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L 000	Initial Comments	L 000		

An Annual Licensure survey was conducted at Ingleside at Rock Creek from February 13 through February 16, 2018. The deficiencies are based on observation, record review, resident and staff interviews for 25 sampled residents.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AD- Associate Director
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
BIMS- Brief Interview for Mental Status
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CFU Colony Forming Unit
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
DON - Director of Nursing
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
LPN- Licensed Practical Nurse

Ingleside at Rock Creek makes its best effort to operate in substantial compliance with both Federal and State Law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State Law.

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L 000	Continued From page 1 LTC- Long Term Care 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 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 PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rap, R/P - Responsible party RN- Registered Nurse SCC Special Care Center Sol- Solution SSD- Social Services Director TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	L 000		
L 024	3206.3 Nursing Facilties Policies shall be reviewed by the committee at least annually with written notations, signatures,	L 024		

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L 024	Continued From page 2 and dates of review. This Statute is not met as evidenced by: Based on policy review and staff interview, the facility failed to develop written policies and procedures to govern nursing care and related medical and other services provided that are reviewed at least annually. Findings included ... During the review of policies and procedures on February 16, 2018 at 1:15 PM, the policy manual provided contained policies to include dental services, abuse, infection control, emergency preparedness, and medication administration. The section reserved for a signature and date was left blank. The last revision date noted on the documents were 2014. During a face-to-face interview with Employee # 1, the employee stated the policies provided are pending approval. When queried about the last revision dated of 2014, Employee #1 stated he recently started at the facility and is most recent documents were provided. Employee #1 was unable to provide further insight into the failure to review the facility's policies at least annually. Employee #1 acknowledged the findings.	L 024	Ingleside at Rock Creek makes its best effort to operate in substantial compliance with both Federal and State Law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State Law. **L 024** 1. The facility's policy and procedures manual that includes dental services, abuse, infection control, and medication administration have been reviewed, updated, and signed. 2. Residents have potential to be affected by the deficient practice. None were affected. 3. The Administrator or designee will educate facility staff on the updated policies and procedures and on the location of said polices.. 4. The Administrator or designee will review the policies and procedures annually and update as needed. The Administrator or designee will report the findings of the annual review and updates at the quarterly QAPI meetings.	04/02/18
L 031	3207.6 Nursing Facilities The physician shall prescribe a planned regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services;	L 031		

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(c)Diet;

(d)Special procedures and contraindications for the health and safety of the resident;

(e)Resident therapeutic activities; and

(f)Plans for continuing care and discharge.
This Statute is not met as evidenced by:

Based on record review and staff interview for five (5) of 25 sampled resident, the physician failed to a review the resident's total program of care for one(1) resident that experienced injury of unknown injury; one (1) resident whose condition deteriorated; one (1) resident indications for use and discontinuation of antipsychotics; and acknowledge receipt of the pharmacist's Consultation Report/Medication Regimen Review and specify, what, if any action would be taken to address the identified irregularity (Residents #21, 22, 26, 33 and 42).

Findings included ...

1. The physician failed to ensure the progress showed the physician evaluate the resident after an injury of unknown origin and review the plan of care.

Resident #22 admitted with diagnoses to include Dementia, Diabetes Mellitus, Schizophrenia, Hypertension and Psychosis.

Review of medical record on February 16, 2018, at 11:30 AM showed Resident #22 experienced an injury of unknown origin. The nursing staff documented the presence of a 2X3X0 centimeter discoloration above the right eye of Resident #22 during routine evening care on January 25, 2018.

L 031

L 031

1. Resident #42 no longer resides in the facility. Residents #21, #22, #26, and #33 areas of discoloration and concerns have been resolved.
2. An audit of residents with change in status notification to the MD will be conducted for timely MD documentation by 04/15/18.
3. The Medical Director will educate the Physicians on timely documentation with change in status by 04/15/18.
4. Medical Director or designee will conduct 10% chart audits for residents with change in status to ensure timely physician documentation has

04/30/18

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According to the nursing note dated January 28, 2018, the physician was made aware of the discoloration above the resident's right eye.

Review of the physician's progress notes showed the physician record the last entry on January 4, 2018. The medical record lacks documented evidence the physician reviewed the resident's condition related to an injury of unknown origin.

During a face-to-face interview with Employee #10 on February 16, 2018, the employee stated the staff notified the physician and the physician came to the unit to see the resident. However, Employee #10 could not provide insight into the omission of documentation related to the resident's treatment plan and follow-up. Employee #10 acknowledged the findings.

2. The physician failed to ensure the progress notes accurately reflect the physician's decisions about the continued appropriateness of care for the percutaneous trans-hepatic drain and Resident #42's declining condition.

Resident #42 admitted on November 17, 2018, with diagnoses to included Acute Cholecystitis Status-post Cholecystectomy, Cerebrovascular Accident with left paresis, Hypertension and Atrial Fibrillation.

On November 17, 2017, the physician order directed the resident to be seen in follow-up by Interventional Radiology on November 27, 2017 at 8 AM. The medical record showed that the appointment with Interventional Radiology was rescheduled. The medical record lacked documented evidence to explain why the appointment was rescheduled and if the

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physician was notified.

On December 4, 2017, Resident #42 was noted with a sacral wound and treatment was initiated to include topical treatment and nutritional support.

Furthermore, the medical record showed Resident #42 experienced a six (6) pound weight loss in less than 30 days. The weights were documented as follows:
11/20/17 - 114.0 pounds (lbs.)
11/27/17- 113.0 lbs.
12/4/17- 109.2 lbs.
12/12/17- 108.0 lbs.

Review of medical record showed the physician staff documented two (2) visits with Resident #42 on November 30, 2017 and December 7, 2017.

On November 30, 2017, the physician documented the resident was receiving physical and occupational therapy, blood pressure was "managed", and disposition was supportive care and severe decondition. The physician's note does not address the percutaneous trans-hepatic tube drainage or the missed appointment with interventional radiology ordered on admission for November 27, 2017.

On December 7, 2017, the physician documented that Resident #42 remained deconditioned and primarily bedbound, and continue diabetic support management.

The physician's progress notes from November 30, 2017 and December 7, 2017 does not reflect the physician reviewed the resident's total treatment plan to include nutrition, weight, or skin. Furthermore, the physician progress notes do not reflect the continued appropriateness of the

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percutaneous trans-hepatic drain.

During a face-to-face interview conducted with Employee #23, Physician, on February 15, 2018, at 2:56 PM, the employee stated that Resident #42 had "a lot of medical issues", which she discussed with family on the day prior to the resident's death. According to Employee #23, the discussion was documented on the Discharge Summary. When asked about the documentation prior to death regarding the resident's condition, the employee stated that she indicated the resident was "deconditioned."

Upon review of the medical record, the employee acknowledged the findings.

3. The physician staff failed to document rationale for ordering and discontinuing of Buspar [anti-anxiety medication] for Resident #21.

The resident was observed moaning loudly during surveyor rounds on February 13, 2018, at approximately 11:00 AM.

A review of the medical record showed Resident # 21 was admitted to the facility on December 16, 2017, with diagnoses which included: Cardiovascular Accident, Aphasia, C-Diff, Hypertension, and dysphagia.
Resident #21 was admitted to Hospice Care on December 16, 2017.

