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L 000	Initial Comments A Licensure Survey was conducted June 8 through 12, 2015. The following deficiencies are based on observation, record review and resident and staff interview for 30 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of	L 000	THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF FOREST HILLS OF DC'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.	

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L 000	Continued From page 1 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000	L050 **Failure to complete comprehensive assessment of respiratory status according to standards of care.** 1. **Corrective Action for Affected Residents:** Licensed staff were Immediately in-serviced during survey on the rationale for conducting a comprehensive assessment prior to initiating respiratory medications, and on pre and post assessments during administration of the medication.	6/8/15
			2. **Identification of Other Residents Potentially Affected by the Same Practice:** The MAR and medical record for two (2) residents receiving nebulizer treatments were reviewed on 06/12/15. Comprehensive assessment were not included.	6/15/15
L 050	3210.3 Nursing Facilities When a licensed practical nurse serves as a charge nurse, he or she shall have ready access to consultation with a registered nurse. This Statute is not met as evidenced by: Based on observation, clinical record review and interview for two (2) of 30 sampled residents, it was determined that the charge nurse failed to consult with the registered nurse to ensure that a comprehensive assessment was conducted for one (1) resident with a change in respiratory status and for one (1) resident with a pressure ulcer that worsened. Resident #34 and 67. The findings include: 1. Mosby ' s Nursing Drug Reference, 24th	L 050	3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** All licensed personnel were in-serviced on the facility policy for pre and post assessments, administration, and documentation of nebulizer treatments. This in-service will be provided as part of new employee orientation and annually.	6/15/15
			4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Medical records for all residents with nebulizer treatments will be audited on monthly to ensure compliance. Results will be reported to QA Committee quarterly x4. Threshold for compliance 100%.	7/23/15

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Edition references nursing considerations with administration of Albuterol and stipulates " ....Assess respiratory function: vital capacity, forced expiratory volume, lung sounds, heart rate and rhythm ... Evaluate therapeutic response: absence of Dyspnea, wheezing after 1 hour, improved airway exchange ... "

Mosby ' s Nursing Drug Reference, 24th Edition references nursing considerations with administration of Ipratropium Bromide and stipulates " ....Respiratory status: rate, rhythm, auscultate breath sounds prior to and after administration ... "

Resident #34 was admitted to the facility March 1, 2012 with diagnoses which included Dementia, Psychotic Disorder, Prostate Cancer, and Gastroesophageal Reflux Disorder.

During the noon meal dining observation conducted on June 8, 215 at approximately 1:00 PM, Resident #34 was observed experiencing excessive coughing and minimal to mild respiratory distress while at the dining table.

According to Resident #34 ' s Comprehensive Minimum Data Set dated February 25, 2015 and the Quarterly Minimum Data Set dated May 22, 2015, Resident #34 had no history of chronic respiratory disease processes. No care plans were required for acute onset respiratory dysfunction.

According to the nursing notes, on June 1, 2015 the resident was " ...noted with congestion during auscultation. Physician updated, new order for Duoneb one (1) vial three (3) times daily for seven (7) days ... " Duoneb is a combination bronchodilator (Albuterol and Ipratropium)

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respiratory medication used in the treatment of shortness of breath and wheezing associated with acute and/or chronic lung disease.

The medical record lacked documented evidence that Resident #34 was assessed according to standards of care relative to the use of respiratory medication to include assessment of vital capacity, forced expiratory volume, and/or respiratory status prior to and at the completion of respiratory medication administration.

Resident #4 received respiratory treatments according to physician orders three (3) times daily at 6:00 AM, 2:00 PM, and 8:00 PM on June 2, 3, 4, 5, 6, and 7, 2015 and at 6:00 AM and 2:00 PM on June 8, 2015. The facility staff failed to perform pre and post nebulizer treatment assessments in all instances.

A face to face interview was conducted with Employee # 8 at 11:45 AM on June 10, 2015. The employee confirmed the absence of clinical staff notes specifying assessment of lungs to include location, amount of congestion, presence of wheezing and/or decreased breath sounds prior to initiation of and with continued use of respiratory medication. Further, the employee confirmed the nursing notes lacked details of the communication with medical staff relative to justifying the use of Duoneb or addition of an antibiotic on June 4, 2015.

Employee #8 stated pre and post respiratory treatment assessments are not required, that the nursing shift notes are the evidence of the overall assessment of the resident, and the notation of vital signs is evidence of the post treatment assessment. The employee confirmed the staff should note details of assessment and treatment

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effectiveness and/or ineffectiveness, as well as details of the medical staff consult in the progress notes.

On June 10, 2015 at approximately 3:25 PM a face to face interview was conducted with Employee # 6. When queried about the requirement of pre and post nebulizer treatment assessment required she/he responded yes, the staff is required to perform and document pre and post nebulizer treatment assessments.

On June 12, 2015 at approximately 12:40 a face to face interview was conducted with Employee # 2 when queried about the requirement of pre & post nebulizer treatment assessment s/he responded the expectation is that the nursing staff would perform and document detailed assessments and details relative to communication with the medical staff for treatment modalities.

2. The facility staff failed to ensure a comprehensive assessment was performed when changes in wound condition was noted in accordance with professional standards of quality.

Resident #67 admitted facility on March 31, 2015 with diagnoses to include status post Open Reduction Internal Fixation of Right Hip for skilled nursing services with plans to return to an assisted living facility upon discharge.

Medical record review conducted on June 10, 2015 revealed that on the Admission Nursing Assessment and admission Physician Orders dated March 31, 2015 the nursing staff documented the presence of present on admission Stage I pressure ulcers to bilateral

Facility staff failed to ensure a comprehensive assessment was performed when changes in wound condition was noted in accordance with professional standards of quality.

1. **Corrective Action for Affected Residents:**
   - Licensed staff were immediately in-serviced on the rationale for comprehensive assessments when deterioration in wounds is observed.
   - RN assessed wound and instructed charge nurse to notify MD of wound status;, new orders received.
   - Comprehensive assessment completed by RN. — 6/8/15
2. **Identification of Other Residents Potentially Affected by Same Practice:** Wound rounds were conducted and skin sheets reviewed. No other residents were affected by this practice. No deterioration detected. — 6/9/15
3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:**
   - RN to conduct wound rounds weekly. (Ongoing) — 6/9/15
   - All licensed personnel in-serviced on the facility policy for wound identification and documentation This in-service will be provided as part of new employee orientation and annually. — 6/13/15
   - Licensed staff in-serviced by AMT wound care nurse on wound identification and staging. — 7/15/15
4. **Performance Monitoring to Make Sure Solutions are Sustained:** TARs and skin sheets will be audited on a monthly basis to ensure compliance. Results will be reported to QA Committee quarterly x2. — 7/23/15

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heels with orders

The Admission Nursing Assessment dated March 31, 2015 revealed the nursing staff documented the presence of multiple present on admission alterations in skin integrity to include the description of the bilateral heels pressure ulcers in the " Skin Condition " section as follows: left heel " redden area " measuring 3x2 centimeters; and right heel " deep purple area, no pain on palpation " measuring 2.5x3.5 centimeters. The Braden Scale - For Predicting Pressure Sore Risk dated March 31, 2015 revealed the nurse assessed Resident #67 as high risk for pressure ulcer as indicated by a total score of 12.

The Pressure Ulcer Record revealed weekly skin assessments for the right heel as follows: March 31, 2105 Stage I, 2.5x2 centimeters no depth, drainage and/or odor; April 7, 2015- Stage I 2.5x2 centimeters no depth, drainage and/or odor, grayish color; April 13, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeter no depth, drainage, and/or odor, " dark red " color; April 21 and 28, 2015- " DTI [Deep Tissue Injury] " 4x2.5 centimeters, " dark black " color; May 5, 2015 " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 12, 2015- " DTI [Deep Tissue Injury] " 2.5x3.8 centimeters , no depth, drainage and/or odor, black in color; May 19, 2015- " DTI [Deep Tissue Injury] " 2.5x3.5 centimeters , no depth, drainage and/or odor, black in color; May 26, 2015 - " DTI [Deep Tissue Injury] " 4x2.5 centimeters , no depth, drainage and/or odor, black in color; May 27, 2015- " Stage II " 3x2 centimeter, no depth, drainage, and/or odor, red color; June 3, 2015- Stage II 3x4 centimeters no depth, drainage and /or odor, pink color; and June 9, 2015- " Stage II " 4x3 centimeters no depth, drainage, odor,

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yellow slough color.

