Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0022	A. BUILDING: _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOLLWOOD HSC	6200 OREGON AVE NW WASHINGTON, DC 20015

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L 000	Initial Comments The Annual Survey was conducted at Knollwood HSC from May 25, 2021 through June 2, 2021. Survey activities consisted of a review of 18 sampled residents. The following deficiencies are based on observation, record review, resident, and staff interviews. It was determined that the facility is not in compliance with the requirements of Title 22B DCMR. The resident census during the survey was 43. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day BIMS - Brief Interview for Mental Status B/P - Blood Pressure cm - Centimeters CPR - Cardiopulmonary resuscitation CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility	L 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Knollwood HSC does not admit that the deficiencies listed on the HRLA statement of deficiencies exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

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L 000	Continued From page 1	L 000		

DVT - Deep Vein Thrombosis

D.C. - District of Columbia

DCMR- District of Columbia Municipal Regulations

D/C Discontinue

Dl - deciliter

DMH - Department of Mental Health

EHR - Electronic Healrh Record

EKG - 12 lead Electrocardiogram

EMS - Emergency Medical Services (911)

ESRD - End Stage Renal Disease

G-tube Gastrostomy tube

HR- Hour

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

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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

O2- Oxygen

PASRR - Preadmission screen and Resident Review

Peg tube - Percutaneous Endoscopic Gastrostomy

PPE - Personal Protective Equipment

PO- by mouth

POS - physician's order sheet

Prn - As needed

Pt - Patient

Q- Every

QIS - Quality Indicator Survey

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L 000	Continued From page 3 RN - Registered Nurse ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on records review and interview, it was determined that facility staff failed to ensure that persons in charge, who are certified food protection managers, obtained a District of Columbia issued Food Protection Manager Identification Card. The findings include: During records review in dietary services on May 25, 2021, at approximately 11:00 AM, two (2) of five (5) designated persons in charge did not have a current District of Columbia issued Food protection Manager Identification Card as required by the 2012 District of Columbia Food	L 012	1-The two managers identified are enrolled in an on-line class that takes 16 hours to complete and are scheduled to go to take the exam by the end of July. They will then receive Servesafe certification that is needed to go to DC health department and get the Food Protection Manager ID card.	

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L 012	Continued From page 4 Code, section 203.3 of Chapter 2 which states the following: "2012 District of Columbia Food Code 203 Certification and District -Issued ID Requirements -Food Protection Manager, Person in Charge 203.3 A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years." Employee #7 acknowledged the findings during a face-to-face interview on May 27, 2021, at approximately 1:00 PM.	L 012	2- There were no other staff that required the District of Columbia issued Food protection Manager ID card. 3- The Food Services Director and the Operations Manager have become Proctors and are able to provide the training for staff required to have the District of Columbia Food Protection Manager certification. Any staff required to have the certification will receive their training at the facility. 4- The Food Services Director or the Operations manager will audit new managers who require the certification monthly for 6 months.	7-28-21
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	L 051	It is Knollwood practice to implement supervision of resident as outlined in the Care plan and according to the resident's needs. It is Knollwood's policy to label irrigation syringes used with Gastrostomy tubes. It is Knollwood policy to change masks used to provide nebulizer treatments weekly.	

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L 051	Continued From page 5 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 staff interview, the charge nurse failed to implement supervision as outlined in the Fall's Care Plan for one (1) resident; to ensure one (1) resident receiving enteral feedings received appropriate care to prevent complications; and to provide the specialized care needs for a resident receiving nebulizer treatments in accordance with the professional standards of practice for one (1) resident. Residents' #5, #10, and #19. The finding include: 1. The charge nurse failed to implement supervision as outlined in the Fall's Care Plan for Resident #5. Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, Legal Blindness and Spinal Stenosis. Review of a Quarterly Minimum Data Set (Assessment Reference Date of 06/05/2020), documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 12, indicating the resident was cognitively intact. In Section E	L 051	1-a- Some of the way supervision of resident #5 has been achieved as outlined in the fall care plan were: providing supervision during shift rounds, medication administration, meal delivery and after meals, during activity of daily living. 1-b-The irrigation syringe used for resident #10 gastrostomy tube was changed immediately 5/25/21 and labelled with the correct date. 1-c- The nebulizer mask for resident #19 was changed immediately 6/2/21. 2-a-An audit of residents who have sustain a fall in the past 60 days will be reviewed by the MDS coordinator or Designee. Supervision provided to those residents will reflect what is outlined in the Fall care plan. 2-b- There are no other resident with a gastrostomy tube.	