A review of the physician's orders showed: "January 1, 2018, 3:35 PM start
buspirone (buspar)" 5mg 1 via g-tube for anxiety.
January 3, 2018 D/C (discontinue) Buspar (by family request)".

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A review of the progress notes section showed no entries were documented by a physician to reflect the reason for discontinuing the use of Buspar.

A face-to-face interview was conducted with the physician at approximately 2:30 PM on February 15, 2018.

During the interview, the physician was questioned regarding why Buspar was ordered and then discontinued within 24 hours. The physician responded, ... " It was ordered because the resident was yelling and anxious upon return to the facility and the family as a physician I have a body of knowledge that should supersede her decision ...The resident did not receive any Buspar."

A face-to-face interview was conducted with Employee #3 [unit manager] at approximately 10:30 AM on February 15, 2018. She stated the resident was never given Buspar because the order was canceled before it was dispensed by the pharmacy."

Another face-to-face interview was conducted with Employees #1, 2 and 3 at approximately 12:00 PM on February 16, 2018. The employees acknowledged that the resident ' s medical record lacked documentation regarding the Buspar.

4. The physician failed to acknowledge receipt of the recommendation to adjust Resident #26' medication or to specify a reason for not adjusting the medication.

Resident #26 was admitted on January 12, 2016

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with diagnoses to include Hypertension, Hyperlipidemia, Alzheimer's Disease, Depression, and Thyroid Disorder. Current medications include Levothyroxine 88mcg one tablet daily by mouth at 6:00 AM for Hypothyroidism.

Review of the medical record showed on January 5, 2018, the pharmacist conducted a Medication Regimen Review with recommendations to consider increasing thyroid supplementation to 100 micrograms and recheck thyroid stimulating hormone in four to eight weeks, in six months and then annually.

Further review of the document showed the physician signed the recommendation form; however, there was no indication of whether the physician accepted or rejected the pharmacist recommendation.

As of February 15, 2018 the resident continues to receive Levothyroxine 88mcg daily.

A face-to-face interview was conducted with Employee #3 at approximately 3:00 PM on February 15, 2018.
The employee reviewed the document and acknowledged the finding.

5. The physician failed to acknowledge review of the pharmacist's recommendation for gradual dose reduction to indicate acceptance or rejection.

Resident #33 was admitted to the facility on April 30, 2017 with diagnoses which included Anxiety Disorder and Dementia.

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Review of the physician order show Resident #33 currently Remeron 7.5mg at bedtime for Mood Disorder since May 04, 2017.

Review of the medical record showed on January 5, 2018, the pharmacist conducted a Medical Regimen Review with recommendations to consider a gradual dose reduction of Remeron to 7.5 mg every other day.

Further review of the pharmacist's Consultant Report showed the physician failed to signed the recommendation form indicating acceptance or rejection of the pharmacist recommendation.

A face-to-face interview was conducted with Employee #12 at approximately 11:00AM on February 15, 2018 regarding the physician's failure to acknowledge and respond to the pharmacist's report. The employee was inable to provide insight into the omission of the physician to acknowledge the recommendation.

The physician failed to acknowledge and/or respond to the pharmacist's recommendation to adjust the resident's medication. Employee #3 acknowledged the finding

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

Provider's Plan of Correction (L 031 / L 051):

L 051

1. Care plans for resident #10 and #22 were completed 03/27/18 and care plan for #21 was completed on 03/29/18. Resident #42 has been discharged from the facility.
2. Audits for communication and hospice care plans to ensure care plans are individualized and interdisciplinary will be completed by 04/15/18.
3. The Interdisciplinary team will be educated on individualizing care plans for Hospice and Communication 04/15/18.
4. Nurse Managers or designee will conduct a 20% chart audit monthly to ensure individualized care plans for Hospice and Communication have been completed as needed and will be reported to QAPI monthly.

Complete date: 05/03/18

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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:

Based on observation, record review and interview for four (4) of 25 sampled residents, the charge nurse failed to develop and implement a baseline care plan to address the communication needs for one (1) non-English speaking resident; address the care needs for one (1) resident with a percutaneous trans-hepatic drain care, develop a care plan to reflect hospice needs of one (1) resident, and revise care plan to reflect addition of splints for contracture management and the discontinuation of psychotrophic medication. (Residents #10, 21, 22 and 42).

Findings included...

1. The charge nurse failed to develop and implement a baseline care plan to address the communication needs of a non-English speaking resident.

During a family interview on February 13, 2018,

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the family stated, "If they need something they call me he speaks French, so I am the person that they call if I have to tell him something that they want to do."

A review of the Annual Minimum Data Set (MDS) with a date of August 15, 2017, showed under section A1100. Language A. Does the resident need or want an interpreter to communicate with a doctor or health care staff? The option Yes- has a check mark in the allocated space. B. Preferred Language, French is written in the allotted space.

An observation on February 18, 2018, at 4:00 PM showed Resident # 10 sitting in a religious service held at the facility. Employee# 15, Chaplain, was observed delivering the service in English. Resident# 10 was observed holding the program written in English.

During an interview, Employee# 15 stated yes, I know he speaks French and he attends church services on Sunday. I can be sure that he receives the programs in French from now on.

During an interview, Employee# 3, Clinical Nurse Manager, stated the Resident understands some English, and there is a nurse that speaks French. But we did not create a care plan for his language barrier. We don't use an interpreter. I can create a care plan. We can put it in his chart.

During an interview, Employee# 14, Certified Nursing Assistant, stated the resident speaks French, and she speaks Creole it is not the same language but he can understand some things and with gestures he tries to understand, like if I give him a wash cloth he knows to wash his face.

Charge nurse failed to develop and implement a

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baseline care plan to address the communicate needs of a non-English speaking resident.

Employee# 3 acknowledged the findings.

2. The charge nurse failed to develop and implement a baseline care plan to address Resident #42 's care needs related to a percutaneous trans-hepatic drain.

Resident #42 admitted on November 17, 2018, with diagnoses to included Acute Cholecystitis Status-post Cholecystectomy, Cerebrovascular Accident with left paresis, Hypertension and Atrial Fibrillation.

On November 17, 2017, the physician orders directed the care for the management of the percutaneous trans-hepatic drain and site. Also, the resident was directed to follow-up with Interventional Radiology on November 27, 2017 at 8 AM.

Review of the History and Physical dated November 19, 2017, showed a percutaneous trans-hepatic drain in Resident #42's abdomen status-post right Hemicolectomy.

Review of the baseline care plans initiated on November 17, 2017 failed to show that the facility staff developed an individualized comprehensive care plan to address Resident #42's specialized care needs related to the management of the percutaneous trans-hepatic drain.

During a face-to-face interview with Employee #3 on February 16, 2017, 2:00 PM, the employee was unable to provide further insight into the failure to develop a care plan to address the resident's needs related to the percutaneous

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trans-hepatic drain.

The employee acknowledged the findings at the time of the record review.

3. The charge nurse failed to develop a care plan specifically addressing the resident's hospice care needs.

A medical record review showed Resident was admitted to hospice program on December 16, 2017, with diagnoses which included: Cardiovascular Accident, Aphasia, C-Diff, Hypertension, and dysphagia.

