care plan meetings." 02/03/22 [Psychosocial Progress Note] documented,"... Current code status is 'CPR' - Full Code." During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 acknowledged that Resident #37 did not have an Advance Directive. Resident #37's medical record lacked documented evidence of an Advanced Directive. 3. Resident #38 was admitted to the facility on 01/28/22 with the following diagnoses: Myasthenia Gravis Without (Acute) Exacerbation, Chronic Obstructive Pulmonary Disease (COPD), Deep Venous Thrombosis (DVT), Hypertension, Benign Prostatic Hyperplasia (BPH), and Non-Alzheimer's Dementia. Review of the Admission Minimum Data Set dated 02/04/22 showed in Section C (Cognitive Patterns) Resident #38 had a Brief Interview for Mental Status (BIMS) summary score of "14"	L 201		

Health Regulation & Licensing Administration

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L 201	Continued From page 22 indicating intact cognition. Review of the resident's medical record showed the following: 02/09/22 [physician order] instructed, "DNR" (Do Not Resuscitate). 02/10/22 [care plan] showed the following: - "Focus Area: Code status showed "DNR." - Goal: All staff will remain aware of the resident's wishes regarding code status and will ensure proper documentation. - Interventions included: Clarify [resident's name] code status upon admission; Inform MD (medical doctor) of resident's wishes and obtain corresponding order, and review code status wishes with [resident's name] and RR (resident representative) as needed and at quarterly care plan meetings." 02/03/22 [Psychosocial Progress Note] documented "...Resident has DNR code status." Resident #38's medical record lacked documented evidence of an Advanced Directive. During a face-to-face interview on 02/22/22 at 4:13 PM, Employee #14 (Director of Social Work) acknowledged that Residents #38 did not have an Advance Directive.	L 201		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the	L 206	Resident #3 did not experience any adverse effect	2/25/2022

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L 206	Continued From page 23 resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on observations, record reviews, and staff interviews, for three (3) of 32 sampled residents facility staff failed to report to the State Agency: (1) a facility-reported-incident (FRI) involving a medication error for one (1) resident;(2) a FRI involving an injury of unknown origin for one resident; and (3) a FRI involving an accident(fall) within the required time frame of 48 hours for one resident. (Residents' #3, #20 and #239). The findings included: 1. The facility's staff failed to report a FRI involving a medication error to the State Agency for Resident #3. Resident #3 was admitted to the facility on 11/05/20 with multiple diagnoses including Major Depressive Disorder, Anxiety, Post-Traumatic Stress Disorder, and Psychosis. During multiple observations from 02/17/22 to 02/25/22 starting at approximately 11:00 AM to approximately 5:00 PM, Resident #3 was noted in his room, well groomed, calm and cooperative with staff. Review of the medical record showed the following: 11/06/20 [physician order] instructed, "Depakote Delayed Release 500 mg (milligrams), give 1 tablet by mouth two times a day for mood	L 206	from this deficient practice. Involved staff was educated on the 24-hour chart check process and disciplinary action taken for not accurately reviewing orders. Resident #239 incident report was submitted to DC Health on 9/10/21 at 4.22pm. Fri late submission for #20 on 4/28/2022. Restrospectively, corrective action can not be accomplished for the resident. 2/24/2022 2. A review of all orders for previous 30 days was conducted, no additional findings was noted. The facility also reviews all previous incident report submitted during the last 30 days to determine if it was reported appropriately and timely. There were no additional findings. 3. Charge Nurses and Nursing Supervisors have been in-serviced on different types of incidents to be reported to DC Health. 2/28/2022 Charge Nurses and Nursing • Supervisor have been in-serviced on the 24-hour chart check process to prevent orders from being missed. Nursing leadership team will monitor • for compliance on a weekly basis to ensure compliance. On-going The results of the monitoring will be • reported to the Director of Nursing immediately. 4. The Director of Nursing will present this report to QAPI for three (3) consecutive months, and quarterly thereafter. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	