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L 051	Continued From page 6 (Behavior), resident was not coded for psychosis, rejection of care or wandering. In Section G (Functional Status), the resident was coded for needing extensive assistance with the assistance of one person for ambulation in room and toileting use. In Section H (Bladder and Bowel) - the resident was coded for frequent incontinence of both bladder and bowel. In Section I (Active Diagnosis)- the resident was coded for diagnoses of Dementia, Parkinson s Disease, and Manic Depression. And in Section J (Health Condition) - the resident was coded for having one (1) fall with major injury since admission/entry/reentry. Review of the resident's record revealed the following sequence of events: "03/07/20 at 8:30AM (Nursing Note) Resident observed sitting on the floor in bathroom. Alert, oriented, able to verbalize what happened. Resident stated she lost her balance while doing oral care in sink ...Verbalized she hit right side of her head and right side of her shoulder in the toilet bowl ..." Review of the radiology report revealed: "03/09/20 at 6:47 PM (Bilateral Ribs and AP [anteroposterior] chest X-ray) - There is a diffuse sever bony demineralization, which limits the diagnostic capability of the study. There is a fracture of the 2nd right rib posteriorly with minimal displacement. No other acute bony abnormalities are seen. Irregularities are seen of the left ribs compatible with old fractures and there is an old fracture of the left clavicle. Impression: 1. Fracture of the right 2nd rib posteriorly. 2. No acute pulmonary infiltrates."	L 051	2-c- An audit of residents receiving nebulizer treatment was conducted 7/6/21, all the masks were changed within the week. 3-a- Licensed nurses will be in-serviced by the MDS Coordinator by 7/20/21 regarding: - The identification of residents' needs during assessment to prevent falls - Implementation of Person Centered interventions noted in the Care plan - Documentation of supervision of these residents 3-b- Licensed nurses will be in serviced to check the date on the Gastrostomy before using it to make sure that the syringe the one they need to use for the day. Licensed nurses will be reminded to follow physician's order on when to change the irrigation syringe. 3-c- Licensed nurses will be reminded to change and date masks used to administer nebulizer treatments as ordered.	

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L 051	Continued From page 7 "03/09/20 at 10:47 PM (Nursing Note) Resident alert and verbal. Xray done, result of chest C-Rays (sp) shows fracture of right 2nd rib posteriorly ..." Review of the care plan (fall) with a start date of 03/10/2020 revealed: Goal: will minimize injuries related to falls. The care plan outlined multiple approaches for the facility's staff to address the resident problem of falls that included: -Increased staff supervision with intensity based on resident's need. -Bed alarm in place. -Implement [an] exercise program that targets strength, gait, and balance. Care Plan (Activity of Daily Living (ADL)/ Rehabilitation Potential Self-Care) with a start date of 03/10/20. Goal: All her ASL (sp) will be anticipated and met by staff on daily basis. The care plan outlined multiple approaches for the facility's staff to address the resident problem with ADLs that included: -Assist with ... personal hygiene... -Assist with ... mobility, transfers, and locomotion. "06/17/20 at 4:23 PM (Nursing Progress Note)- This writer was at the end of the hall at 4:05 PM, Resident seen coming out of room. Upon getting closer to resident's room, a audible screeching sound heard. Upon entering resident's room, resident noted in supine position in entrance way of room door. Commented she was looking for bathroom assist and went to turn around and go into bathroom and fell on left hip. Resident c/o (complained of) left hip pain ..."	L 051	4-a-An audit of 10% of residents, who are at risk for fall will be completed weekly X 4 then Monthly X 4 then Quarterly to ensure that interventions in the care plan are documented to show staff monitoring of residents safety. 4-b- An audit of residents with a gastrostomy tube will be conducted to ensure that the irrigation syringe is appropriately dated and labelled. The audit will be conducted weekly X 8 then monthly 4 then quarterly. The result of this audit will be presented to the Quality Assurance Performance Improvement Committee for further recommendations. 4-c- An audit of residents receiving nebulizer treatment will be conducted weekly X 8 then monthly X 4 then Quarterly to ensure that mask used to administer Nebulizer treatments are changed weekly as ordered. The result of this audit will be presented to the Quality Assurance Performance Improvement Committee for further recommendations.	7-28-21