A review of the Physician Order Sheet for the month of `February 2018 directed: Admit to [Name of Hospice Agency] ...with a diagnosis of CVA[Cardiovascular Accident] start date [December 16, 2017].

A review of Resident# 21's care plan on February 13, 2018 at 11:00 AM, failed to show goals and approaches addressing the individualized hospice care and responsibilities of care providers for the resident.. The care plan lacked specific identification of the disciplines (hospice, facility or responsible party).

During a face-to-face interview on January 15, 2018, at 3:00 PM the unit manager acknowledged the findings.

4. The charge nurse failed to revise Resident #22 care to reflect addition of splints for contracture management and the discontinuation

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of psychotropic medication.

Resident #22 admitted with diagnoses to include Dementia, Diabetes Mellitus, Schizophrenia, Hypertension and Psychosis.

An observation on February 14, 2018 at 8:30 AM showed Resident #22's left hand with fingers tightly held in placed. A subsequent observation on February 16, 2018 at 9:47 AM showed Resident #22 lying in bed with left hand held in a fixed position.

Review of the Minimum Data Set dated January 2, 2018, showed the functional limitation in range of motion on one (1) side for both upper and lower extremities.

Review of the medical record on February 16, 2018 at 9: 55 AM showed a physician order dated January 24, 2018 for Occupational Therapy- apply finger separator for bilateral hands at all times except washing.

According to the "Rehab Discharge Program Occupational Therapy" form dated January 24, 2018, the discharge instruction for "Splint/Brace Assistance" directed the nursing staff to apply finger separator on bilateral hand at all time except for washing. The form contained signatures for the Certified Nursing Assistant and Licensed Practical Nurse attesting to receipt of instructions.

Review of the care plans for activities of daily living and rehabilitation showed the facility staff failed to revise the resident's care plan to include the use of finger separator for management of contractures.

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During a face-to-face interview with Employee #10, on February 16, 2018, at 10:00 AM, the employee acknowledge that the care plan was not revise to reflect the resident' use of a finger separator from contracture management.

In addition, review of Resident #22's physician's order showed an order to discontinue Depakote (medication used as a mood stabilizer) dated January 19, 2018.

Review of Psychotropic Drug Use care plan showed Depakote as an intervention related to "Depression and Schizophrenia." The medical record lacked documented evidence the facility staff revised the Psychotropic Drug Use care plan when medication interventions changed.

Employee #10 acknowledged the finding during a face-to-face interview on February 16, 2018. The employee was unable to provide insight into the failure to revise the care plan to accurately reflect the resident's needs.

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

Provider's Plan of Correction

L 051

L 052

1. Resident #11 and Resident #42 have been discharged from the facility. No other residents have been affected.
2. Residents identified with delayed appointments will be reviewed for documentation and physician notification by 04/15/18.
3. Education will be completed with all nurses on documentation and physician notification of all delayed appointments by 04/15/18.
4. Nurse Managers or designee will conduct audits on all doctors' appointments weekly to ensure delayed appointments have proper documentation and physician notification documented and results will be reported to QAPI monthly.

04/15/18

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evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;

(d) Protection from accident, injury, and infection;

(e)Encouragement, assistance, and training in self-care and group activities;

(f)Encouragement and assistance to:

(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(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:

Based on record review and staff interview, the nursing staff failed to ensure three (3) of 25 sampled residents received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by the failure to provide

Provider's Plan of Correction (L 052):

1. Resident #22 had her finger separator applied on 02/22/18.
2. An audit of residents identified that require the use of a finger separator was completed on 02/22/18 with no other residents were affected.
3. Finger separator education was completed by therapy staff with Nurse Managers and nurses on 03/22/18.
4. Nurse Managers or designee will conduct audits weekly on all finger separators to ensure finger separators are applied as ordered and results will be reported to QAPI monthly.

Complete date: 03/30/18

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follow-up care in accordance with physician's order for a percutaneous trans-hepatic drain, in a timely manner for one (1) resident; and failure to reposition one (1) resident every two (2) hours who remain in wheelchair for approximately four (4) hours, and failed to apply hand splints (finger separator) to prevent contractures in a resident with identify limited range of motion. (Residents #22, 42 and 11).

Findings included...

1. The nursing staff failed to ensure receive follow-up medical care in accordance with physician's order for a percutaneous trans-hepatic drain, in a timely manner.

Resident #42 admitted on November 17, 2018, with diagnoses to included Acute Cholecystitis Status-post Cholecystectomy, Cerebrovascular Accident with left paresis, Hypertension and Atrial Fibrillation.
Review of the History and Physical dated November 19, 2017, showed a percutaneous trans-hepatic drain in Resident #42's abdomen status-post right Hemicolectomy.

MDS Admission Assessment dated November 24, 2017 showed Resident #42's Brief Interview for Mental Status (BIMS) score of three (3) indicating severe cognitive impairment.

Review of the admission orders dated November 17, 2017, showed a physician order to provide percutaneous trans-hepatic (PT) drain site care every shift, and empty "PT" drain every shift and document amount. Also, the physician order directed the resident to be seen in follow-up by Interventional Radiology on November 27, 2017 at 8 AM.

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Review of the nursing notes dated November 27, 2017 at 6:59 AM showed the resident was "going for an appointment at 8:00 AM for JP bag removal." On November 27, 2017 at 10:15 PM, the nursing staff documented the resident needs to "rescheduled appointment with Interventional Radiology for removal of PT drain."

The medical record showed that the appointment with Interventional Radiology was rescheduled. The medical record lacked documented evidence to explain why the appointment was rescheduled and if the physician was notified of the delay.

Review of the nursing notes from December 8, 2018, showed Resident #42 was seen by Interventional Radiology for percutaneous drain removal with instruction to leave the dressing in place, keep catheter site clean and dry, and follow-up in six (6) weeks to evaluate, on December 8, 2018. This appointment with Interventional Radiology occurred 11-days after the initial appointment date.

The medical record lack documented evidence of the Interventional Radiology consult report and physician notification of the Interventional Radiology recommendations.

Furthermore, review of the physician's progress notes, from November 30 through December 7, 2017, showed the medical staff did not address the percutaneous trans-hepatic drain, delayed Interventional Radiology appointment, or rationale for continued use of the percutaneous trans-hepatic drain.

On February 15, 2018, Employee #3 was interviewed about the nursing care delivery for the

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percutaneous trans-hepatic drain. Employee #3 stated the drain is managed in accordance with the physician orders. When asked specifically about the appointment scheduled for November 27, 2017, the employee was unable to provide further insight into the reason for rescheduling, or if the physician was notified.

During a face-to-face interview conducted with Employee #23, Physician, on February 15, 2018, at 2:56 PM, the employee stated that Resident #42 had "a lot of medical issues", which she discussed with family on the day prior to her death. When asked if the nursing staff informed her of the appointment delay and the recommendations, Employee #23 could not recall. When asked about care for the percutaneous trans-hepatic drain, Employee #23 stated it was not a problem with the tube remaining in place.

Employees #3 and 23 reviewed the record and acknowledged the findings.