The assessments relative to the right heel pressure ulcer document on the Pressure Ulcer Record revealed that on April 7, 2015, April 21, 2015, April 28, 2015, May 5, 2015 and June 9, 2015 were performed by the Licensed Practical Nurse. The documentation on the Pressure Ulcer Record and medical record lacked documented evidence that a Registered Nurse performed a comprehensive assessment and/or co-signed the assessment to support evaluation of the resident ' s intrinsic risks and other factors to include causal factors for delayed wound healing.

A subsequent review of the medical record revealed the medical record lacked documented evidence of depth after the debridement performed on May 27, 2015 and June 3, 2015. The nursing staff failed to document the amount depth after debridement down to the subcutaneous tissue of right heel pressure ulcer.

The assessments relative to the right heel pressure ulcer documented on the Pressure Ulcer Record revealed that on April 7, 2015, April 21, 2015, April 28, 2015, May 5, 2015 and June 9, 2015 were the assessments were performed by the Licensed Practical Nurse. The medical record lacked documented evidence that a Registered Nurse performed a comprehensive assessment to evaluate the resident ' s needs related to deteriorating wound.

On June 9, 2015 at 3:50 PM, the surveyor observed the Licensed Practical Nurse return to nurse ' s station and placed a call to the physician to report changes in wound condition. Upon completion of the call, the Licensed Practical

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Nurse requested the wound/skin for Resident #67 from the surveyor reviewing documentation.

The pressure ulcer assessment documented on June 9, 2015 indicated " Response to Treatment: Deteriorated " . The medical record lacked documented evidence the Registered Nurse assessed Resident #67 ' s right heel ulcer when the Licensed Practical Nurse identified a change in the wound condition.

According to D.C Municipal Regulations for Registered Nurses 5414.1(a) Scope of Practice, it stipulates The practice of registered nursing means the performance of acts requiring substantial specialized knowledge, judgment, and skill based upon the principles of the biological, physical, behavioral, and social sciences in the following: (a) The observation, comprehensive assessment, evaluation and recording of physiological and behavioral signs and symptoms of health, disease, and injury, including the performance of examinations and testing and their evaluation for the purpose of identifying the needs of the client and family. (b) The development of a comprehensive nursing plan that establishes nursing diagnoses, sets goals to meet identified health care needs, and prescribes and implements nursing interventions of a therapeutic, preventive, and restorative nature in response to an assessment of the client ' s requirements. "

The Licensed Practical Nurse performed a focused pressure ulcer assessment; however, the facility failed to establish a mechanism to ensure a registered nurse performed a comprehensive assessment in accordance with applicable professional standards of practice.

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L 050	Continued From page 8 Subsequent review of nursing notes following the identification of wound " deterioration " revealed the nursing staff failed to document any further information relative to the right heel wound from June 9- 11, 2015. Resident #67 was seen by Plastic Surgeon in follow-up to the changes to the right heel wound condition on June 11, 2015.	L 050		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observation, interview and medical record review, it was determined the nursing staff failed to ensure a comprehensive care plan was	L 051		

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developed with measureable outcomes and interventions relative to pain and oral/dental care in one (1) of 30 records reviewed Resident #55.

The findings include:

The facility staff failed to develop an individualized plan of care relative to pain and oral/dental care for Resident #55

A review of the medical record was conducted on June 10, 2015 at approximately 9:00 AM. The Admission Nursing Assessment dated September 23, 2014 revealed the nursing staff documented an oral assessment. The oral cavity exam revealed Resident #55 had " few broken teeth " and partial upper and lower dentures that fit.

The Minimum Data Set Admission Assessment with Assessment Reference Date of October 10, 2014 revealed the clinical staff failed to document the presence of the broken teeth noted during the admission oral assessment documented on September 23, 2014. The clinical staff failed to accurately code the Minimum Data Set Section L Item L0200- " D. Obvious or likely cavity or broken natural teeth " for Assessment Reference Date October 2, 2014.

The medical record revealed a Significant Change in Status Assessment with Assessment Reference Date of February 27, 2015. The Care Area Assessment (CAA) Summary identified the " Dental Care " Care Areas was triggered with location and date of CAA documentation noted as " Dental consult note 01/20/2015 " . The " Pain " Care Area was not triggered.

Resident #55's medical record contained Dental Care Notes from June 15, 2010 prior to the

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current admission. On October 14, 2014, an annual dental exam and debridement was completed. The exam revealed Resident #55 had poor oral hygiene and stated s/he had adjusted to the discomfort. "Patient has root tips and mobile teeth. On January 20, 2015 a follow-up dental exam was completed and at that time a full mouth x-ray was taken and revealed the following issues: teeth #03, 07 and 08 were mobile, #06 was missing, #22, 23, and 24 showed some mobility.

Resident #55 was referred to oral surgeon for possible extraction and then possible fabrication of new dentures. The dental visit note dated February 24, 2015 stated "Per social worker, family wants no Tx. [treatment] at this time. " On June 5, 2015, a consult with oral surgeon was conducted for "non-restorable teeth". The oral surgeon recommended full Maxillary extraction. The resident was informed of recommendations and requested no treatment to be completed at this time.

Review of Resident #55 ' s care plans revealed the clinical staff initiated care plan for oral care, nutrition and pain. The " Oral care " care plan revealed the " Problem: Start Date: 10/2/14 [typed in] and 2/27/15 [handwritten in] Needs routine oral/dental care by assistance R/T Dx Dementia, generalized weakness " ; and " Resident is wearing partial upper/lower denture. The " Oral care " care plan lacked documented evidence of the oral/dental problems of discomfort, broken, and loose teeth as identified on the Dental Notes from October 14, 2014 and January 20, 2015. The " Goal " was documented as " Resident will be free from oral/dental problems. " The approaches for oral care do not reflect intermediate steps for each goal as the

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L 051	Continued From page 11 resident was admitted with ongoing oral/dental problems. The clinical staff failed to develop an accurate care plan to address the oral/dental care problem identified for Resident #55 upon assessment. According to the Dental Note dated October 14, 2015, Resident #55 " stated s/he has adjusted him/herself to discomfort. " The medical record lacked documented evidence the clinical staff care planned for refuse of care relative to dental discomfort. The " Pain " care plan contained in the medical record identified the " Problem: Pain Prevention " . The " Goal " was documented as " Minimal to no discomfort through next review " . The care plan failed to identify the area of pain concern. The clinical staff failed to develop a care plan to address Resident #55 reported adjustment to dental discomfort and/or resident refusal of treatment for discomfort. A face to face interview was conducted with Employee #8 on June 10, 2015 at approximately 3:45 PM. When queried about the status of Resident #55 ' s oral/dental status, s/he stated that Resident #55 does not complain of pain or discomfort because of declining cognitive status related to Dementia. According to Employee #8, Resident #55 has been observed not eating a lot of meal especially meats; however, s/he enjoys soft texture food such as ice cream and yogurt. On June 9, 2015, speech therapy evaluated resident for texture tolerance, and new order was received for ground meats to assist with chewing and meal consumption. The facility staff failed to ensure the development an individualized care plan and establish measureable goals to manage Resident #55's identified problem(s).	L 051	**L 051 – Failure to ensure the development of an individualized care plan and establish measureable goals to manage Resident #55's identified problem(s)**	
			1. **Corrective Action for Affected Resident:** Individualized care plan relative to pain and oral/dental care for Resident #55 was developed immediately during survey.	6/10/15
			2. **Identification of Other Residents Potentially Affected by Same Practice:** Dental records for all residents were reviewed. No other residents were affected.	6/15/15
			3. **Systemic change to Ensure Deficient Practice Does not Recur:** Mobile dentist progress note after each visit will be reviewed and care plan developed based on residents' need.	7/23/15
			4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Monthly care plan audits will be conducted for all residents seen by dentist. Compliance threshold is 100%. Results will be presented to QA committee quarterly.	7/23/15