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L 051	Continued From page 8 "06/17/20 at 5:22 PM (Nursing Progress Note) - 2 Ambulance staff arrived. Resident transferred via stretcher, resident conversing with ambulance staff at this point. No change mentation. Scheduled to go to [hospital's name] for evaluation ..." "06/18/20 (Physician's Order)- Transfer to [hospital ' s name] ER (emergency room) for Further eval (evaluation) & TX (treat) left hip pain and fall." "06/21/20 (Nursing Progress Note)- Admission Note: Resident alert and oriented to time, place and person, arrived on the unit at 1:15PM accompanied by 2 paramedics, readmitted to room [room number] ...left hip noted with two surgical incision sites, upper left hip site with six intact staples and slight serosangenous (sp) exudate, lower left hip with nine intact staples with no drainage noted, resident is non weight bearing at this time ..." Review of nursing notes, medication and treatment records from 03/10/2020, to 06/17/2020, lacked documented evidence that facility staff provided intense supervision (to include to type and frequency) based on the resident's assessed needs to minimize injuries related to falls, as outlined in the previously mentioned care plan. During a face-to-face interview on 06/02/2021, at approximately 3:00 PM, Employee #5 (RN/ Unit Charge Nurse) stated that intense supervision is every two hours. She also said that nurses may or may not document supervision in their nursing notes.	L 051		

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L 051	Continued From page 9 2. The Charge nurse failed to ensure a resident receiving enteral feedings received appropriate care to prevent complications. Resident #10. Resident #10 was admitted to the facility 03/11/2020, with diagnoses that included: Anemia, Hypertension, Dysphagia (Oropharyngeal Phase), and Gastrostomy Status. A physician's order dated 03/11/2020, revealed, " Enteral Feeding: Change G [gastrostomy] Tube irrigation set QD [every day] Once a Day 09:00 AM". Review of Resident #10's care plan for the focus area, "Feeding Tube" created on 11/04/2020, revealed the approach, "change feeding syringe label with date and time daily". During an observation inside of Resident #10's room on 05/25/2021, at approximately 11:15 AM, it was noted that there was an unlabeled syringe irrigation set at the resident's bedside. During a face-to-face interview conducted on 05/25/2021, at approximately 11:15 AM with Employee #4 (Licensed Practical Nurse), when asked if she used the irrigation set observed at Resident #10's bedside, she stated that she did use that syringe irrigation set to feed and administer Resident #10's morning medications and feeding. At the time of the interview, Employee #4 acknowledged the findings and proceeded to change and label a new syringe irrigation set.	L 051		

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L 051	Continued From page 10 3. The Charge nurse failed to provide the specialized care needs for a resident receiving nebulizer treatments in accordance with the professional standards of practice. Resident #19. Resident #19 was admitted to the facility on 03/09/2021, with diagnoses that included: Asthma, Hyperlipidemia, Muscle Weakness, and Hypertension. A physician's order dated 03/09/2021, revealed, "Start Date Change neb [nebulizer] mask every week on Wednesdays (3-11 PM shift) ...". Review of the Treatment Administration Record for May 2021 revealed that facility staff signed off in the area that documented, "Change neb [nebulizer] mask every week on Wednesdays (3-11 PM shift)" indicating that it was done on the date 05/26/2021. During an observation of Resident #19's room on 06/02/2021, at approximately 10:30 AM, revealed a nebulizer treatment set at the resident's bedside with a pink label that was dated, "5/19/21". During a face-to-face interview conducted with Employee #5 (Charge Nurse) on 06/02/2021, at approximately 10:35 AM, she stated, "The nebulizer mask should have been changed. There's an order to it change every Wednesday."	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident	L 052		

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L 052	Continued From page 11 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 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,	L 052	It is Knollwood's Practice to ensure that residents who had a recent history of pressure ulcer receive monitoring of the area to decrease the potential of reoccurrence of a pressure ulcer. Note: Some of this has been achieved for resident # 5 by observation of her skin by the Certified Nursing Assistant during Bed bath and Incontinence Care. It is Knollwood's Certified Nursing Assistants practice to report any change in skin integrity to the Charge Nurse that they might observe during care. This was verified as the surveyor interviewed several of our Certified Nursing Assistants. Also, the Treatment Administration record shows that resident # 5 received daily application of Calmoseptine by the Medication Nurse between 10/30/20 and 11/4/2021. 1- Resident # 5 pressure ulcer on the coccyx is healed.	