2. The nursing staff failed to reposition the resident every two (2) hours while sitting in a chair in the dayroom.

On February 13, 2018, from approximately 10:00 AM - 2:00 PM (4 hours) Resident # 11 was observed in a recliner chair sitting in the same position in the day room area sitting.

Review of the medical record showed a quarterly Minimum Data Set (MDS) dated November 18, 2017. Resident #11 is moderately impaired; and requires two-person physical assistance for transfer and support dressing for toilet use and

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personal hygiene.

According to the resident's ADL flow sheet for February 2018, the resident received two-person assistance and total care for bed mobility and bathing.

On February 13, 2018, at approximately 2:30 PM, a review of the resident care plan showed the resident has a self-care deficit with an intervention requiring the staff to turn and reposition every two hours.

There was no evidence that facility staff repositioned Resident #11 every two hours on February 13, 2018.

A face-to-face interview was conducted with Employee #7 on February 13, 2018, at approximately 3:30 PM. Employee #7 acknowledged the findings.

3. The nursing staff failed to apply finger separator to prevent contracture for one (1) with limited range of motion of hand.

Resident #22 admitted with diagnoses to include Dementia, Diabetes Mellitus, Schizophrenia, Hypertension and Psychosis.

An observation on February 14, 2018 at 8:30 AM showed Resident #22's left hand with fingers tightly held in placed. A subsequent observation on February 16, 2018 at 9:47 AM showed Resident #22 lying in bed with left hand held in a fixed position.

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Review of the Minimum Data Set dated January 2, 2018, showed the functional limitation in range of motion on one (1) side for both upper and lower extremities.

Review of the medical record on February 16, 2018 at 9: 55 AM showed a physician order dated January 24, 2018 for Occupational Therapy- apply finger separator for bilateral hands at all times except washing.

According to the "Rehab Discharge Program Occupational Therapy" form dated January 24, 2018, the discharge instruction for "Splint/Brace Assistance" directed the nursing staff to apply finger separator on bilateral hand at all time except for washing. The form contained signatures for Employee #25 and Licensed Practical Nurse attesting to receipt of instructions.

During a face to face interview with Employee #25 on February 16, 2018, at 10:00 AM, the employee stated it was the rehab staff's responsibility to apply the splint. Employee #25 was unable to provide insight into the failure to apply the finger separator.

Employee #10, Unit Manager, present at the time of observation and record review, confirmed the findings.

L 056 3211.5 Nursing Facilities — L 056

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

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L 056	Continued From page 22 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 interview during a review of staffing [direct care per resident day hours], it was determined that the Nursing Facility failed to meet the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on one (1) of the ten (10) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. Findings included ... 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 tenth (0.6) hour 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. A review of Nurse Staffing from February 6, 2018, through February 14, 2018, was conducted on February 15, 2018, at approximately 11:00 AM. The following days did not meet the required Registered Nurse (RN) number of 0.6 direct care hours per resident per day:	L 056	**L 056** 1. Additional Registered Nurses (RN) were added to the daily staffing schedule to provide a minimum daily average of 0.6 RN hours of the required minimum four and one-tenth hours of direct nursing care per resident per day. 2. Residents have potential to be affected by the deficient practice. None were affected. 3. The Administrator or designee will educate the staffing coordinator on the importance of ensuring the RN hours are 0.6 each day. 4. The Administrator or Director of Nursing will check the nursing schedule daily for compliance. Results of the daily audits will be reported to the Quality Assurance Process Improvement Committee monthly for 12 months to ensure compliance.	2/23/18

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L 056	Continued From page 23 February 10, 2018 - 0.5 RN direct care nursing hours The findings were acknowledged during a face-to-face interview Employee #1 on February 16, 2018, at approximately 3:00 PM.	L 056	**L 091** 1. Resident #11 no longer resides at the facility. There were no residents identified as being affected. 2. The policies for infection control have been reviewed and updated **on** 03/07/18. A system for monitoring infection surveillance has been instituted 01/2018 and will be ongoing. 3. The facility staff will be in serviced on the updated policies by 04/15/18. 4. The Infection Control program will be monitored monthly by the QAPI committee through the surveillance data monthly.	04/30/18
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 record review and staff interview, the facility failed to review and update Infection Prevention and Control Program (IPCP) as necessary and annually, develop a system of surveillance to identify infections or communicable diseases, and failed to use standard precautions when administering medications. Findings included ... 1. Review of the facility's Infection Prevention and Control Program (IPCP) showed generic policies and procedures without review dates and signatures. During a face-to-face interview on February 16, 2018, at approximately 10:30 AM, Employee #5, infection control Nurse, acknowledged that the policies and procedures have not been reviewed	L 091		

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for updates and changes.

2. A review of the facility's Infection Prevention and Control Program during the look-back period showed a lack of infection control surveillance documentation for the following months; May, June July-September and December 2017.

During a face-to-face interview on February 16, 2018, at approximately 10:30 AM, Employee #5, acknowledged the findings.

3. Facility staff failed to practice standard and transmission-based precautions to decrease the spread of infection by using an ink pen to access medication (calcium carbonate) during a medication pass observation.

During Medication observation conducted on February 14, 2018, at approximately 9:40 AM, Employee #7 was observed popping a pill pouch with an ink pen tip and pouring medication into a cup in preparation to administer to the Resident #11.

A face-to-face interview was conducted on February 14, 2018, at approximately 9:45 AM with Employee #7. When asked about the technique for obtaining medication, the employee acknowledged the finding.

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.

L 091 / L 099 — Provider's Plan of Correction:

L 099

1. On February 13, 2018 the Fire Suppression sprinkler heads were cleaned. No residents were affected.
2. An audit of the fire suppression system for cleanliness was conducted on 2/14/18.
3. Maintenance director or designee will educate maintenance staff on Fire suppression system cleaning by 04/03/18.
4. The maintenance director or designee will audit all fire suppression systems for cleanliness monthly and report finding to QAPI monthly for review and follow up.

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L 099	Continued From page 25 This Statute is not met as evidenced by: Based on observations on February 13, 2018, at approximately 9:30 AM, the facility failed to prepare foods under sanitary conditions, as evidenced five (5) of five (5) fire suppression sprinkler heads that were soiled. The findings included ... Five (5) of five (5) fire suppression sprinkler heads located above the gas stove, the flat top griddle and a grease fryer were soiled with dust and a sticky substance. The observations made, in the presence of Employee #18, were acknowledged.	L 099	**L 115** 1. Resident #20 is currently no longer resides in the facility. 2. An audit of residents with Increase PO fluid orders will be conducted by 04/15/18. 3. Education will be completed with the Licensed Nurses on Increase PO fluid orders by 04/15/18. 4. Nurse Managers or designee will conduct audits weekly for all orders requiring increased fluid intake to ensure fluids are being consumed as ordered results will be reported to QAPI monthly for review.	04/15/18
L 115	3220.9 Nursing Facilities An adequate supply of fresh water shall be available to residents at all times. This Statute is not met as evidenced by: Based on medical record review and interview for 1 of 25 sampled residents facility staff failed to offer sufficient fluid to Resident# 20 to maintain proper hydration. Findings included .... Facility staff failed to show evidence Resident# 20 received 1200 milliliters (ml) of fluid daily in accordance with physicians order. A review of Resident# 20's, Profile Face Sheet showed diagnoses that include: Difficulty in walking, Aphasia following Cerebral Infarction, Muscle Weakness, Gout ... On February 15, 2018, a review of the medical	L 115		

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record showed a physician's order with a date of November 30, 2017 "increase fluid intake to 1200 ml [milliliters mls] per day."