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L 051	Continued From page 12	L 051		
	B. Based on observations, record review and staff interview for two (2) of 30 sampled residents, it was determined that facility staff failed to review and revise care plans to reflect goals and approaches to ensure one (1) resident's nutritional needs were met and to include measureable effect interventions relative to falls for one (1) resident. Residents # 7 and 24, The findings include: 1 . Facility staff failed to revise a care plan to address Resident #7 ' s refusal to eat his/her meals when served. During a dining observation on June 8, 2015 at approximately 1:30 pm Resident #7 was observed sitting at a table with two residents who were served their lunch meals , and Resident was served a can of a supplemental nutritional to drink and no meal. On June 9, 2015 at approximately 9:00AM Resident #7 was noted sitting in dining room without a meal drinking a supplemental nutritional drink. On June 10, 2015 at approximately 9:30 AM during breakfast, Resident #7 was observed dining without a meal drinking a supplemental nutritional drink. Resident#7 was not offered any food during the observation. A review of the clinical record revealed: Physicians Order Form dated June 2015; Diet Mechanical soft texture, regular diet with thin liquids. Dietary supplements Ensure Plus 8oz by mouth three times a day, provide ice cream with		**L 051 - Facility staff failed to revise a care plan to address Resident #7's refusal to eat his/her meals when served.** **1. Corrective Action for Affected Resident:** • Prescribed diet was offered to resident during survey, which she refused. • Individualized care plan relative to Resident #7's refusal to eat his/her meals when served was developed during survey.	6/9/15
			2. Identification of Other Residents Potentially Affected by Same Deficient Practice: Review of all diet orders revealed no other residents were affected.	6/15/15
			3. Systemic change to Ensure Deficient Practice Does not Recur: New policy developed to require care plans to be compared to prescribed diet orders quarterly and updated, as needed, to reflect resident's dietary preferences.	6/26/15
			4. Performance Monitoring to Make Sure Solutions Are Sustained: Findings will be reported to the QA committee quarterly. Compliance threshold is 100%.	7/23/15

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lunch and dinner provide 8 oz. (ounce) 2%milk with breakfast lunch and dinner.

A review of the Quarterly Nutrition review dated March 18, 2015 revealed; " Current weight stable with minimal changes x 6 months appetite for meals poor but takes 100% of ensure supplement, ice cream and milk ...f/u [follow-up] as needed " .

A review of Resident #7's Intake and Output records revealed a zero (0) intake for breakfast and lunch for seven (7) out of seven (7) days reviewed.

There was no evidence Resident # 7"s care plan was updated with goals and approaches to address the resident ' s refusal to accept meals.

A face-to-face interview with Employee #7 on June 10, 2015 at 10:00 AM at when queried why Resident #7 was not being given meals he/she stated, " Resident #7 pushes the food away so they stop giving it to him/ her and since he/she likes the ensure that ' s what we serve."

A face to face interview was conducted with Employee's # 2 and# 11 on June 11, 2015 at approximately 3:00 PM. Both were informed of the aforementioned findings.

Employee ' s # 2 and # 11stated they were not aware Resident # 7 was not being served his/ her scheduled diet.

Employees #2 and #11 acknowledged the findings. The clinical record was reviewed on June 11, 2015.

2. Resident #24 was admitted September 9, 2013

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with diagnoses which included Anemia, Non-Alzheimer's 's Dementia and Depression. During staff interview on June 9, 2015 at 11:39 AM, the staff member noted Resident #24 sustained a Hematoma status post fall on May 28, 2015 on the 3:00 PM to 11:00 PM shift. Further record review revealed Resident #24 sustained a fall without documented injury March 4, 2015 on the 3:00 PM to 11:00 PM shift.

According to the Minimum Data Set Comprehensive Assessment dated September 19, 2014 for Resident #24 Item 11 ' Falls ' care area was triggered, and care planning decision was checked, and Section E of the MDS relative to Behavior, was coded as no for rejection of care.

Resident #24's written care plan initiated March 12, 2015 included the following general approaches: use walker to ambulate under supervision and resident to be assisted to the bathroom at all times. Measurable approaches included " as needed fall risk assessment and physical therapy for gait and strength. " Resident #24's Quarterly Fall Risk Assessments for September 2014 through March 2015 reflected a total score of 11, interpreted as high risk for falls.

Handwritten entries noted that Resident #24 had a fall on March 4, 2015 with subsequent care plan interventions of evaluation by rehabilitation therapy and reminders to the resident to ask for help. Subsequent entry on the written care plan dated May 20, 2015 reflected " as needed evaluation by rehabilitation therapy and reminders to ask for help. " The care plan was again updated May 29, 2015, directing " continue to remind resident to ask for assistance, cold compress to head per orders ... " The

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L 051	Continued From page 15 aforementioned interventions did not detail the frequency of evaluations, monitoring and reminders, and were not measurable. Resident #24 was evaluated by Rehabilitation Services (Physical Therapy) on June 2, 2015 and determined low risk for falls as evidenced by a score of three (3) of ten (10) on the rehabilitation fall screen. Previously, on March 13, 2015 Resident #24 scored five (5) of ten (10) indicative of moderate risk or falls, however the therapist noted evaluation not indicated because " Patient has no complaint of pain and is able to ambulate with rolling walker. " The facility staff failed to update the care plan with measurable interventions relative to the prevention of falls and resident safety. A face to face interview was conducted with Employee #14 on June 9, 2015 at approximately 10:45 AM . When queried Employee #14 stated " Resident # 24 is impulsive, and wants to do as [s/he] pleases when [s/he] pleases. The resident refused care after the fall initially, and would only take ice packs for the hematoma. " The employee acknowledged Resident #24 ' s care plan was not revised with goals and approaches to address the residents fall status. A face to face interview was conducted with Employee # 15 who reiterated Resident #24 is impulsive. The employee explained interdisciplinary team meetings occur weekly, and resident s who have fallen are discussed and care plans updated as required. Employee #15 was unable to explain how information from the meeting is incorporated into the resident ' s record or how discrepancies in assessments are reconciled between nursing and rehabilitation	L 051	**L 051- Facility staff failed to update the care plan with measurable interventions relative to the prevention of falls and resident safety.** 1. **Corrective Action for Affected Resident:** Resident's care plan reviewed and updated to include measurable individualized approaches to fall prevention during survey 2. **Identification of Other Residents Potentially Affected by Same Practice:** Care plans of all residents with fall risk assessments scores of 10 or greater were reviewed and updated to reflect residents' individual needs and safety. 3. **Systemic change to Ensure Deficient Practice Does not Recur:** Review and update facility policies on falls and care plan reviews. In-service staff on policy changes. Monitor implementation of policies through random chart audits of residents who experience falls. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MDS coordinator will review and update falls care plans randomly. Compliance threshold 100%. Findings will be reported to QA quarterly.	6/9/15. 7/23/15 7/23/15 7/23/15

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L 051	Continued From page 16 therapy. The employee acknowledged the care plan for Resident #24 was not updated with all information and interventions, measurable or not, relative to Resident #24 ' s fall status and/or care plan.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and	L 052	**L052 A-1 Facility staff failed to administer medications with timeliness.** 1. **Corrective Action for Affected Resident:** Employee was immediately counseled re: facility's established med-pass times. No negative resident outcomes resulted from this deficient practice. 2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents had the potential to be affected by this practice on the date the practice was identified. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were re-educated on facility's policy for medication administration times. Random med pass observations will be conducted monthly until all licensed staff has been observed. (Ongoing) Pharmacy consultant will conduct med pass observations twice annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results Of med pass observations will be reported with any corrective action taken to QA Committee quarterly	6/10/15 6/10/15 6/15/15 7/23/15 7/23/15 7/23/15.

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recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:

A. Based on observations, record review and interview for three (3) of 30 sampled residents, it was determined that facility staff failed to ensure that sufficient nursing time was given as evidenced by failure to administer medications as prescribed by the physician for one (1) resident; administer medications with timeliness for two (2) residents and properly assess an apical pulse prior to medication administration for one (1) resident. Residents #27, 44 and 45

The findings include:

1. During a medication administration observation on June 10, 2015 at approximately 10:20AM, it was determined the charge nurse administered greater than twice the prescribed dosage of an ' as needed ' expectorant medication (Siltussin) to Resident #45. The medication that was administered (Siltussin) was not the intended medication. There was no documented evidence that the healthcare team of the oncoming shift(s) were notified about the medication error and subsequent review of the medical record lacked

L052 A-3 Failure to properly assess apical pulse prior to med administration.