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L 052	Continued From page 12 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 observation, record review, and staff interview, sufficient nursing time was not given to ensure that Resident #5, who had a history of pressure ulcers in the coccyx area, received continuous monitoring, consistent with professional standards of practice, to prevent the reoccurring of an unstageable pressure ulcer in the sacral region for one (1) residents; and to provide adequate supervision and monitoring to prevent falls with major injuries (fractures) for two (2) residents. Residents' #5 and #31. This failure resulted in actual harm to Residents' #5 and #31. The findings include: 1.Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, and Hypothyroidism. Review of the Significant Change Minimum Data Set (Assessment Reference Date of 11/25/2020), documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 14, indicating the resident was cognitively intact. In Section I, 18000-(Additional Active Diagnoses) coded the resident for Pressure Ulcer of Sacral Region, Stage 3. In Section G (Functional Status) coded the resident for extensive assistance with the	L 052	2-Residents who have sustained a pressure injury that healed within 30 days were reviewed on 7/13/2021 to verify that interventions to decrease the potential for the area to reopen are in place. One resident was identified and this resident has interventions in place to prevent the reoccurrence of the pressure ulcer. 3- To enhance currently compliant process regarding management of healed pressure ulcer Certified Nursing Assistants will re-in-serviced to report any changes in skin integrity with bathing, shower and incontinence care. Licensed Nurses will be reminded: - That a newly closed pressure area is fragile - The importance of treatment to protect the newly healed areas to decrease the potential of it reopening.	

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KNOLLWOOD HSC	6200 OREGON AVE 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 052	Continued From page 13 assistance of one (1) person for bed mobility and personal hygiene. In Section H (Bladder and Bowel)- the resident was coded as frequently incontinent of both bladder and bowel. In section, M0300 (Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage) coded the resident for having one (1) Stage 3 pressure ulcer. In section, M 1200 (Skin and Ulcer/Injury Treatments), coded the resident for pressure ulcer/injury care and applications of ointments/medications. Observation: On 05/25/21 at 2:45 PM, observation of Resident #5's sacral wound showed approximately three (3) pinpoint open areas, red in color, no drainage, no smell, no depth, surrounding tissue was pink and intact. Also noted was barrier cream on the resident's buttock area. At the time of the observation, Resident #5 was lying on an air mattress, awake, alert, oriented to name, denied pain and continent of bladder and bowel. Review of the resident's care plan revealed the following: Care Plan (Pressure Ulcer) with a start date of 03/10/20. Goal: will minimize skin irritation and skin will remain intact. Approaches (start date of 06/29/20) included: -Monitor for skin irritation, document, report. -Turn and reposition Q (every) 2 hrs (hours) and prn (as needed), maintain pressure relieving device in bed and in w/c (wheelchair) monitor for placement. -Provide gentle care avoid friction. Provide incont (incontinent) care q (every) 2 hrs (hours) and prn (as needed), keep skin dry and oder [odor] free, apply [cream], lotion with incont. (incontinent)	L 052	4- An audit of residents with healed pressure ulcers will be completed weekly X4 then monthly X 4 then quarterly to ensure that there is evidence of monitoring of healed pressure ulcers to decrease the potential of reoccurrence. The result of this audit will be presented to the Quality Assurance Performance Improvement Committee for further recommendations. It is Knollwood Practice to provide adequate supervision of residents to decrease the potential of major injuries 1-a-Some of the ways this has been achieved are by providing resident #5 reminders during rounds to call for assistance when she needs help, by reminding her to use her walker during charge nurses rounds, and Certified nursing Assistants rounds. Housekeeping staff cleaning the resident's room will alert staff if the resident is observed engaging in an unsafe activity and activity staff providing activities	