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L 206	Continued From page 24 disorder. The medication order had a discontinue date of 10/20/21. 11/18/21 [Lab result] - Valproic Acid (Depakote) result = 18 ug/ml [microgram/milliter](Reference range 50-100). Employee #8 (Nurse Supervisor/Registered Nurse) documented on the back of the lab result, "MD will review further on visit." 11/18/21 to 11/23/21 [nursing progress notes] lacked documented evidence that Resident #3 displayed behaviors such as yelling, screaming, crying, hallucination, delusion, cursing, agitation, hitting, wandering, or pacing. 11/24/21 [nurse practitioner progress note] documented, "Valproic Acid level 18 (level range 50-100) on 11/18/21. It appears that medication was discontinued for unknown reason one month ago. Staff report pt (patient) remains combative and aggressive toward staff ...restart depakote, repeat level in Jan(uary)." 11/24/21 [physician order] instructed, "Start Depakote Delayed Release 500mg (milligram) BID (two-times-a-day) for mood disorder. Repeat Depakote level in January." 01/03/22 [Lab result] - Valproic Acid (Depakote) result = 40 ug/ml. MD made aware no new orders given. Review of electronic Medication Administration Records from 10/19/21 to 11/24/21 showed that the blocks (9:00 AM and 5:00 PM) for nurse initials were marked with an "X" indicating that the medication was discontinued by pharmacy. Review of the electronic Treatment Administration	L 206		

Health Regulation & Licensing Administration

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L 206	Continued From page 25 Records from 10/19/21 to 11/24/21 revealed that Resident #3 did not display behaviors such as yelling, screaming, crying, hallucination, delusion, cursing, agitation, hitting, wandering, or pacing. Review of Quarterly Minimum Data Set dated 08/10/21 revealed the following: In section C (Brief Interview for Mental Status) - was blank indicating the resident was severely cognitively impaired. In section E (Behavior) - Resident #3 was coded for exhibiting physical behavior symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) which occurred 1 to 3 days during the assessment period. The resident was also coded for Rejection of Care which occurred 1 to 3 days during the assessment period. In section I (Active Diagnoses)- the resident was coded for Dementia, Anxiety, Depression and Post-Traumatic Stress Disorder (PTSD). Review of Resident #3's care plans showed the following: Focus area- [Resident's name] has a mood problem r/t (related to) admission, with diagnosis of PTSD, major depression and anxiety revision date of 08/04/21. Interventions included Monitor/document/report PRN (as needed) any risk for harm to self ...Offer gentle words of support, concerns and encouragement to resident as needed. Focus area- The resident uses psychotropic medications r/t dementia with aggressive	L 206		

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L 206	Continued From page 26 behavior. Interventions included monitor/record occurrence of the target behavior symptoms ...violence/aggression towards staff/others ...and document per facility protocol. During a face-to-face interview on 02/24/22 at 4:04 PM, Employee #8 (Nursing Supervisor/RN) stated that the pharmacy discontinued the medication (Depakote) in the electronic medication administration record. The employee then said, "The resident was prescribed Depakote for mood disorder." During a face-to-face interview on 02/25/22 at 8:52 AM, Employee #2 (DON) stated that the medication error information was not sent to the Department of Health because her staff did not make her aware of the error. The employee then said that she would submit information about the medication error to the Department of Health. 2. The facility's staff failed to report a FRI involving an injury of unknown origin to the State Agency for Resident #20. Resident #20 was admitted to the facility on 10/26/21 with multiple diagnoses including Parkinson's Disease, Osteoporosis, Osteoarthritis, History of Hip Fracture, Alzheimer's Disease, Non-Alzheimer's Dementia, Orthostatic Hypotension, History of Falls with Multiple Injuries, Dislocation of Internal Right Hip Prosthesis and Depression. Review of a Quarterly Minimum Data Set (MDS) dated 12/16/21 showed that facility staff coded the resident in the following manner:	L 206		

Health Regulation & Licensing Administration

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L 206	Continued From page 27 In Section C (Cognitive Patterns)- Resident #20 had a Brief Interview for Mental Status (BIMS) summary score of "06" indicating severely cognitive impaired. In Section G (Functional Status)- the resident was coded for being totally dependent and requiring one person physical assist for bed mobility and dressing. Resident #20 was also coded for total dependence and requiring two or more persons for physical assistance with toilet use and personal hygiene. In Section G0300 (Balance During Transitions and Walking)- the resident was coded as not being steady when moving from a seated to a standing position and transferring between bed, chair, or wheelchair. In Section G0400 (Functional Limitation in Range of Motion)- Resident #20 was coded for impairment on one side to the lower extremity (hip, ankle, foot). Resident #20 's medical record revealed the following: 12/03/21 [Physician's Telephone Order]: "Daughter- [Resident representative's name] will call the hospital to obtain follow up orthopedic return for mother and inform nursing." 12/03/21 [Physician's Telephone Order]: "F/u(follow-up) Appt (appointment) with [Orthopedic Physician's Name] on 12/06/21 @ (at) 9:30AM [Address and Telephone number of Orthopedic Physician's Office] one time only until 12/05/2021 23:59 (11:59 PM). Escort needed." 12/06/21 at 10:34 AM [Nursing Progress Note]:	L 206		