1. **Corrective Action for Affected Resident:** Nurse was counseled on rationale and appropriate method for obtaining apical pulse prior to administration of Coreg (and drugs in this class). No negative resident outcome was identified — 6/10/15.
2. **Identification of Other Residents Potentially Affected by Same Practice:** Records of all other residents with orders for medications from the same class were reviewed. Findings indicated that only radial pulse was documented for five of six residents. — 6/15/15
3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were in-serviced on rationale and proper method for assessing apical pulse. Medication administration policy was updated to include this information. — 6/15/15 Competency testing for licensed staff will include apical pulse measurements. — 7/23/15
4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MARs will be monitored monthly for documentation of apical pulse readings for Coreg and similar drugs. Outcomes will be reported to QA committee quarterly. — 7/23/15

Addendum to page 18

	L052 – A(2) Facility staff failed to administer medications with timeliness. 1. **Corrective Action for Affected Resident:** Employee was immediately counseled re: facility's established med-pass times. No negative resident outcomes resulted from this deficient practice . 2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents had the potential to be affected by this practice on the date the practice was identified. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur**: Licensed staff were re-educated on facility's policy for medication administration times. Random med pass observations will be conducted monthly until all licensed staff has been observed. (Ongoing) Pharmacy consultant will conduct med pass observations twice annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results of med pass observations will be reported with any corrective action taken to QA Committee quarterly 7/23/15.	6/10/15 6/10/15 6/15/15 7/23/15 7/23/15

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evidence that Resident #45 was comprehensively assessed and/or closely monitored following the incident.

A. Employee #20 administered the wrong medication to Resident #45.

Employee #20 was observed administering medications for Resident #45 on June 10, 2015 at approximately 10:20 AM. During the observation, a record of each of the medications prepared by the nurse was recorded, as required for the survey process. The nurse [Employee #20] retrieved a multidose bottle of " Siltussin " [an oral syrup - expectorant; used to treat coughs and congestion] from the medication cart and poured 30 cc into a medication cup. He/she gathered the remainder of the medications that had been prepared and entered Resident #45 ' s room. Employee #20 handed Resident #45 the medication cup and as the resident drank the syrup, Employee #20 said " that is your potassium. "

Employee #20 returned to the medication cart and was queried regarding the comment made to the resident regarding " potassium. " He/she stated that potassium was given to the resident. In contrast, the employee was informed that he/she was observed to retrieve a bottle of " Siltussin " and poured the syrup into the medication cup; the documentation detailing the sequence of observations that was recorded was shared with Employee #20. It was requested that the nurse pour a sample of each of the medications for the purpose of observation, he/she complied and it was determined that the medications are similar in appearance [both were red colored syrup]. The samples were discarded after the observation.

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A review of physician ' s orders signed May 14, 2015 included the following:

Potassium Chloride 30 ml (40 MEq) by mouth every day for supplement.

Siltussin AF/SF [alcohol free/sugar free] liquid (aka: Diabetic tussin) 100mg/5 [give] 10ml by mouth 3 times a day as needed for cough.

Employee #20 was observed to pour 30 ml of Siltussin instead of the intended 30cc of Potassium. The dosage of Siltussin that was administered to Resident #45 was greater than twice the prescribed (10 ml) dosage. There was no evidence that Resident #45 sustained any untoward effect from the medication error. Employee #20 acknowledged the findings.

B. Facility staff failed to conduct a comprehensive assessment of Resident #45 after he/she received greater than twice the prescribed dosage of an expectorant medication that was administered in error. Additionally, there was no evidence that Resident #45 was closely monitored following the incident.

A review of Resident #45 ' s clinical record on July 12, 2015 at 9:00 AM, two (2) days after the medication error, lacked evidence that licensed staff conducted a comprehensive assessment and/or close monitoring of Resident #45 on June 10, 2015 after the aforementioned medication error. The most recent progress note recorded by nursing staff was dated June 3, 2015 [days prior to the incident].

According to the Nursing Spectrum Drug Handbook 2012, adverse effects of Siltussin

L052-B Failure to conduct a comprehensive assessment following medication administration error.

1. **Corrective Action for Affected Resident:** No negative resident outcome occurred as a result of this deficiency. Employee involved was counseled during survey re: importance of assessment/monitoring following unusual occurrences. Med error repot completed and MD was notified by DON. — 6/10/15

2. **Identification of Other Residents Potentially Affected by Same Practice.** No other residents were affected by this deficiency. — 6/10/15

3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were in-serviced on facility's policy and procedure for comprehensive assessment and documentation of unusual incidents/accidents. In-service will be repeated annually. — 6/15/15

4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Medical records for all residents experiencing unusual incidents/accidents will be reviewed monthly for compliance with the policy. Threshold for compliance is 100%. Results will be reported to QA Committee quarterly. — 7/23/15

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	include: headache, dizziness, nausea, vomiting, diarrhea, stomach pain, rash and urticaria.		**L052 C Failure to communicate to oncoming shift to follow-up and or monitor resident's condition.**	
	A face-to-face interview was conducted with Employee #2 on July 12, 2015 at approximately 9:30 AM. In response to a query regarding the lack of evidence of assessment and monitoring of Resident 45 following the medication error, he/she reviewed the record and acknowledged the lack of documentation, however, asked to follow up after researching the events. Employee #2 followed up and stated that the doctor was notified but the nurse did not document it.		1. **Corrective Action for Affected Resident:** No negative outcome occurred as a result of this practice.	6/10/15
			2. **Identification of Other Residents Potentially Affected by Same Practice.** No other residents were affected by this deficiency.	6/10/15
	There was no evidence that licensed staff conducted a comprehensive nursing assessment following the medication error. Additionally, there was no evidence that Resident #45 was closely monitored for potential adverse effects after receiving more than twice the prescribed dosage of Siltussin. There were no nursing progress notes recorded after June 3, 2015.		3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were re-educated on facility policy and procedure for completing twenty-four hour report to communicate all unusual occurrences and/or changes in residents' condition. This in-service will be included as part of new employee orientation.	6/20/15
	C. Facility staff failed to communicate to oncoming shifts that Resident #45 required follow-up and/or monitoring after he/she was administered medication greater than twice the prescribed dosage and that the medication that was administered was unintended.		4. **Performance Monitoring to Make Sure Solution Are Sustained:** The Twenty-four hour report will be monitored on a random basis, not less than once each week to ensure proper communication and follow up. Results will be documented and reported to the QA Committee quarterly.	7/23/15
	A review of facility ' s 24-hour report for the period of June 10 thru 11, 2015, under the heading, " Residents requiring follow up over next twenty-four hours " lacked evidence of documentation related to the medication error sustained by Resident #45. Resident #45 was not included as a resident requiring follow-up for the evening or night shift on June 10, 2015. Resident #45 was not included on the 24-hour report for June 10th or June 11th 2015.			

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According to the facility ' s policy entitled " Twenty-Four Hour Report " stipulates, " It is the policy of the Methodist Home to maintain a nursing 24-hour report. This report communicates changes in resident status over a 24-hour period. It also documents actions taken or clinical/administrative actions needed ... "

A face-to-face interview was conducted with Employee #2 on June 12, 2015 at approximately 9:30 AM. He/she reviewed the 24-hour report for June 10 - 11, 2015 and acknowledged the findings.

There was no documented evidence that facility staff communicated to the oncoming healthcare team regarding the medication error that Resident #45 sustained on June 10, 2015. There was no documentation noted in the nursing progress notes and the resident was not included on the 24-hour report. The records were reviewed June 12, 2015.

2. During a medication administration observation on June 10, 2015 at approximately 11:45AM, it was determined that Employee #20 administered an antihypertensive medication outside of the prescribed parameters for Resident #27 and failed to properly assess the resident ' s Apical pulse. Additionally, there was no evidence that the resident was comprehensively assessed and/or closely monitored following the administration of the antihypertensive medication.

A. Facility staff failed to follow the physician ' s parameters of administration by failing to withhold an antihypertensive medication when the resident ' s blood pressure and pulse was less than the

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range for administration.