A review of Resident# 20's undated care plan showed "Risk for dehydration, give me increased fluids as tolerated, please provide me fluids during meals, please offer and encourage fluids between meals unless contraindicated ..."

A further review of the treatment administration record (TAR) showed a date of January 2018, in the space allotted, it reads a start date of November 30, 2017, Increase fluid intake to 1200 ml per day between meals for hydration.

Under the section on the TAR for the hour of the day, it reads 10 AM, 2 PM and 7 PM and the percentage (%) of fluid intake. Upon further review of the daily percentage totals recorded for January 2018, there was no evidence Resident# 20 received 1200 mls. of fluid daily.

During an interview with Employee # 10, Clinical Nurse Manager, stated "as I can see here the intake does not total 1200 ml for the days of the month of January and the staff did not fill in the percentages for some of the days, I see what you mean. I don't have the order written on the December TAR or the February TAR, so I can't say if the resident received the additional fluid."

A review of the medical record failed to show evidence Resident # 20 was offered an increase in fluid for the three months (December, January, and February) to maintain proper hydration.

Employee#10 acknowledged the finding.

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INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(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 123 Continued From page 27 L 123

L 123 3223.3 Nursing Facilities L 123

Rehabilitative services shall be provided under a written plan of care which includes modality, frequency, duration, and goals of care.
This Statute is not met as evidenced by:

Based on record review and interview for two (2) of 25 sampled residents rehabilitative staff failed to provide rehabilitative services (speech evaluation) for Resident #10.

Findings included ...

Rehabilitative staff failed to perform a speech evaluation as indicated on an Interdisciplinary Screening form.

On February 15, 2018, a review of the medical record showed an Interdisciplinary Screening form with a date of January 15, 2018, reads "Reason for Screen Nursing Referral, nursing states pt. (patient)[Resident#10] appears to be having difficulty eating, intake has dramatically decreased." Under section Speech therapy Indicators there is a check mark in the box "intake at meals has decreased" ST Eval (Speech Therapy) [sic].

On February 15, 2018, at approximately 1:00 PM, Resident #10 was observed eating (unassisted) comfortably at the table with other residents in the dining area of the facility.

A further review of the medical record showed a Dietician note with a date of January 12, 2018, "cont (continue) to monitor PO (by mouth) intake, resident eats independently in the dining room, avg (average) meal intake approximately 85%....he sometimes has difficulty tolerating mech (mechanical) soft veggies (spits out)."

L 123

1. Resident #10 did not experience any negative outcomes.
2. Rehab screen policy has been reviewed and revised to include a tracking form to ensure therapy screens requiring evaluations are completed by 03/05/18.
3. Rehab director has in-serviced staff regarding therapy screen to evaluation and tracking form on 03/22/18.
4. Rehab Director or designee will conduct audits monthly of all therapy screens to ensure therapy screens that require evaluations are completed and results will be reported to QAPI monthly for review.

03/30/18

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L 123	Continued From page 28 A nursing note with a date of January 12, 2018, showed an Interdisciplinary care plan meeting was held via telephone conference with RP (responsible party) .....he has a good appetite, able to feed self with set-up and eats meals in dining room, weight has been stable over the past 6 months and current weight is 178 lbs..." During an interview with the Employee# 3, Clinical Manager, stated "I am not aware of any problem with the resident having any difficulty with eating, or that this referral was put in I am going to talk to the director right now, nursing should have been informed of this, I did not know anything about this referral, usually they interview the nurse a CNA (certified nursing assistant) may have initiated this and it was not verified by the nurse, as far as I know, the resident did not have a problem with eating." During an interview with Employee# 9, Director of Rehabilitation Service stated, "yes here is our policy, and we did not evaluate the resident because we were waiting to get consent from the family, so we never did the evaluation." There was no evidence facility staff performed a speech evaluation in accordance with the resident's plan of care. Employees# 3 and #9 acknowledged the findings.	L 123	**L 128** 1. Resident #93 has been discharge from facility. 2. An Audit of the Narcotic count will be completed for the accurate count by 04/15/18. 3. Nurses will be educated on completing the Narcotic count for accuracy by 04/15/18. 4. Nurse Managers or designee will conduct audits monthly on all narcotic counts sheets to ensure narcotic counts are accurate and results will be reported to QAPI monthly by.	04/30/18
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at	L 128		

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L 128	Continued From page 29	L 128		

least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;

(b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;

(c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;

(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and

(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.
This Statute is not met as evidenced by:

1. Based on record review and staff interview, it was determined that the facility failed to ensure that in-service training for nursing personnel was conducted by a pharmacist.

Findings included ...

According to the District of Columbia Municipal Regulations for Nursing Facilities: 3224 Supervision of Pharmaceutical Services (3c).

"The supervising pharmacist shall provide a minimum of two (2) in services sessions per year to all nursing employees, including one (1)

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L 128 Continued From page 30 L 128

session that includes indications, contraindications and possible side effects of commonly used medications..."

A review of the in-service training files revealed one (1) pharmacy in-services was provided during the survey look back period, in accordance with state law that included indications, contraindications, and possible side effects of commonly used medications.

The review failed to show the pharmacist conducted a second in-serivce with the staff during the look-back period.

During a face-to-face interview conducted on February 16, 2018, at approximately 2:00 PM Employee # 2 acknowledged the findings.

2. Based on record interview and staff interview for one (1) of two (2) nursing units reviewed for controlled substance reconciliation, it was determined that facility staff failed to consistently maintain records to account for the receipt, usage, disposition and reconciliation of controlled medications.

Findings included ...

A review of the destruction of discontinued controlled II-V substances records unit 1 on February 13, 2018, at approximately 3:00 PM, showed; The allotted spaces Physician names

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were blank.

There were no accompanying individual medication sheets attached to verify the reconciliation of controlled substances

L 138 3225.5 Nursing Facilities — L 138

The attending physician shall record on the resident's medical record each condition for which the medication has been ordered.

This Statute is not met as evidenced by:

Based on observation, record review and staff interview for one (1) of 25 sampled residents facility staff failed document rationale for ordering and discontinuing of Buspar [anti-anxiety medication] for Resident #21.

Findings included ...

The resident was observed moaning loudly during surveyor rounds on February 13, 2018, at approximately 11:00 AM.

A review of the medical record showed Resident # 21 was admitted to the facility on December 16, 2017, with diagnoses which included: Cardiovascular Accident, Aphasia, C-Diff, Hypertension, and dysphagia.

Resident #21 was admitted to Hospice Care on December 16, 2017.

A review of the physician orders showed: January 1, 2018, 3:35 PM start buspirone (Buspar)" 5mg 1

L 138

1. Resident #42 no longer resides in the facility. Resident #22 area of discoloration has resolved. Resident #21 was not affected by this deficient practice.
2. An audit of residents with change in status notification and newly-ordered medications refused by the family will be conducted for timely MD documentation by 04/15/18.
3. The Medical Director will educate the Physicians on timely documentation with change in status and for the need to document discussions regarding refusal by family of newly-ordered medications by 04/15/18.
4. Medical Director or designee will conduct 10% chart audits for residents with change in status and family refusals of newly-ordered medications

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via g-tube for anxiety January 3, 2018 D/C (discontinue) Buspar (by family request).

