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	095025	A. BUILDING ______ B. WING ______	08/25/2016

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LISNER LOUISE DICKSON HURTHOME	**5425 WESTERN AVE NW WASHINGTON, DC 20015**

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F 000	INITIAL COMMENTS	F 000		

An unannounced Quality Indicator Survey was conducted at Lisner-Louise-Dickson- Hurt Home from August 22, 2016 through August 25, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 29 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

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

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan M. Hargraves   TITLE: Administrator   (X6) DATE: 9/15/16

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

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F 000	Continued From page 1 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000	**F241 Meal Not Served In Unison** **1. Immediate Response:** Resident received her meal tray and ate her lunch. **2. Risk Identification:** No other resident was identified without tray service while tablemates were being served meals. **3. Systemic Changes:** Staff was in serviced on the need for all residents seated at a table to be served together. **4. Monitoring:** The Director of Nursing or her designee will conduct quarterly random observations of staff serving residents to ensure compliance. Observation findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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F 241

Continued From page 2

enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on an isolated dining observation on August 22, 2016 at approximately 12:30 PM, it was determined that facility staff failed to maintain/enhance dignity for one (1) of 29 sampled residents as evidenced by failing to serve Resident #13's lunch meal in unison with other residents in his/her company; the resident sat in the presence of others that dined.

The findings include:

At approximately 12:30 PM Resident #13 was observed seated at a dining table with another resident who was served his/her lunch and began eating. By 12:40 PM all of the residents in the dining room except Resident #13 had received their meals and were eating.

At approximately 12:43 PM Employee #10 was queried why Resident #13 had not received a tray? The employee responded " I do not know what happened but we will get [him/her] a tray. [He/she] probably wanted a different meal. " A few minutes later at approximately 12:45 PM the employee removed a tray from the meal cart and served it to Resident #13.

A face-to-face interview was conducted with Employee #10 at approximately 1:30PM on August 22, 2016. The employee was again queried why Resident #13 had not received [his/her] lunch tray in unison with others in the dining room. In response, the employee stated, "

F 241

F246 Call Bell Not Reachable

1. Immediate Response:
Call bell was placed within reach of resident.

2. Risk Identification:
All resident call bells were checked to ensure proper placement in reach of resident.

3. Systemic Changes:
All nursing staff were in serviced as to the importance of placing a call bell within reach of each resident.

4. Monitoring:
The Director of Nursing or her designee will do quarterly random observations of resident rooms to ensure proper call bell placement. Audit findings will be reported and tracked at the quality assurance meetings held quarterly.

5. Completion: October 5, 2016

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F 241	Continued From page 3 I do not know but the tray had been sitting at the back of the meal cart while we were looking for it. "	F 241	**F253 Marred Bathroom and Bedroom Walls** **1. Immediate Response:** The identified marred bathroom and bedroom walls in the two rooms were painted. **2. Risk Identification:** All rooms were inspected for any marred bathroom and bedroom walls and touched up if needed. **3. Systemic Changes:** An in-service was held with employees conducting room checks to ensure that any marred walls are touched up. Monthly room checks will be conducted to ensure all walls are in good condition. **4. Monitoring:** Findings of the monthly room checks will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016** **F253 Two Torn Privacy Curtains** **1. Immediate Response:** The two identified torn privacy curtains were removed and replaced. **2. Risk Identification:** All rooms were inspected for torn privacy curtains.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, for one (1) of 29 sampled residents, it was determined that facility staff failed to ensure that the resident's call bell was readily accessible as evidenced by the call bell observed wrapped around the bed side rail and out of reach for use by Resident #10 The findings include: During a resident observation conducted on August 22, 2016 at approximately 3:11 PM it was observed that Resident #10 's call bell was wrapped around the side rail of his/her bed. The resident was sitting in his/her wheelchair which was positioned in front of the bedrail and the call bell was out of reach of the resident. The observation was made in the presence of Employee #7 who acknowledged the findings on August 22, 2016.	F 246		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=E

Continued From page 4

MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observations made on August 22, 2016 at approximately 10:45 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain an orderly environment as evidenced by marred bathroom and bedroom walls in two (2) of 20 resident rooms, torn privacy curtains in two (2) of 20 resident rooms and a marred footboard in one (1) of 20 resident rooms.

The findings include:

1. Bathroom walls were marred under the toilet paper holder in room #101 and the walls in resident room #106 were also marred.

2. Privacy curtains were torn in resident room #105 (bed A) and #106 (Bed B), in two (2) of 20 resident rooms observed.

3.The footboard of the bed in resident room #117 was marred and scarred with scuff marks.

These observations were made in the presence of Employee # 5 who acknowledged the findings.