A review of physician ' s orders signed May 7, 2015 revealed Resident #27 ' s medication regimen included the following:

Coreg 6.25 mg 1 tablet by mouth twice daily before meals breakfast and supper for Atrial Fibrillation.

" Monitor B/P [blood pressure] daily prior to administration of antihypertensive medication. Notify MD [doctor] if SBP [systolic blood pressure] <100 mm HG [millimeters mercury] and or DBP [diastolic blood pressure] <60 mm Hg x2 [twice] consecutive readings "

" Apical pulse daily "

A review of the Medication Administration Record [MAR] for June 2015 revealed that Coreg was scheduled for administration at 9:00 AM and 10:00 PM daily and the Apical pulse was scheduled at 9:00 AM daily.

Employee #20 was observed administering medications to Resident #27 on June 10, 2015 at 11:45 AM. The employee assessed the resident ' s vital signs with the automatic electronic vital sign apparatus. Employee #20 recorded the resident ' s blood pressure as 90/52 and pulse 59 and proceeded to administer the medications [including Coreg].

In response to a query regarding whether or not parameters of administration were prescribed for Resident #27, Employee #20 reviewed the MAR and identified the prescriber ' s parameters [delineated above]. Thereafter, Employee #20 used the automatic electronic apparatus to

reassess the resident ' s blood pressure and pulse

L 052

L052-2A Failure to hold anti-hypertensive medication when resident's B/P less than range of administration.

1. **Corrective Action for Affected Resident:** Attending physician notified 06/10/15. No new orders obtained. Employee making error was counseled on facility's policy and procedure, for anti-hypertensive medication administration and notification of physician for changes in residents condition. Resident did not experience negative outcome. — 6/10/15

2. **Identification of Other Residents Potentially Affected by Same Practice:** MAR"s for all residents receiving anti-hypertensive medications were reviewed for compliance with facility policy for administration of anti-hypertensive medications. All were in compliance. — 6/15/10

3. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Licensed staff were in-serviced on safe medication administration practices and the eight rights of medication administration. (Nursing 2012 Drug Handbook Lippincott Williams and Wilkins Philadelphia PA.). — 6/15/15

4. **Performance Monitoring to Make Sure Solutions Are Sustained:** MAR's will be monitored monthly for compliance. Findings will be reported to QA Committee quarterly. — 7/23/15

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L 052	Continued From page 23	L 052		

reassess the resident ' s blood pressure and pulse. He/she recorded the repeat blood pressure as 100/60 and pulse 61 (after the medication was administered).

In response to a query regarding the technique used to assess the resident ' s " Apical " pulse, Employee #20 stated he/she did not have a watch or stethoscope to obtain it otherwise.

According to the Nursing Spectrum Drug Handbook 2012, Coreg is a ' Beta blocker ' antihypertensive medication indicated for use in Hypertension and Heart Failure. Under the section labeled Administration ... " Give with food to slow absorption and minimize orthostatic hypotension [low blood pressure]; check apical pulse before administering, if it ' s below 60 beats per minute withhold dosage and contact prescriber ... "

Employee #20 administered Coreg even though the physician ' s parameters of administration directed that the medication be ' held ' if the SBP was less than 100 and the DBP was less than 60 on two (2) consecutive readings. The resident ' s blood pressure was assessed at 90/52 and pulse 59 [less than manufacturer ' s recommendation for administration - " hold if pulse less than 60]. The employee did not reassess the resident ' s blood pressure and pulse until after the medication was administered. Additionally, the resident ' s Apical pulse was not assessed in accordance with acceptable standards of practice.

A face-to-face interview was conducted with Employee #20 at the time of the observations. She/he stated that the resident ' s blood pressure was within administration range upon

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L 052	Continued From page 24 reassessment. B. Facility staff failed to comprehensively assess and closely monitor Resident #27 after the nurse administered an antihypertensive medication (Coreg) outside of the prescribed parameters for administration (listed above). A review of Resident #27 ' s clinical record on June 12, 2015, two (2) days after the medication observation [detailed above], lacked evidence that licensed staff conducted a comprehensive assessment and/or close monitoring of Resident #27 following the morning administration of Coreg on June 10, 2015. The record revealed a nursing entry dated June 11, 2015 at 5PM that read, " Residents monthly POS [physician order sheet] reviewed/signed to by Nurse Practitioner. " The nursing entry preceding the June 11th note (above) was dated June 2, 2015. The clinical record lacked evidence that Resident #27 was comprehensively assessed and/or closely monitored after the administration of the morning Coreg. The resident was not included on the 24-hour report and there was no evidence that the oncoming shift was informed. A face-to-face interview was conducted with Employee #2 on June 12, 2015 at approximately 9:30 AM who acknowledged the findings. 3. Facility staff failed to administer medications with timeliness for Residents #27 and 44. During a random medication observation on June 10, 2015, Employee #20 was observed administering medications prescribed more frequently than	L 052	**L052-B Failure to comprehensively assess and closely monitor resident after administering anti-hypertensive medication outside the parameter.** 1. **Corrective Action for Affected Resident:** Attending physician was notified 06/10/15. No new orders given. Employee making error was counseled during survey on facility's policy and procedure, for anti-hypertensive Medication Administration and notification of physician for changes in residents condition. Resident did not experience negative outcome. 2. **Identification of Other Residents Potentially Affected by Same Practice:** MAR's for all residents receiving anti-hypertensive medications were reviewed for compliance with facility policy for administration of anti-hypertensive medications. All found to be in compliance. 3. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Licensed staff were in-serviced on safe medication administration practices and the eight rights of medication administration. (Nursing 2012 Drug Handbook Lippincott Williams and Wilkins Philadelphia PA.). 4. **Performance Monitoring to Make Sure Solutions Are Sustained**: MAR's will be reviewed monthly for compliance. Findings will be reported to QA Committee quarterly	6/10/15 6/15/15 6/15/15 7/23/15

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L 052	Continued From page 25 once daily, greater than one (1) hour after the scheduled administration time. According to "The Institute for Safe Medication Practices," guidelines for timely medication administration for Non-Time Critical scheduled medications are as follows: " Daily, weekly or monthly medications - [administer] within 2 hours, before or after the scheduled time ....for medications prescribed more frequently than daily but no more frequently than every 4 hours - [administer] within 1 hour, before or after the scheduled time." A. Employee #20 was observed administering medications scheduled for 9:00 AM at 11:45 AM for Resident #27. A review of the June 2015 Medication Administration Record [MAR] revealed five (5) of the 8 medications administered were prescribed for twice daily or more. One (1) of those five (5) medications (Coreg) was to be administered before breakfast. However, the resident had already consumed his/her breakfast prior to its administration. Employee #20 failed to administer medications for Resident #27 with timeliness. Medications prescribed for administration more frequently than ' once ' daily were administered greater than two (2) hours beyond the scheduled time and one (1) medication that was to be administered before breakfast was not. B. Employee #20 was observed administering medications scheduled for 10:00 AM at 11:30 AM for Resident #44. A review of the June 2015 Medication Administration Record [MAR] revealed one (1) of the 2 medications administered to Resident #44 were prescribed for	L 052	**L052-A Facility staff failed to administer medications with timeliness for Resident #27 and #44** 1. **Corrective Action for Affected Resident:** Employee involved was counseled during survey re: facility's established med-pass times. No negative outcomes identified by this deficient practice. 2. **Identification of Other Residents Potentially Affected by Same Practice:** All residents could have been affected by this practice on the date of this finding. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Licensed staff were re-educated on facility's policy for medication administration times. Staff development will conduct random med pass observation monthly until all licensed staff has been observed. The pharmacist will conduct med pass observation twice annually. 4. **Performance Monitoring to Make Sure Solutions Are Sustained:** Results will be reported with any corrective action taken to QA Committee quarterly.	6/10/15 6/10/15 6/15/15 7/23/15