A review of the progress notes section showed no entries were documented by a physician to reflect the reason for discontinuing the use of Buspar.

A face-to-face interview was conducted with the physician at approximately 2:30 PM on February 15, 2018.

During the interview, the employee was questioned regarding why Buspar was ordered and then discontinued within 24 hours. The physician responded, ... " It was ordered because the resident was yelling and anxious upon return to the facility and the family requested that it be discontinued ...The family doesn't always make decisions that are in the best interest of the resident and I feel as a physician I have a body of knowledge that should supersede her decision ...The resident did not receive any Buspar."

A face-to-face interview was conducted with Employee #3 [unit manager] at approximately 10:30 AM on February 15, 2018. She stated the resident was never given Buspar because the order was canceled before it was dispensed by the pharmacy."

Another face-to-face interview was conducted with Employees #1, 2 and 3 at approximately 12:00 PM on February 16, 2018. The employees

Provider's plan of correction:

to ensure timely physician documentation has occurred and results will be reported to QAPI monthly.

Complete date: 04/30/18

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acknowledged that the resident ' s medical record lacked documentation regarding the Buspar.

L 170 3228.2 Nursing Facilities — L 170

Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees.
This Statute is not met as evidenced by:
Based on a review of records and interview, it was determined that the facility failed to ensure that in-service training for nursing personnel was conducted by a podiatrist.

Findings included ...

A review of the in-service training files revealed no podiatry in-services were provided during survey look back period, in accordance with state law.

The facility was unable to provide documentation to support podiatry in-serving during the survey look-back period.

The findings were acknowledged during a face-to-face interview with the Employee # 1 on February 16, 2018, at approximately 3:00 PM.

L 170

1. Podiatrist was informed of the non-completion of in-service training for nursing staff as required by Federal and State regulations. In-service is scheduled and will be completed on 4/5/18.

2. All District and Federal required in services were reviewed and scheduled at specific times throughout the year. Podiatrist will be notified by the Staff Educator when those in-services are due. No residents were affected by the deficient practices.

3. Monthly in-service review will be conducted by the Staffing Educator to review in-services that were completed and reschedule as needed. Record or in-services and staff attendance will be kept by the staffing coordinator.

4. Any required in-services that were not completed during the month or had to be rescheduled will be reported to the monthly QAPI meetings for review and follow up.

4/2/18

L 180 3229.2 Nursing Facilities — L 180

A nursing facility with more than 120 beds shall employ a full-time social worker who is licensed in the District of Columbia pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986, D.C. Law 6- 99, D.C. Code section 2-3301 et seq.

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L 180 (Summary Statement of Deficiencies)

This Statute is not met as evidenced by:
Based on record review and staff interview for seven (7) of 25 sampled residents, the facility failed to ensure that medically related social services were supervised by qualified staff. Resident #'s 11, 21,33,93,192, 243,and 244.

Findings included ...

District of Columbia Municipal Regulations for Social Work; 7012 Supervision of Practice 7012.1 The following persons may practice under supervision: (b) A licensed graduate social worker ...

A review of the facility ' s job description for " Director of Social Services included: Job Summary - " This position is primarily responsible for providing psychological needs and services to residents in the Health Center, especially at times of application, transition, or crisis through timely assessments, counseling, education, support services, and referrals ..."

A review of full-time Social Worker employee record on February 16, 2018, at 1:30 PM showed she is a licensed graduate social worker(LGSW).

1. A review of the provision of social services for Resident #11 showed "IDT[Interdisciplinary Team] (SSD, DON, AD, dietician) met for a care plan meeting with resident's guardian. Resident is LTC [long-term care]. Resident prefers to feed herself. Medication changes were reviewed. Resident is taking ensure plus. Her weight has been stable for the last six months. Resident does not choose to attend group activities for the

L 180 (Provider's Plan of Correction)

1. A licensed clinical social worker (LICSW) has been hired by the facility on March 21, 2018 to supervise the graduate Social Worker.

2. Residents #11, #21, #33, #93, #192, #243, and #244 suffered no negative outcome from the deficient practice. The LICSW will audit charts of all other resident to ensure compliance with Social Work regulations.

3. The LICSW will be in the facility weekly to provide necessary supervision for the graduate social worker.

4. The LICSW will communicate with the Administrator on any event that will prevent her from performing her contracted duties. The report will be forwarded to the QA committee monthly.

Complete date: 3/30/18

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most part. Code status was reviewed and resident remain full code, Social Services will continue to support "eSignature by the [Employee Name] 01/12/2018, 11:36".

2. A review of the provision of social services for Resident #21 was conducted. The clinical record showed " IDT (SSD, DON, AD, dietician) met for a care plan with resident's daughter who was present by telephone. Resident is LTC (Long term care) and hospice. Medications and labs were discussed, Social Services will continue to support. "eSignature by the [Employee Name] 12/19/2017 14:29:58".

3. A review of the provision of social services for Resident #33 was conducted. The clinical record showed a social service entry documented by the Graduate Social Worker 1/23/2018 that read, " SSD saw [Resident's Name] and asked him how he is today. He said everything is fine and he is doing well." eSignature by the [Employee Name] 02/07/20187 12:53:16".

4. A review of the provision of social services for Resident #93 was conducted. The clinical record showed a social service entry documented by the Graduate Social Worker 2/07/2018 at 12:53, that read, " SSD called and arranged for application to be sent for resident to apply for housing at senior housing in DC. Scheduled a care plan meeting for February 13 at 11:00 am.". " eSignature by the [Employee Name] 12/19/2017 14:29:58".

5. A review of the provision of social services for Resident #192 was conducted. The clinical record

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showed a social service entry documented by the Graduate Social Worker 02/06/2018 at 14:06, that read, " IDT (SSD, DOR, dietician, AD, RN) met with resident, his wife, and his son for a care plan meeting. In therapy, resident is working on strength and independence. Resident has been upgraded to chopped meats The goal for activities is to provide in-room activities. Medications were discussed. Social Services will continue to provide support. Code status was reviewed and resident is a DNR(Do not resuscitate).

6. A review of the provision of social services for Resident #243 was conducted. The clinical record revealed a social service entry documented by the Graduate Social Worker 02/10/2018 at 15:01, that read, " SSD spoke to [family member], gathered and faxed relevant information to an ALF(Assisted living facility) where [family member] is interested in having her go." " eSignature by the [Employee Name]".

7. A review of the provision of social services for Resident #244 was conducted. The clinical record revealed a social service entry documented by the Graduate Social Worker 02/10/2018 at 14:06 " SSD met with [Resident's Name] [family member] and she will bring in a copy of the advance directive she has at home. Care plan meeting scheduled for February 13th. Resident refused to do BIMS (Brief Interview for Mental Status) and mood assessment. eSignature by the [Employee Name]"

A review of personnel files revealed one (1) Graduate Social Worker Director, Employee # 4 is employed by the facility on a full-time basis. Resident records revealed that initial social

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service assessments, .quarterly social service summaries, social service progress notes, evaluation of abuse allegations, significant change evaluations, and notification of a change in skilled services notices were conducted by the Social Service Associates in the absence of required oversight and supervision.