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L 052	Continued From page 14 care ... Review of the resident's medical record revealed the following: 06/24/2020, to 07/30/2020, (Wound/Skin Records) showed the resident had a Stage II (pressure ulcer) in the sacral area with a start date of 06/24/2020 and a "healed" date of 07/30/2020. 09/11/2020, to 10/26/2020 (Wound/Skin Records) showed that the resident had a Stage II (pressure ulcer) in the coccyx area with a start date of 09/11/2020, and a "resolved" date of 10/26/2020. The record included bi-weekly Bath/Shower Days Skin Observation Sheets where the facility's staff documented their observation of Resident #5's skin. However, there were no Bath/Shower Sheets to reflect observations of the resident skin integrity from 10/30/2020, to 11/04/2020. The medical record also lacked documented of staff observations of Resident #5 's skin during incontinent care." "11/05/20 (Wound/Skin Record) site - A (coccyx), stage - unstageable, size - 1.2 X 1.2 cm (centimeters), depth "-", exudate - 0, odor - 0, wound bed - dark red, surrounding skin color - WNL (with in normal limits), surrounding tissue/wound edges" - this area was left blank. A nursing note dated 11/05/2020, at 10:51 AM revealed " ...Resident noted with recurrent open are on coccyx approx (approximately)1.2 By 1.2 CM (centimeters) area with deep red appearance. At baseline, no significant muscle mass in sacral region (very boney). No active bleeding noted. Denies discomfort tx (treatment) order given ..."	L 052	1-b-Some of the ways this has been achieved for Resident # 31 was by hourly rounds by our charge nurses documented on the Monitoring of resident who are ambulatory or able to self-propel on the wheelchair form, our Certified Nursing assistants rounds, the housekeeping staff and the Activity staff. 2-a-b- Residents who are mobile by moving independently or those using an assistive device to move will be reviewed to ensure that the medical record documents that the facility is providing supervision based on the resident's assessed need.	

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L 052	Continued From page 15 The physician's order dated 11/05/2020 directed staff to, "cleanse [coccyx area] with NS (normal saline), pat dry, apply Xeroform (fine mesh gauze occlusive dressing)/dry gauze dressing and cover with Mepilex (border lite foam adhesive dressings) BID (twice-a-day) until healed." "11/10/20 (Wound/Skin Record) site - A (coccyx), stage - unstageable, size - 3.5 X 3.5 cm (centimeters), depth " - ", exudate - small serous sanguenous (sp), odor - 0 ,wound bed - dark red [and] yellow 10%, surrounding skin color - this area left blank, surrounding tissue/wound edges- granulation tissue". The nursing note dated 11/10/2020, at 2:03 PM, revealed, "Followed up with previously noted coccyx wound area is spreading toward left buttock. Cluster measurement of affected area is approx. approximately) 3.5 by 3.5 CM (centimeters). Small amt (amount) of serous sanquenous (sp) drainage noted. Denies discomfort. Center of wound bed with a deep red appearance and some yellow covering (10%) granulation tissue noted at edges ...ADON (Assistant Director of Nursing) assessed, MD (physician) updated. TX (treatment) order written ...ADON ...request for full air mattress." The physician's order dated 11/10/2020, directed, "sacral opened area: cleanse with NS (normal saline), pat dry, apply Intrasite (autolytic debridement agent) gel and dry gauze dressing, cover with Mepilex BID (twice-a-day) until healed." There was no documented evidence that facility's staff assessed and/or monitored Resident #5's skin to identify potential changes in the resident's	L 052	3-a-b- To enhance the compliance regarding the supervision of our residents to decrease the potential of falls with major injuries Staff will be in serviced by the DON or Designee regarding: - Identification of residents at risk for fall - Identifying personalized interventions to decrease the potential for falls with major injuries. - Documenting supervision of those residents in the clinical record 4-a-b- An audit of 10% of residents who are mobile by moving independently or those using an assistive device will be conducted weekly X 4, then monthly X 4 then Quarterly and the result of this audit will be presented to the Quality Assurance Performance Improvement Committee for further recommendations.	7-28-21

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L 052	Continued From page 16 skin from 10/30/2020, to 11/04/20, subsequently ten days (11/05/2020) after the sacral wound was resolved on 10/26/2020, the staff documented that Resident #5 had an unstageable wound in the same (coccyx) area. During a face-to-face interview on 06/02/2021, at approximately 2:30 PM, Employee #8 (Licensed Practical Nurse/Wound Nurse) stated that nurses and certified nursing assistants conduct observations (skin rounds) of the residents' skin twice a week (shower days). The staff then documents "all" observations on the Bath/Shower Days Skin Observation Sheets. During a face-to-face interview on 06/02/2021, at approximately 3:30 PM, Employee #2 (Director of Nursing) and Employee #3 (Assistant Director of Nursing) acknowledged the finding and stated that staff assessed Resident #5's skin frequently during incontinent care and shower days. However, they did not have documented evidence of the skin assessment(s) performed during shower day(s) from 10/30/2020, to 11/08/2020. 2. Sufficient nursing time was not given to provide adequate supervision to prevent a fall with major injuries (fractures) for Resident #5. Resident #5 was admitted to the facility on 09/05/2019, with multiple diagnoses including, Parkinson's Disease, Coronary Artery Disease, Atrial Fibrillation, Legal Blindness, and Spinal Stenosis.	L 052		