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L 052	Continued From page 26 twice daily or more (Methylphenidate - a Central Nervous System stimulant prescribed for depression medication). Employee #20 failed to administer medications to Resident #44 with timeliness. The Medication prescribed for administration more frequently than ' once ' daily was administered greater than one (1) hour beyond the scheduled time. A face-to-face interview was conducted with Employee #20 at the time of the medication observations. In response to a query regarding the lack of timeliness of medication administration, he/she acknowledged and stated " I don ' t know what happened today, why I am so late. " B. Based on observations, interview and record review for one (1) of 30 sampled residents it was determined that sufficient nursing time was not given to ensure one (1) resident received a therapeutic diet as ordered by the physician. Resident # 7 The findings include: During a dining resident observation on June 8, 2015 at approximately 1:30 PM, Resident #7 was observed sitting at a table without a meal with two residents who were actively eating their meals , after further observation Resident #7 was served a can of a supplemental nutritional to drink . On June 9, 2015 at approximately 9:00AM Resident #7 was observed sitting in dining room alone without a meal drinking a supplemental nutritional drink.	L 052	**L052- B Staff failed to administer resident's diet as prescribed.** 1. **Corrective Action for Affected Resident:** Prescribed diet was offered to resident during survey, which she refused. 2. **Identification of Other Residents Potentially Affected by Same Practice:** Diet orders were reviewed for all residents. All residents received prescribed diets. 3. **Systemic changes to Ensure Deficient Practice Does Not Recur:** New policy developed to require care plans to be compared to prescribed diet orders quarterly and updated, as needed. 4. **Performance Monitoring to Make Sure solutions are sustained:** Findings will be reported to the QA committee quarterly. Compliance threshold is 100%.	6/8/15 6/11/15 6/18/15 7/23/15

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L 052	Continued From page 27 On June 10, 2015 at approximately 9:30 AM during breakfast Resident #7 was observed during dining without a meal drinking a supplemental nutritional drink. There was no observation of Resident#7 being offered or served his/her prescribed diet during the above noted observations. A review of the clinical record revealed: Physicians Order Form dated June 2015; Diet Mechanical soft texture, regular diet with thin liquids. Dietary supplements Ensure Plus 8oz by mouth three times a day, provide ice cream with lunch and dinner provide 8 oz. (ounce) 2%milk with breakfast lunch and dinner. A review of the Quarterly Nutrition review dated March 18, 2015 revealed; Current weight stable with minimal changes x 6 months appetite for meals poor but takes 100% of ensure supplement, ice cream and milk ...f/u as needed. A review of residents Intake and output revealed a zero (0) intake for breakfast and lunch seven out of seven days reviewed. There was no evidence Resident # 7 was receiving his/her diet as ordered. A face to face interview with Employee #7 on June 10, 2015 at 10:00 AM at when queried why Resident #7 was not being given meals he/she stated, " Resident #7 pushes the food away so we stop giving them and since he/she likes the ensure that ' s what we serve " . A Face to face interview was conducted with Employee's # 2 and 11 on June 11, 2015 at	L 052		

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L 052	Continued From page 28 approximately 3:00 PM. Both were informed of the aforementioned findings. Employee ' s #2 and 11 both stated they were not aware Resident #7 was not receiving his/her meals as ordered. Employee #11 stated " the supplemental nutrition is in addition to his her prescribed therapeutic diet not in place of it " . Facility staff failed to administer Resident # 7 ' s diet as prescribed. Employee # 2 acknowledged the above findings. The clinical record was reviewed on June 11, 2015	L 052	**L056 - Failure to comply with applicable Federal, State, and Local laws and regulations** 1. **Corrective Action for Affected Resident:** Staffing schedules reviewed. No resident was negatively affected by this practice.	6/12/15
			2. **Identification of Other Residents Potentially Affected by Same Practice**: Review of daily staffing post survey revealed 0.6 RN mandate was not met for period identified. This not a consistent pattern.	6/12/15
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by the staff's failure to ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	L 056	3. **Systemic changes to Ensure Deficient Practice Does Not Recur:** Facility continues to actively recruit RN's to meet the 0.6 staffing requirement mandated by DC regulations. (Ongoing)	7/23/15
			4. **Performance Monitoring to Make Sure solutions are sustained**: Human Resources will generate quarterly reports for direct care provided by RNs. Findings will be reported QA committee quarterly.	7/23/15

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L 056	Continued From page 29	L 056		

The findings include:

According to 3211.5 of the District of Columbia Municipal Regulations titled, 'Nursing Personnel and Required Staffing Level, ' "Each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse ... "

The facility failed to ensure that there was sufficient registered nurse staffing and total nursing staffing from June 5 to June 8, 2015, as indicated below:

	Registered Nurse Staffing	Total Nursing Staff
June 5, 2015	0.33	4.3
June 6, 2015	0.33	3.7
June 7, 2015	0.33	3.7
June 8, 2015	0.50	4.3

A review of the facility's staff ratios from June 5, 2015 to June 8, 2015 revealed an average of .37 for registered nurse staffing and 4.0 for overall direct nursing care.

On June 19, 2015 at approximately 11:12 AM, a telephone interview was conducted with Employee #14 regarding the aforementioned staffing levels for the facility. He/she acknowledged the findings. Employee #1 also

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L 056	Continued From page 30 acknowledged the findings. The records were reviewed on June 9, 2015 and re-visited on June 19, 2015. Facility staff failed to ensure that sufficient nursing staff was available to provide nursing and related services to all residents within the facility.	L 056		
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 made on June 8, 2015 at approximately 9:30 am, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by soiled equipment such as one (1) of one (1) convection oven, four (4) of four (4) scoops to the cereal dispenser and one (1) of one (1) tilt skillet, a dirty kitchen floor, two (2) of two (2) dusty fire sprinklers, an uncovered pan of rolls, five (5) of five (5) torn steam table lids, five (5) of five (5) stained storage racks and an employee who was storing clean dishes with his/her bare hands. The findings include: 1. One (1) of one (1) convection oven was soiled with accumulated burnt food deposits on the racks and throughout the interior. 2. Four (4) of four (4) scoops to the cereal dispenser were soiled. 3. One of one tilt skillet, one (1) of one (1) fryer, and one (1) of one (1) stove were soiled with	L 099	**L099** A. One (1) of one (1) convection oven was soiled with accumulated burnt food deposits on the racks and throughout the interior. 1. **Corrective Action for Affected Resident/Equipment:** Oven was Cleaned on June 9, 2015 2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other ovens were inspected and found clean on August 6, 2015 3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the ovens daily, as part of the managers opening and closing checklist. The Master cleaning schedule has been updated to include signature for the associate that is assigned the cleaning task. August 6, 2015 4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the opening and closing checklist findings weekly to ensure corrective actions are effective and sustained. Dining Services will report findings to QA quarterly. August 6, 2015 B. Four (4) of four (4) scoops to the cereal dispenser were soiled. 1. **Corrective Action for Affected Resident/Equipment:** Scoops were washed and sanitized during Survey June 8, 2015 2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other scoops were inspected and found clean. August 6, 2015	06/09/15 08/06/15 08/06/15 08/06/15 06/08/15 08/06/15

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L 099	Continued From page 31 cooked food deposits and/or grease. 4. The kitchen floor was unclean throughout with wasted food residue and debris. 5. Two (2) of two (2) fire sprinklers in the walk-in refrigerator were covered with dust. 6. A pan of uncooked rolls was stored uncovered, on top of the convection oven. 7. Five (5) of five (5) steam table lids were bent and torn and needed to be replaced. 8. The shelves from five (5) of five (5) storage racks used to store clean dishes and clean utensils were marred. 9. An employee in dietary services was observed storing clean dishes with his/her bare hands. These observations were made in the presence of Employee #3 who acknowledged the findings during the survey.	L 099	3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the scoops daily, as part of the opening and closing checklist. Daily assignments for Dining Services staff have been updated to included washing and sanitizing all scoops. All associates will be in-serviced in the change in task by August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the opening and closing checklist findings weekly to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015	08/06/15
			C One of one tilt skillet, one (1) of one (1) fryer, and one (1) of one (1) stove were soiled with cooked food deposits and/or grease. 1. **Corrective Action for Affected Resident/Equipment:** Tilt skillet, fryer, and stove were cleaned on June 9, 2015	06/09/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other equipment was inspected and found clean June 9, 2015	06/09/15
L 130	3224.5 Nursing Facilities If the facility does not have a pharmacy, it shall arrange for prompt and convenient methods to obtain prescribed medications and biological twenty-four (24) hours a day from a provider pharmacy and shall contract with a consultant pharmacist who shall supervise pharmaceutical services. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was	L 130	3. **Systemic changes to ensure deficient practice does not recur:** A member of the Dining Services Management Team will inspect the production equipment daily, as part of the opening and closing checklist. The Master cleaning schedule has been updated and the frequency of the equipment has increased to once a week. The production staff will be in-serviced on the changes by August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** A member of Dining Services Management will monitor the opening and closing checklist findings weekly and report findings to QA quarterly. August 6, 2015	08/06/15