There was no evidence the Graduate Social Worker was performing her services under the supervision of an Licensed independent social worker (L.I.S.W) or Licensed independent clinical social worker (L.I.C.S.W.).

During a face- to- face interview with the LGSW on February 16, 2018, at 2:00 PM she acknowledged that there was no supervision of her practice since she was hired in November 2017 and that she was the only social worker employed in the facility.

L 191 3231.2 Nursing Facilities (L 191)

A designated employee of the facility shall be assigned the responsibility for implementing and maintaining the medical records service.
This Statute is not met as evidenced by:

Based on record review and interview for two (2) of 25 sampled residents, the facility staff failed to ensure that each medical record included a quarterly inventory of the residents personal clothing, belongings, and valuables. Residents #11, and 22.

Findings included ...

1. A review of the Resident # 11s medical record

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L 191	Continued From page 38 showed an " Inventory List " on February 15, 2018, showed an inventory list dated and signed on 1/28/2015. There was no evidence that staff documented quarterly inventory lists beyond that date. Employee #3 acknowledged the findings during a face-to-face interview on February 15, 2018, at 10:00 AM. 2. A review of the Resident 22' s medical record showed an showed an inventory log dated and signed on May 26, 2016 . There was no evidence that staff documented quarterly inventory list in the medical record. Employee #10 acknowledged the findings during a face-to-face interview on February 15, 2018, at 10:00 AM.	L 191	**L 191** 1. Residents #11 and Resident #22 no longer reside in the facility. We cannot retroactively correct the record. 2. An audit was conducted by the medical records coordinator to determine if other residents were affected by the deficient practice. No other residents were affected. 3. The Administrator or designee will educate the Unit Managers the importance of implementing, maintaining, and updating inventory logs quarterly and as needed. 4. The Unit Manager or designee conduct chart audits quarterly for compliance. The report will be forwarded to the QA committee monthly for review and follow up.	04/15/18
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;	L 201		

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L 201	Continued From page 39 (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, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing	L 201	**L 201** 1. Resident #192 has had no negative outcome. MD was made aware and spoke with the resident and family to ensure an accurate code status was obtained and an order was written 02/15/18. 2. An audit was completed on 03/28/18 to ensure that documentation on code status is accurate. Other residents were noted to be affected and orders have been corrected by 04/02/18. 3. Education will be completed with Nurses, Social Services and Physicians regarding code status documentation by 04/15/18. 4. Social services or designee will audit 20% of orders for accuracy of Advance Directives monthly and will be reported to QAPI monthly for review and follow up.	03/30/18

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service;

(n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;

(o)The plan of care;

(p)Consent forms and advance directives; and

(q)A current inventory of the resident's personal clothing, belongings and valuables.

This Statute is not met as evidenced by:

Based on record review, and staff interview for one (1) of 25 sampled residents, the facility failed to establish a mechanism to accurately communicate the resident's advance directive and code status to the interdisciplinary team and direct care staff to ensure the resident wishes were clear (Resident #192).

Findings include ...

The facility failed to establish a mechanism to accurately communicate the resident's advance directive and code status.

Resident #192 admitted on January 31, 2018, with diagnoses to include Altered Mental Status, History of Cerebrovascular Accident.

Review of the medical record February 15, 2018, 8:34 AM showed the admission "Physician Order Sheet and Plan of Care" recorded the Advance Directives for Resident #192 as "No CPR [Cardiopulmonary Resuscitation] (see

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Documentation)" dated January 31, 2018.

Further review of the medical record, the physician's "History and Physical" dated February 2, 2018 showed the area reserved for documentation of the "Advance Directive" determination was documented as "unknown."

Review of the care plan note dated February 2, 2018, by the nursing care staff, showed that the resident was a "Full Code" (all resuscitative measures to be delivered in the event of a cardiac arrest). On the contrary, the social worker note from the same interdisciplinary care team meeting held on February 2, 2018, showed that the resident's code status was "DNR [do not resuscitate]."

During a face-to-face interview with Employee #4 on February 15, 2018, the employee stated that she had not provided information related advance directive policies and procedures to the resident or family representative. When asked about the conflicting code status documentation from nursing and social work after the interdisciplinary team meeting, Employee #4 stated she followed the order in the chart.

During a face-to-face interview, Employee #10, Registered Nurse Manager, stated advance directives are discussed in the interdisciplinary team meeting. When asked about the conflicting documentation in the medical record regarding resident advance directives and code status, the employee stated that she cannot explain the conflicting documentation. Employee #10 stated the usually all resident and their family member complete and sign the "Direction Regarding Life-Sustaining Measure" form; however, the signed form could not be located. When asked

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how the staff is able to readily identify a resident's code status, she stated a sticker is placed in the chart. She was unable to provide insight into why the social services and nursing notes from the interdisciplinary team meeting shows conflicting code status.

During a face-to-face interview conducted with Employee #23, physician, on February 15, 2018, at approximately 3:15 PM, the employee stated that during the admission history and physical assessment, the resident indicated that he had an advance directive. However, the resident refused to provide details related to the advance directives. As a result of the resident's refusal to disclose details related to advance directives, Employee #23 documented the advance directives as "unknown." When asked about the physician order signed on January 31, 2018, for 'No CPR', the employee could not provide an explanation for signing the order. Instead, the employee asked if the information contained on the form was necessary. The employee further explained that advance directives are discussed in the interdisciplinary team meeting. When shown the conflicting documentation in the medical record from the interdisciplinary team meeting, the employee stated she was unaware. No further insight was given.

Employee #10 confirmed the medical record contained conflicting information related to the advance directives and code status for Resident #192.

L 204 3232.2 Nursing Facilities — L 204

A summary and analysis of each incident shall be completed immediately and reviewed within

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forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:

(a)The date, time, and description of the incident;

(b)The name of the witnesses;

(c)The statement of the victim;

(d)A statement indicating whether there is a pattern of occurrence; and

(e)A description of the corrective action taken.

This Statute is not met as evidenced by:

Based on record review, and staff interview of one (1) of 25 sampled residents, the facility failed to conduct an investigation for an injury of unknown origin to provide a summary of the incident, determine possible cause or need for corrective action with forty-eight hours of the incident (Resident #22).

Finding include ...

The facility failed to conduct an investigation to determine possible cause and need for corrective action within forty-eight hours of the incident.

Resident #22 admitted with diagnoses to include Dementia, Schizophrenia, and Hypernatremia.

Review of the medical record on February 16, 2018 at 1:35 PM showed the nursing staff documented the presence of a discoloration around the right eye of Resident #22 on January 25, 2018, measuring 2 X 3 X 0 centimeters discovered during routine evening care. However, the medical record lacked documented evidence

L 204

1. Resident #22 discoloration has resolved. No other residents were affected.
2. All injuries of unknown origin will be reviewed to ensure a complete investigation has occurred by 04/15/18.
3. Nurse Managers and Supervisors will be educated on conducting an investigation for Injuries of Unknown origin by 04/15/18.
4. Nurse Managers or designee will conduct audits weekly to ensure complete investigations have occurred for all injuries of unknown origin and will be reported to QAPI monthly for review and follow up.