Health Regulation & Licensing Administration

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L 206	Continued From page 28 Incident Note- "Spoke with ortho (Orthopedic) doctor this morning; he stated that the resident's right hip was dislocated. Sending driver with RN (Registered Nurse) to take resident to the ER (emergency room) from the doctor's office." 12/06/21 at 10:34 AM [Nursing Administration Progress Note]- Incident Note: "Resident went out to F/U (follow-up) ortho appointment at 0900 (9:00 AM) with escort. Observed resident at nurses' station smiling, no c/o (complaint of) pain or discomfort prior to leaving. Had breakfast and left the facility in stable condition. Driver informed me that daughter met them at doctor's office. Daughter stated that the doctor told her the hip was dislocated and needed the driver to take a resident to the ER..." Review of the facility's investigative report showed a progress/incident note dated 12/06/21, which documented a description of the incident. The investigative report also included four (4) written witnesses statements all of which were dated 12/06/21. However, Resident #20's medical record lacked documented evidence that the facility reported the FRI on 12/06/21 to the State Agency. During a face-to-face interview on 02/25/22 at 2:50 PM, Employee #2 (DON) stated, "I did not report it to DOH (Department of Health). She (Resident #20) was not showing any signs of pain when she left our facility. I was present when she left. Her doctor called the facility and said her hip was dislocated. We had no x-ray at the time. I should have reported it (the incident) as an injury of unknown origin." 3. The facility's staff failed to report a FRI	L 206		

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L 206	Continued From page 29 involving an accident (fall) within the required time frame of 24 hours to the State Agency for Resident #239. Resident #239 was admitted to the facility on 01/14/20 with multiple diagnoses, including, Coronary Artery Disease, Cerebral Vascular Accident (CVA), Spastic Hemiplegia Affecting Unspecified Side, Seizure Disorder, Cataracts, Diabetes Mellitus Type 2, and Non-Alzheimer's Dementia. Review of a Quarterly Minimum Data Set (MDS) dated 10/05/21 showed that facility staff coded the resident in the following manner: In Section B 1000 (Vision) - the resident was coded as highly impaired to see with adequate lighity. In Section C (Cognitive Patterns)- Resident #239 had a Brief Interview for Mental Status (BIMS) summary score of "99" indicating that the resident was unable to complete the interview. In Section G (Functional Status)- the resident was coded for being totally dependent and requiring the physical assistance of one-person for locomotion on and off the unit, eating, and toileting. Resident #239 was also coded for being totally dependent and requiring the physical assistance of two or more persons for bed mobility, transfers, dressing, and personal hygiene. In Section G0300 (Balance During Transitions and Walking)- the resident was coded for not being steady when moving from a seated to a standing position and transferring between bed and chair or wheelchair.	L 206		

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L 206	Continued From page 30 In Section G0400 (Functional Limitation in Range of Motion)- Resident #239 was coded as having an impairment of the upper and lower extremities. In Section G0600 (Mobility Devices) - the resident was coded as normally using a wheelchair. In Section H (Bowel and Bladder)- Resident #239 was coded as always incontinent for bowel and bladder. Review of the medical record revealed the following: 09/10/21 at 4:06 PM [Nursing Progress -Late Entry Note]: - Change in Condition Note: "Situation: Resident ['s] husband visited this afternoon, got resident out of bed and put her on the floor. Background: Resident transfers daily out of bed to w/c (wheelchair) with [manufacture's name] lift, 2-person assist. Assessment (RN)/Appearance (LPN): Observed lying on the floor, pillow under the head, POA (power-of-attorney) stated that he put her on the floor that she did not fall, Resident responsive but cannot tell what happen[ed], Nursing supervisor call and came to assess. Recommendations: [resident's physician]gave [an] order to send to ER, 911 called and came to [the] unit, but POA refused to transfer to ER,(911 reassess[ed] [the resident] and got [the] resident out of the floor to w/c per POA request." Review of the facility's investigative report dated 09/10/21 included the following: 1. A screenshot from the facility's Risk Management Department that described the	L 206		