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		L099	D. The kitchen floor was unclean throughout with wasted food residue and debris.	
			1. **Corrective Action for Affected Resident/Equipment:** Floor was swept and mopped during Survey June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or Equipment was affected by practice.	
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will inspect the Floor after each meal. The Dining service daily assignment has been revised to include sweeping and mopping after each meal or as needed. The director of dining services will schedule power washing of the kitchen floor monthly. This will be added to the safety and sanitation audit. All associates will be in-serviced and the first power washing will be completed by August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** The Director of Dining Services will monitor the findings from the Safety and Sanitation audit to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015	08/06/15
			E. Two (2) of two (2) fire sprinklers in the walk-in refrigerator were covered with dust.	
			1. **Corrective Action for Affected Resident/Equipment:** Sprinkler in walk-in were cleaned during survey on June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** All other sprinklers in the kitchen were inspected and found clean. June 8, 2015.	06/08/15
			3. **Systemic changes to ensure deficient practice does not recur:** Maintenance supervisor will randomly inspect all kitchen sprinklers every 2 weeks to ensure they are free of dust. A weekly inspection will be conducted by maintenance staff and recorded on the Maintenance Inspection Logs. August 6, 2015	08/06/15

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		L099	4. **Performance Monitoring to ensure solutions are sustained:** Logs will be reviewed by the Maintenance Director weekly for completion. Findings will be reported to QA quarterly. August 6, 2015	08/06/15
			F. A pan of uncooked rolls was stored, uncovered, on top of the convection oven	
			1. **Corrective Action for Affected Resident/Equipment:** The rolls were covered immediately during Survey June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident was affected by practice. June 8, 2015	06/08/15
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will in-service the production staff on proper storage of food. The team will hold any associate accountable if the policy is not followed. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will continue to monitor and educate the staff to ensure corrective actions are effective and sustained. Dining Services will report progress to QA quarterly. August 6, 2015	08/06/15

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	095038	A. BUILDING ______ B. WING ______	06/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETION DATE
		L099	G. Five (5) of five (5) steam table lids were bent and torn and needed to be replaced.	
			1. **Corrective Action for Affected Resident/Equipment:** The lids were discarded immediately during survey June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident was affected by practice. New lids were purchased and are in place. June 8, 2015	06/08/15
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team will inspect the lids monthly by using our safety and sanitation audit. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will monitor the findings to ensure corrective actions are effective and sustained. Dining Services will report finding to QA quarterly. August 6, 2015	08/06/15
			H. The shelves from five (5) of five (5) storage racks used to store clean dishes and clean utensils were marred.	
			1. **Corrective Action for Affected Resident/Equipment:** No corrective action could be taken as the racks could not be repaired. August 6, 2015	08/06/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or equipment was affected by practice. August 6, 2015	08/06/15
			3. **Systemic changes to ensure deficient practice does not recur:** Replacements for the marred shelving have been purchased and will be placed as soon as they arrive. Dining Services Management Team will add all kitchen shelving/racks to the Safety and Sanitation audit for inspecting monthly. August 6, 2015	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** The Director of Dining Service will monitor the inspection reports to ensure the storage racks remain in good condition. Dining Services will report findings to QA quarterly. August 6,	08/06/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	06/15/2015

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		L099	I. An employee in dietary services was observed storing clean dishes with his/her bare hands.	
			1. **Corrective Action for Affected Resident/Equipment:** Dishes were rewashed and sanitized June 8, 2015	06/08/15
			2. **Identification of other Residents/Equipment Potentially Affected by same practice:** No resident or equipment was affected by practice. June 8, 2015	06/08/15
			3. **Systemic changes to ensure deficient practice does not recur:** Dining Services Management Team has conducted in-services on proper handling of clean dishes and single use gloves. Dining services staff will also continue 100% participation in infection control in-services offered at Forest Hills of DC. August 6, 2016	08/06/15
			4. **Performance Monitoring to ensure solutions are sustained:** Dining Services Management will continue to monitor and educate the staff to ensure corrective actions are effective and sustained. Dining Services will report progress to QA quarterly. August 6, 2015	08/06/15

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 ______	06/15/2015

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L 130	Continued From page 32 determined that the facility failed to acquire a vaccine/medication that was prescribed for Resident #48. The findings include: A review of the clinical record History and Physical revealed: Resident # 48 was admitted to the facility February 12, 2015 with a diagnoses of Osteoporosis, Pulmonary Hypertension and Increased Lipids. A review of the physician ' s order dated May 14, 2015 revealed "Zostavax " [a vaccine indicated for the prevention of Herpes Zoster - Shingles] was ordered for immunization." A review of the Nurses Notes May 14, 2015 read: "MD ordered Zostavax for resident ... order faxed and transcribed...9:50 PM " . A nurse ' s note dated May 21, 2015 6:00 PM revealed; " Writer called several times to [name] Pharmacy about vaccination Zostavax ... [referring to 5/14/15 nurses note] ... Finally information that Allied pharmacy does not carry the vaccine ... unable to send ...message communicated to resident ' s [next of kin] who will verify from either Walgreens or CVS if vaccination is available ... there after they obtain prescription from [physician's name] to purchase pending response from [next of kin]. " SIC A nurses note dated June 6, 2015 at 9:15 PM revealed ; " Writer called residents [next of kin] following up on Zostavax immunization for [resident] ... was to follow up with local pharmacy like Walgreens, CVS etc.. for [resident] ...Family presently out of country on Vacation ... " .	L 130	**L130 - Facility failed to acquire a vaccine/medication that was prescribed for Resident #48.** 1. **Corrective Action for Affected** Pharmacy notified in writing on 6/15/15 regarding medication for resident. 2. **Identification of Other Residents Potentially Affected by Same Practice:** No other residents were affected by this practice. 3. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Facility policy regarding the pharmacy services was developed whereby pharmacy will notify facility in writing within 72 hours if unable to obtain a medication. Physician will be notified of unavailability of any 4. **Systematic Changes to Ensure Deficient Practice Does not Recur:** Staff development coordinator will monitor and report to QA committee quarterly.	On-going

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	HFD02-0004	A. BUILDING ____ B. WING ____	06/15/2015

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L 130	Continued From page 33 There was no evidence the pharmacy attempted to acquire the prescribed medication. The medication was not in facility as of June 12, 2015. Face to face interview with Employee #2 was done on June 12, 2015 at approximately 9:00 AM when queried regarding Zostavax he/she was aware of the medication not being available due to it being a very sensitive medication and the vaccine was not delivered because the pharmacy does not have a viable mechanism in place for delivery. Employee #2 acknowledged aforementioned findings. The clinical record was reviewed on June 12, 2015	L 130		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on June 8, 2015 at approximately 11:30 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 wall clocks in five (5) of 21 resident rooms that were not functioning and detached privacy curtains in two (2) of 21 resident rooms. The findings include: 1. Wall clocks in five (5) of 21 resident rooms	L 410	**L 410 - Wall Clocks with Incorrect Times** **1. Corrective Action for Affected Residents:** Upon discovery of the inoperable clocks, the staff immediately replaced batteries In the clocks that were displaying the wrong times. **2. Identification of Other Residents Potentially Affected by Same Practice:** A complete healthcare wall clocks inspection was conducted to ensure accurate times were being displayed. **3.Systemic Changes to Ensure Deficient Practice Does Not Recur:** Maintenance staff will inspect healthcare rooms every two weeks to ensure correct times are being displayed. **4. Performance Monitoring to Make Sure Solutions Are Sustained:** Maintenance supervisor will conduct monthly room inspections and review logs. Findings will be reported to the QA Committee X2 quarters.	06/08/15 06/8/15 06/08/15 06/08/18