F 278 SS=D

483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the

F 253

3. Systemic Changes:
An in-service was held with employees conducting room checks to ensure that any privacy curtains found to be torn will be replaced immediately. Monthly room checks will be conducted to inspect privacy curtains for tears.
4. Monitoring:
Findings of the monthly room checks will be reported and tracked at the quality assurance meetings held quarterly.
5. Completion: October 5, 2016

F253 Housekeeping & Maintenance Marred Footboard
1. Immediate Response:
The identified marred footboard was temporarily patched and a new footboard ordered.
2. Risk Identification:
All footboards were inspected and repaired if needed.
3. Systemic Changes:
An in-service was held with employees conducting room checks to ensure that any marred footboards are reported and touched up. Monthly room checks will be conducted to make sure all footboards are in good condition.
4. Monitoring:
Findings of the monthly checks of footboards will be reported and tracked at the quality assurance meetings held quarterly.
5. Completion: October 5, 2016

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F 278	Continued From page 5 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 29 sampled residents, it was determined that facility staff failed to accurately code the quarterly Minimum Data Set (MDS) assessment under Section G (Functional Status). Resident #51. The findings include:	F 278	**F278 Incorrect MDS Coding** **1. Immediate Response:** Coding on MDS for resident #51 was modified to reflect correct assessment of bilateral limitation in range of motion. **2. Risk Identification:** The MDS for all residents who have bilateral limitation in range of motion were reviewed for proper coding for section G. **3. Systemic Changes:** MDS Coordinator was educated in proper coding for section G. **4. Monitoring:** Director of Nursing or her designee will do quarterly audits of MDS's of residents who have bilateral limitation in range of motion to ensure accurate coding on section G. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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According to the " Resident Assessment Instrument (RAI) User ' s Manual, " October 2015; Page G-37 stipulates: " G0400: Functional Limitation in Range of Motion ... Coding Tips-Do not look at limited ROM (Range of Motion) in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury ... This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit ... Code 1, impairment on one side; Code 1 impairment on both sides"

A hospital discharge summary dated April 13, 2016 revealed: " ... Also [Resident #51] has b/l [bilateral] weakness and movement limitation likely [secondary] to chronic extensive pannus compressing cord ... "

A physician ' s progress note dated June 15, 2016 revealed: " ... remains with bilateral hand contractures ... contractures and bilateral upper extremity paresis ... cervical spine stenosis [with] Quadra paresis ... "

Nurse ' s notes revealed the following:

" May 19, 2016- 07:33...resident has weakness in bilateral lower extremities and staff uses a Hoyer lift with [his/her] for transfer ... May 22, 2016- 13:17 (1:17 pm)- Resident remains alert and verbally responsive. Total care provided ..."

A review of the quarterly MDS dated June 20, 2016 revealed Section G0400 (Functional Limitation in Range of Motion) was coded as a/b, 1/1, indicative that Resident #51 had impairment of upper and lower extremities on one side.

Facility staff failed to accurately code the

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F 278	Continued From page 7 quarterly Minimum Data Set (MDS) assessment for bilateral limitation in range of motion. A face-to-face interview was conducted with Employee #8 on August 25, 2016 at approximately 2:00 PM regarding the aforementioned findings. He/she acknowledged the findings. Further stated he/she was coding resident for the left sided weakness from a stroke. The clinical record was reviewed on August 25, 2016.	F 278	**F280 Care Plan Amendment** **1. Immediate Response:** Care Plan for resident #51 was updated with specific goals and interventions for resident's refusal to wear splints. **2. Risk Identification:** The care plans of all residents who have bilateral hand splints were audited to ensure care plans with specific goals and interventions were in place.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	**3. Systemic Changes:** Licensed nursing staff were in serviced on the necessity to amend care plans with specific goals and interventions of all residents who have bilateral splints for refusal of care. **4. Monitoring:** Random sample of care plans will be audited quarterly by the Director of Nursing or her designee for the presence of current care plans with specific goals and interventions for refusal to wear bilateral splints. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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Based on record review and staff interview for one (1) 29 sampled residents, it was determined that facility staff failed to amend the care plan [related to the resident's refusal to wear splints] with specific goals and interventions for application of bilateral splints. Resident #51.

The findings include:

During the course of the survey, Resident #51 was observed on August 23 and 24, 2016 during the hours of 10:00 AM to 4:00 PM with bilateral splints applied to his/her upper extremities.

According to an interim physician order dated June 7, 2016 directed; " OT (Occupational Therapy) order: Resident fitted for (B- bilateral) resting hand splints. Resident to don splints throughout day; can remove at night, to protect hand joints. "

A physician's order dated August 10, 2016 directed: " ... Special Instructions: Resident fitted for bilateral resting hand splints. Resident to wear splints all throughout the day; can remove at night, to protect hand joints.

An occupational therapy plan of care dated June 7,2016 revealed: " Therapy necessary for orthotic fitting to reduce further contractures on [bilateral] PIPs (Proximal interphalangeal joints) and DIPS (Distal interphalangeal Joints) ... "

The comprehensive care plan lacked evidence of a revision to include the specific interventions to manage Resident #51's bilateral contractures and the application of adaptive devices (splints).