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L 052	Continued From page 17 Review of a Quarterly Minimum Data Set with an Assessment Reference Date of 06/05/2020, documented the following: In Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 12, indicating the resident was cognitively intact. In Section E (Behavior), resident was not coded for psychosis, rejection of care or wandering. In Section G (Functional Status), the resident was coded for needing extensive assistance with the assistance of one person for ambulation in room and toileting use. In Section H (Bladder and Bowel) - the resident was coded for frequent incontinence of both bladder and bowel. In Section I (Active Diagnosis) - the resident was coded for diagnoses of Dementia, Parkinson's Disease, and Manic Depression. And in Section J (Health Condition), - the resident was coded for having one (1) fall with major injury since admission/entry/reentry (9/5/2019). Review of the medical record revealed the following: 03/07/20 at 8:30AM (Nursing Note) documented, "Resident observed sitting on the floor in bathroom. Alert, oriented, able to verbalize what happened. Resident stated she lost her balance while doing oral care in sink ...Verbalized she hit right side of her head and right side of her shoulder in the toilet bowl ..." Review of the Physician's order dated 03/09/2020 stipulated, "bilateral rib xray (sp) and lubar [lumbar]/sacral spine xray to r/o (rule out) fracture"	L 052		

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L 052	Continued From page 18 Review of the radiology report dated 03/09/2020, at 6:47 PM, revealed, "(Bilateral Ribs and AP [anteroposterior] chest) - There is a diffuse sever bony demineralization, which limits the diagnostic capability of the study. There is a fracture of the 2nd right rib posteriorly with minimal displacement. No other acute bony abnormalities are seen. Irregularities are seen of the left ribs compatible with old fractures and there is an old fracture of the left clavicle. Impression: 1. Fracture of the right 2nd rib posteriorly. 2. No acute pulmonary infiltrates." "03/09/20 at 10:47 PM (Nursing Note) Resident alert and verbal. Xray [x-ray] done, result of chest C-Rays (sp) shows fracture of right 2nd rib posteriorly ..." Review of the care plan section of the record revealed: The "fall" care plan with a start date of 03/10/2020. Goal: will minimize injuries related to falls. The care plan outlined multiple approaches for the facility's staff to address the resident problem of falls that included: -Increased staff supervision with intensity based on resident's need. -Bed alarm in place. -Implement [an] exercise program that targets strength, gait, and balance. The "Activity of Daily Living (ADL)/ Rehabilitation Potential Self-Care" care plan with a start date of 03/10/2020. Goal: All her ASL (sp) will be anticipated and met by staff on daily basis. The care plan outlined multiple approaches for	L 052		

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L 052	Continued From page 19 the facility's staff to address the resident problem with ADLs that included: - "Assist with ... personal hygiene... mobility, transfers, and locomotion." Review of the nursing note dated 06/17/20 at 4:23 PM revealed..."This writer was at the end of the hall at 4:05 PM, Resident seen coming out of room. Upon getting closer to resident's room, a audible screeching sound heard. Upon entering resident's room, resident noted in supine position in entrance way of room door. Commented she was looking for bathroom assist and went to turn around and go into bathroom and fell on left hip. Resident c/o (complained of) left hip pain ..." "06/17/20 at 5:22 PM (Nursing Note) - 2 Ambulance staff arrived. Resident transferred via stretcher, resident conversing with ambulance staff at this point. No change mentation. Scheduled to go to [hospital's name] for evaluation ...]." The physician's order dated 06/18/20 directed, "Transfer to [hospital's name] ER (emergency room) for Further eval (evaluation) & TX (treat) left hip pain and fall." The Nursing Progress noted dated 06/21/20 revealed, "Admission Note: Resident alert and oriented to time, place and person, arrived on the unit at 1:15PM accompanied by 2 paramedics, readmitted to room [room number] ...left hip noted with two surgical incision sites, upper left hip site with six intact staples and slight serosangenous (sp) exudate, lower left hip with nine intact staples with no drainage noted, resident is non weight bearing at this time ..."	L 052		