04/30/18

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to indicate the cause of the discoloration.

According to the Minimum Data Set (MDS) dated July 3, 2017, the resident is moderately impaired cognitive skills for daily decision making, requiring extensive assistance of two (2) or more for bed mobility, transfers, dressing, and toilet use.

Review of the nursing note dated January 25, 2018, at 8:27 PM, the nursing staff notified the physician and no new orders were received.

During a face-to-face interview with Employee #24, Director of Nursing, the employee stated that he was unable to find documentation of an investigation related to the incident.

In a follow-up interview with Employee #1, Administrator, the employee confirmed that the facility notified the state agency; however, documentation of an investigation was not available for review.

L 214 3234.1 Nursing Facilities (L 214)

Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public.
This Statute is not met as evidenced by:

Based on observations made on February 13, 2018, at approximately 11:45 AM, the facility failed to provide an environment that is free from accident hazards as evidenced by a portable heater that was observed in one (1) of 23 resident's rooms.

The findings included ...

L 214

1. Portable heater was removed from resident's room 186 immediately.
2. An audit of residents rooms was conducted on 02/21/18 and no other resident room were identified with portable heaters.
3. The Facilities Director or designee will educate maintenance staff to identify portable heaters in resident room during daily rounds by 04/3/18.
4. Maintenance Director or designee will conduct audits daily to ensure portable heaters are identified and removed from resident rooms and results will be reported to QAPI monthly.

04/30/18

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One (1) of one (1) portable heater was observed in resident room #186 located on the upper level, one (1) of 12 resident's rooms.

This observation was made in the presence of Employee #16 and employee #17 who acknowledged the finding.

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 on February 13, 2018, at approximately 2:30 PM, the facility staff failed to provide housekeeping services necessary to maintain a sanitary environment as evidenced by soiled exhaust vents in six (6) of 23 resident rooms and rusted and soiled air conditioning units in three (3) of 23 resident rooms.

Findings included ...

1. Exhaust vents in six (6) of 11 resident rooms located on the Lower Level of the facility, were soiled with dust,
specifically rooms # 070, #073, #084, #086, #089 and #096.

2. Air grills from packaged terminal air conditioners (P-TAC) were rusted and soiled in three (3) of 12 resident rooms
on the Upper Level (#177, #196, and #199).

L 214

L 410

L 410

1. Exhaust vents for rooms 070, 073, 084, 086, 089, and 096 were cleaned on 02/22/18.

   The PTAC units in room 177,196 and 199 have been cleaned and repaired on 02/22/18.

2. An audit of all healthcare center rooms was on 2/21/18 to ensure that no other rooms were affected. All findings were corrected during the audit.

3. The Maintenance Director or designee will conduct education on a Safe, Clean, Home- like environment for housekeeping and maintenance by 04/05/18.

4. The Maintenance supervisor will complete audits of 6 rooms weekly and the results will be reported to QAPI monthly for review and follow up.

04/2/18

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L 410	Continued From page 46 Employee #16 and Employee #17, present at the time of observations, acknowledged the findings.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made on February 13, 2018, at approximately 11:45 AM, the facility failed to maintain an effective pest control program as evidenced by a rodent that was spotted in one (1) of 12 resident's rooms and mouse traps that were noted in six of 12 resident's rooms on the upper level. The findings included ... 1. A rodent was seen moving through one (1) of 12 resident's rooms (#186) and running under the air conditioning unit. 2. Mouse traps were observed behind dressers, next to air conditioning units or along the walls in six (6) of 12 resident's rooms located on the upper level (Rooms #176, #177, #180, #181, #186, #187). These observations were made in the presence of Employee #16 and employee #17 who acknowledged the findings.	L 426	**L 426** 1. Pest control was notified immediately on 02/13/18 to treat room 186, 176,177,181,186, and 187. 2. All resident rooms were treated for pest control and were no other rooms identified as being affected. This is an ongoing process. 3. The maintenance director will in-service maintenance staff to ensure pest control services are scheduled and occurring weekly by 04/15/18. 4. The maintenance director will monitor weekly to ensure all scheduled pest services are occurring and report to QAPI monthly to monthly for review	ongoing
L 430	3258.1 Nursing Facilities The facility shall have detailed plans and procedures to meet all potential emergencies and	L 430		

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disasters such as fire, severe weather, and missing residents.

This Statute is not met as evidenced by:
Based on record review and staff interview, the facility failed to develop and maintain an emergency preparedness plan which included a facility-based and community-based risk assessment, policies and procedures that ensure continuity of business, and ensures collaboration with local emergency preparedness officials. The facility census was 44.

Findings included ...

On February 14, 2018, at 2:48 PM, review of the facility's "Emergency Preparedness and Response Policy and Procedure Manual" revised January 2011 showed a 'Facility Hazard Vulnerability Assessment' and an Emergency Action Plan located in the inside pocket. The completion dates of the facility hazard vulnerability assessment and emergency action plan are unknown.

The Emergency Action Plan indicated that emergency medical supplies and equipment are available in central supply room to include "at least one (1) intravenous cut-down tray". Also, each nurses' station and each director's office has a list of agencies, vendors, etc. to contact for additional supplies and equipment and a record of available supplies and equipment is also kept on file in each location. Furthermore, many sections of the Emergency Action Plan were left blank in areas that a template was provided such as alternate facilities, transportation, Evacuation Route Planning, Shelter-in-Place Considerations, Outside Evacuation Assembly Areas, Building Captains, and Maps.

L 430

1. Ingleside at Rock Creek's (IRC) Emergency Preparedness and Response Policy and Procedure Manual, including the Emergency Action Plan, is being revised by the Senior Leadership team. A revised plan will be put into place by 4/2/18 after Life Safety Compliance Review. A fully customized Emergency Procedure Manual will be delivered to IRC by April 19, 2018.

2. Residents have potential to be affected by the deficient practice. None were affected.

3. The Administrator or designee will educate facility staff on the hazard vulnerability assessment and its content by May 3, 2018. Staff will be notified of where the document is located in the emergency plan.

4. The Administrator or designee will review the emergency plan and its components annually and update as needed. The Administrator or designee will report the findings of the annual review and updates at the quarterly QAPI meetings.

05/03/18

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A tour of the facility failed to show the facility maintained the intravenous cut-down tray, list of supplies and vendors, and other items as indicated in the action plan.

During a face-to-face interview with Employee #16 and 13 on February 14, 2018, Employee #16 stated that the Emergency Preparedness Program is in development and has not been implemented. According to Employee #16, the administrative leadership has received training concerning emergency preparedness; however, the other staff has not been trained on the emergency preparedness aside from fire safety and a missing resident.

When asked about the Emergency Preparedness and Response Policy and Procedure Manual provided to the survey team for review, the employee indicated that the manual provided is outdated and had not been revised to meet the new requirements. When asked to provided further insight into signatures affixed to several pages of the manual indicating revisions February 2018. Employee #16 acknowledged the signature, however, could not provide further insight.

Employee #16, Director of Facilities Management, confirmed the facility failed to develop and maintain an emergency plan.