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	HFD02-0004	A. BUILDING ______ B. WING ______	06/15/2015

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L 410	Continued From page 34 surveyed did not display correct time including rooms #159, #246 on the 'A' side, #247 on the 'A' and 'B' side, #252 on the 'B' side and #253 on the 'A' side. 2. Privacy curtains in two (2) of 21 resident rooms were completely detached from its hooks, including rooms #159 and #261. These observations were made in the presence of Employee # 4 who confirmed the findings.	L 410	**L 410 – Privacy Curtains Detached from Hooks** **1. Corrective Action for Affected Residents:** Upon discovery, the detached privacy curtains were immediately re-attached on the tracks. **2. Identification of Other Residents Potentially Affected by Same Practice:** A complete inspection of healthcare privacy curtains was conducted to ensure all curtains are hanging properly. No additional deficient practice was identified. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a. Housekeeping staff were trained to inspect Healthcare rooms daily to ensure that privacy curtains are properly hung. b. Maintenance checklist has been revised to include Inspection of curtain tracks and replacing curtain hooks as needed. **4. Performance Monitoring to Make Sure Solutions Are Sustained** Housekeeping supervisor will conduct bi-weekly room inspections to ensure that curtains are attached on tracks. Results will be reported to the QA Committee quarterly.	06/08/15 6/9/15 6/11/15 7/23/15

FOREST HILLS OF DC

INCLUSIVE SENIOR LIVING

August 6, 2015

Sharon Williams Lewis, DHA, RN-BC, CPM
Program Manager, Health Facilities Division
Department of Health
899 North Capitol Street, NE
Washington, DC 20002

Dear Dr. Lewis:

Enclosed please find executed Statement of Deficiencies and Plan of Correction (Life Safety Code) for Forest Hills of DC.

This plan of correction is submitted for purposes of regulatory compliance and as part of Forest Hills of DC's ongoing efforts to continuously maintain the high quality of care and services provided. As such it does not constitute an admission of the facts or conclusions cited in the survey report for any purpose whatsoever.

If you have any questions, please contact me directly at 202-777-3320. Thank you.

Sincerely,

Mary Savoy, RN, MS, LNHA
Administrator

Enclosure (life Safety Code)

4901 Connecticut Ave NW | Washington, DC 20008 | www.foresthillsdc.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/09/2015

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K 000	INITIAL COMMENTS The following findings were observed during the Life Safety Code Inspection conducted June 9, 2015.	K 000	**THIS PLAN OF CORRECTION IS SUBMITTED FOR PURPOSES OF REGULATORY COMPLIANCE AND AS PART OF FOREST HILLS OF DC'S ONGOING EFFORTS TO CONTINUOUSLY MAINTAIN THE HIGH QUALITY OF CARE AND SERVICES PROVIDED. AS SUCH IT DOES NOT CONSTITUTE AN ADMISSION OF THE FACTS OR CONCLUSIONS CITED IN THE SURVEY REPORT FOR ANY PURPOSE WHATSOEVER.**	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**Life Safety Code k 018** **1. Corrective Action for Affected Residents:** Upon discovery of the two doors in the kitchen that were non-compliant, we immediately shaved the double doors and removed the door stopper from the dry storage room door. **2 . Identification of Other Residents Potentially Affected by Same Practice:** A complete inspection of the all doors in the kitchen and throughout the Health Care Center was conducted. Door stoppers were observed in use and removed.	06/08/15 06/8/15
	This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code inspection it was determined that doors between the Main Kitchen and the Dishwasher Area failed to close without assistance when tested and the Dry Storage Room was held open with a door stop in three (3) of three (3) observations. These findings were observed in the presence of the Maintenance Director.		**3.Systemic Changes to Ensure Deficient Practice Does Not Recur:** Inspection logs have been created for bi-weekly inspection by Maintenance staff of all fire doors in the Health Care Center. Maintenance supervisor will inspect fire doors randomly to ensure compliance and will record findings. **4.Performance Monitoring to Make Sure Solutions Are Sustained:** Maintenance supervisor will report findings to the QA Committee quarterly.	06/08/15 07/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Savoy RN, NHA	Administrator	8/7/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 018	Continued From page 1 The findings include: Based on observations during a tour of the Main Kitchen it was determined that double doors between the Main Kitchen and Dishwasher Area failed to close without assistance when tested. The entrance door to the Dry Storage Room was improperly propped open with a door stop in three (3) of three (3) door observations at 10:50 AM on June 9, 2015. The observations were made in the presence of the Maintenance Director who acknowledged the findings.	K 018		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on a review of records during the Life Safety Code Inspection, it was determined that Sprinkler Alarm Devices, such as (Flow and	K 056	K 056 Life Safety Code 1. Corrective Action for Affected Residents/Equipment: No corrective action was available since deficient practice occurred Quarters 3-4, 2014 and Quarter 1, 2015. 2. Identification of Other Residents Potentially Affected by Same Practice: No residents were affected by this deficient practice. 3. Systemic Changes to Ensure Deficient Practice Does Not Recur: New vendor (inspection company) has been selected to conduct quarterly inspections of sprinkler system. Comprehensive reports of these inspections will be generated by the vendor and reviewed by the Maintenance supervisor. 4.Performance Monitoring to Make Sure Solutions Are Sustained: Completion of the selection process will be reported to the QA committee.	06/08/15 06/8/15 7/17/15 7/23/15

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K 056	Continued From page 2 Tamper Switches) including Supervisory Signal Devices and Water Gongs were not tested on a quarterly basis in three (3) of four quarters reviewed. These findings were observed in the presence of the Director of Maintenance. The findings include: The Sprinkler Inspection Report was reviewed on June 9, 2015 at 3:00 PM to verify that the facility conducted quarterly testing to assess the functionality of Sprinkler Alarm Devices such as Mechanical Flow, Tamper switches and Signal Devices. The report lacked documented evidence of inspection reports for the third and fourth quarters of 2014 (July though December 2014) and the first quarter of 2015 (Jan - March 2015). The inspection report for the second quarter (May - June) of 2015 was reviewed; however, the quarter was not complete by the time of this review. The findings were acknowledged by the Director of Maintenance at the time of the review.	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that sprinklers	K 062		

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K 062	Continued From page 3 were not free from dust accumulation and/or paint on the shaft and head surfaces which could potentially affect sprinkler operation in the event of an emergency in 14 of 16 observations. These findings were observed in the presence of the Maintenance Director. The findings include: Through observation and interview it was determined that sprinklers were not maintained to ensure that sprinklers heads and shaft surfaces are free of dust accumulation and residual paint and grease in the Main Kitchen, which could affect the spray pattern and operation of sprinklers in the event of an emergency in the following instances. 1. The head, shaft and sprinkler supply line surfaces were soiled with dust accumulation in the Main Laundry Room and Washer Areas in (six) (6) of six (6) observations at 9:45 AM on June 9, 2015. 2. Residual paint was observed on sprinkler head and shaft surfaces in the east side of the Dining Rooms on the First and Second Floors in three (3) of four (4) observations between 9:50 AM and 11:02 AM on June 9, 2015. 3. The head and spray nozzle surfaces of Ansul Sprinklers in the Main Kitchen were soiled with dust and grease accumulation in five (5) of six (6) observations at 10:20 AM on June 9, 2015.	K 062	**Life Safety Code K 062** **1. Corrective Action for Affected Residents:** Upon discovery, the ansul heads and the head shaft, and sprinkler supply line surfaces identified as soiled were immediately cleaned.	06/08/15
			2. Identification of Other Residents Potentially Affected by Same Practice: No residents were affected by the deficient practice.	06/8/15
			3. Systemic Changes to Ensure Deficient Practice Does Not Recur: a. A bi-weekly inspection of all sprinklers, including kitchen ansul nozzles, will be conducted for dust and grease accumulation. The Maintenance staff will immediately clean any spray nozzle found to have accumulated dust and grease. Findings will be logged for reporting. b. Staff have been re-trained on the importance of covering sprinkler heads when surfaces are being painted.	7/7/15
			4. Performance Monitoring to Make Sure Solutions Are Sustained: Maintenance supervisor will report results of the Bi-weekly to the QA committee quarterly.	7/23/15