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L 052	Continued From page 20 Review of nursing notes, medication and treatment records from 03/10/2020, to 06/17/2020, lacked documented evidence that facility staff provided intense supervision (to include to type and frequency) based on the resident's assessed needs to minimize injuries related to falls, as outlined in the previously mentioned care plan. During a face-to-face interview on 06/02/2021, at approximately 3:00 PM, Employee #5 (RN/ Unit Charge Nurse) stated that intense supervision is every two hours. She also said that nurses may or may not document supervision in their nursing notes. 3. Sufficient nursing time was not given to provide adequate supervision to prevent a fall with major injuries (fractures) for Resident #31. Resident #31 was admitted to the facility on 10/19/2019, with multiple diagnoses that included: Dementia, Parkinson's Disease, Hypertension, Diabetes Mellitus, Heart Failure, Ulcerative Blepharitis Right Eye and History of Repeated Falls. Review of the Quarterly Minimum Data Set dated 01/09/2021, showed the following: In Section C0500 BIMS (Brief Interview for Mental Status), the resident had a summary score of 4, indicating that the resident was severely cognitively impacted. Under Section G0110 (Activities of Daily Living Assistance), the resident was coded as requiring extensive assistance (two (2) person physical assist with bed mobility. Transfers (how resident moves between surfaces	L 052		

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L 052	Continued From page 21 including to or from: bed, chair, wheelchair, standing position), the resident was coded as requiring one (1) person physical assist. Under section G0300 (Balance during transitions and walking), the resident was coded as not steady and required staff physical assistant for stability when moving from a seated to standing position. Under Section J1800 (Any Falls Since Admission/Entry or Reentry or Prior Assessment), the resident was coded as having one (1) fall. And under J1900 (Any Falls Since Admission/Entry or Reentry or Prior Assessment), the resident was coded as having one (1) fall without injury. Review of Resident #31's medical record revealed the following: 04/13/20 at 5:59 PM [Nursing Note] documented, "Staff heard bed alarm, upon entering resident room, resident was observed sitting on floor in front of her bed ...no injuries noted ..." 12/15/20 at 4:32 PM [Nursing Note] documented, "Resident ...loss her balance while trying to sit [in] wheelchair and then sat on floor ...no injury and no c/o (complaint of) pain ..." 01/28/21 at 12:30 PM [Nursing Note] documented, "At about 12:30 PM CNA (certified nursing assistant) reported that she observed resident lying on the floor in her room on her back ...Upon assessment resident pointed to her r/arm (right arm). She did show facial grymasing (sp) for pain/discomfort ...staff medicated resident with Tylenol 650 mg (milligrams) ...for pain ...order was obtained to transfer ... to ER (emergency room) to be evaluated for FX (fracture) ..."	L 052		

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L 052	Continued From page 22 01/28/21 at 8:27 PM [Nursing Note] documented, " ...Received a call from [hospital name] spoke with nurse ... who stated, "patient will be coming back after midnight with a sling to the right side due to clavicle displacement/fracture and antibiotic for UTI (urinary tract infection) ..." 01/29/21 at 10:30 AM [Nursing Note] documented, "Resident returned from [hospital name] ... at 0800 (8:00 AM) ... Resident is alert and verbally responsive and confused. Resident has a sling on the right upper extremity. ER (emergency room) diagnoses revealed closed displaced fracture of unspecified part right clavicle ..." Review of the nurses progress notes from 04/13/2020, to 01/28/2021, lacked documented evidence of how staff were monitoring (type and frequency) and supervising the resident to ensure her safety from potential accidents (falls). Review of the care plan section of the record showed: The "fall" care plan with a start date of 01/16/20 and updated on the following dates: 2/4/20 and 7/21/20. Goal: resident will function safely within environment; injuries will be minimized. The care plan failed to include approaches or interventions of how staff was to supervise or monitor (to include type and frequency) the resident to mitigate or prevent falls (accidents) with or without injury. There was no update to the falls care plan between 7/21/20 to 1/27/21 ensuring that interventions are implemented correctly and consistently and were evaluated for the effectiveness. Subsequently Resident #31 fell	L 052		

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L 052	Continued From page 23 and sustain a fractured right clavicle on 1/28/21. During a face-to-face interview on 06/02/2021, at 1:00 PM, Employee #12 (Registered Nurse] stated that the resident's fall [1/28/2021] was not witnessed by staff and she believed the fall was due to the resident's "new slippers". Employee #12 then stated, "She [Resident #31] refused therapy that is why she is not walking."	L 052		