Health Regulation & Licensing Administration

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L 206	Continued From page 31 incident the date and time of the incident documented as 09/10/21 at 4:25 PM. 2. Written statements from four (4) facility staff who worked on 09/10/21 and witnessed Resident #239 on the floor. All the previously mentioned witness statements were signed and dated on 09/10/21. 3. A statement from Resident# 239's husband which documented: " ... an incident that did occur at [name of the facility] on Friday, 09/10/2021 at 1:45 PM in [resident's room number] ..." Review of the "Incident Investigation Report" form revealed that facility staff reported the allegation of an accident (fall) to the State Agency on 09/20/21 at 10:09 AM, which was ten days after the incident occurred. During a face-to-face interview on 02/24/22 at 3:49 PM, Employee # 5 (Charge Nurse/ Licensed Practical Nurse) stated, "It was me who observed the incident and reported it to the Assistant Director of Nursing. I was called to the room by the housekeeper and saw her (Resident #239) on the floor. The incident was documented in the progress notes, and I know we [the facility] reported it to Department of Health (State Agency)."	L 206		
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, resident and staff	L 389	1. The correct amount of linen was purchased on 2/23/2022 to correct the deficient practice. 2. The Director of Laundry checked the other linen par levels and there were no other identified deficient practice. 3. The Director of Laundry in-serviced laundry staff on maintaining the correct	2/24/2022 2/23/2022 2/22/2022

Health Regulation & Licensing Administration

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L 389	Continued From page 32 interview, it was determined that facility staff failed to maintain linen that was at least three (3) times the amount that is needed for the licensed occupancy (50 Beds); as evidence by failure to ensure there was enough bed pads. The findings included... During a tour of the laundry room on 2/22/2022 at 4:58 PM in the presence of Employee # 23, it was observed that the facility 34 bed pads stored for use. During a face-to-face interview with Employee #23 at the time of the observation, stated that there was linen in the clean linen rooms on the health care center (1st and 2nd floors). She further stated that she will order more linen. There was no evidence that facility staff maintained three times the amount of bed pads needed for the facility occupancy of 50.	L 389	par levels in the designated emergency supply area. Inventory checks will be performed by the Director of Laundry and the laundry attendant. The Director of Laundry or designee will monitor compliance monthly. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee.	On-going
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) high temperature dishwashing machine in the main kitchen that did not reach a minimum final rinse temperature of 180 degrees Fahrenheit on two (2) of three (3) observations, and one (1) of one (1) dishwashing machine in the second floor kitchen that consistently leaked from the bottom when in use.	L 442	1. Dishwashing vendors were called out and inspected and identified needed repairs for both the dishwashing machine in the main kitchen and the second-floor pantry dishwashing machine. The second-floor pantry dishwashing machine was repaired. The repair vendor ran several tests on the kitchen machine, confirmed that the final rinse reached 180 degrees Fahrenheit consistently. 2. The Director of Dining purchased plater eached 180 degrees Fahrenheit. Repair vendor scheduled for follow up parts and service on March 22, 2022. No resident was affected by deficient practice.	2/25/2022 2/25/2022

Health Regulation & Licensing Administration

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L 442	Continued From page 33 The findings include: 1. One (1) of one (1) dishwashing machine in the main kitchen failed to reach a minimum of 180 degrees Fahrenheit on two (2) of three (3) observations on February 24, 2022, at approximately 9:45 AM. The contracting repair company (Hobart) came in and determined that one (1) of three (3) heater elements inside the machine was inoperative, but the machine was still able to reach a minimum final rinse temperature of 180 degrees Fahrenheit on most occasions. A replacement part was ordered, and the machine was used to clean and disinfect dishes along with a disinfectant solution from the three-compartment sink. 2. One (1) of one (1) dishwashing machine located on the second-floor pantry leaked from the bottom when used. These observations were acknowledged by Employee #6 during a face-to-face interview on February 25, 2022, at approximately 2:45 PM.	L 442	3.The Director of Dining in-serviced dining staff to inform maintenance immediately if they find any issues with any equipment. The Director of Maintenance or designee will monitor compliance monthly to ensure all kitchen equipment are working properly. 4. Performance will be monitored, and compliance reported quarterly to the QAPI committee by the Director of Maintenance or designee.	2/25/2022 On-going