Facility staff failed to amend Resident #51 ' s care

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F 280	Continued From page 9 plan to include specific interventions for his/her bilateral resting hand splints. A face-to-face interview was conducted with Employees #3 and #6 on August 25, 2016 at approximately 1:00 PM regarding the aforementioned findings. Both acknowledged there was a care plan regarding resident ' s refusal to wear splints at times; however, it did not include specific interventions. The clinical record was reviewed on August 25, 2016.	F 280	**F309 Bilateral Splints per Physician's Orders** **1. Immediate Response:** Resident #51 was offered her bilateral hand splints. **2. Risk Identification:** Residents with MD orders for bilateral hand splints were checked for compliance. **3. Systemic Changes:**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to apply splints in accordance with physician's orders. Resident #51 The findings include: During the course of the survey, Resident #51 was observed on August 25, 2016 at approximately 10:00 AM sitting in his/her wheelchair in the activity room. The resident was not wearing bilateral splints on his/her upper	F 309	Staff was in serviced on the need to educate residents with MD orders to wear bilateral hand splints and about the importance of communicating the benefits of wearing them. **4. Monitoring:** The Director of Nursing or her designee will perform random quarterly observations of residents who have MD orders for bilateral hand splints for compliance. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 309	Continued From page 10 extremities. A review of the physician's order signed August 10, 2016 directed, " Special Instructions: Resident fitted for bilateral resting hand splints. Resident to wear splints all throughout the day; can remove at night, to protect hand joints. A face-to-face interview was conducted with Employee #9 (staff assigned to resident) on August 22, 2016 at approximately 10:15 AM. When asked if the resident's splints were applied? He/she stated, that the resident did not want the splints applied until after lunch. Facility staff failed to apply Resident #51's bilateral splints to upper extremities in accordance with physician's orders. A face-to-face interview was conducted with Employees #1 and #6 on August 22, 2016 at approximately 3:00 PM regarding the observation. Both stated, they honor resident's preference to not wearing the splint(s). The observation and clinical record review were conducted on August 22, 2016.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	**F318 No Restorative Care Implemented in Clinical Record** **1. Immediate Response:** Order clarified with MD and resident noted to not be appropriate for restorative nursing program. Physician order was discontinued. **2. Risk Identification:** Clinical records for residents with physician orders for restorative nursing services were assessed for proper restorative documentation. **3. Systemic Changes:** Staff were in serviced on proper restorative documentation as directed by physician order. **4. Monitoring:** Director of Nursing or her designee will conduct random monthly audits of medical records for residents receiving restorative nursing services to ensure proper documentation. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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This REQUIREMENT is not met as evidenced by:

Based on record and staff interview for one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to ensure that Resident #51 who was observed with limited range of motion of upper extremities received treatment and services to increase range of motion and/or prevent further decrease in range of motion as evidenced by a failure to follow through on a physician ' s order for restorative nursing care.

The findings include:

A physician's progress note dated June 15, 2016 revealed Resident #51's diagnoses included the following: " ... remains with bilateral hand contractures ... contractures and bilateral upper extremity paresis ... cervical spine stenosis [with] Quadra paresis ... "

An interim physician's order signed July 20, 2016 [no time indicated] directed: "D/C (Discontinue) of orders from therapy for positioning [and] self-care. PT (Patient) remaining on restorative nursing care. "

A face-to-face interview was conducted with Employee #13 on August 25, 2016 at 2:00 PM. He/she stated that the resident is not on restorative.

The clinical record lacked evidence that restorative nursing care was implemented to manage Resident #13 ' s functional limitations as directed by the physician ' s order of July 20, 2016.

A face-to-face interview was conducted on August

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F 318	Continued From page 12 25, 2016 at approximately 5:00 PM with Employee #12. He/she acknowledged the findings. The record was reviewed on August 25, 2016.	F 318	**F323 Unsecured Surge Protector** **1. Immediate Response:** The identified unsecured surge protector was secured to the desk. **2. Risk Identification:** All surge protectors in the facility were inspected to assure they are secured. **3. Systemic Changes:** Monthly room checks on surge protectors will be conducted to make sure they are secured. An in-service was held with employees conducting these room checks to ensure all surge protectors in the facility are secured. **4. Monitoring:** Findings of the monthly checks of surge protectors will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on August 22, 2016 at approximately 10:45 AM, it was determined that the facility failed to maintain resident environment free of accident hazards as evidenced by a surge protector that was observed on the floor of one (1) of one (1) family room next to the Louise Terrace unit. The findings include: A surge protector was observed on the floor and unsecured in the family room next to the Louise Terrace unit. The unsecured surge protector posed a potential trip hazard. This observation was made in the presence of Employee # 5 who acknowledged the findings.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		

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F 334	Continued From page 13 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334	**F334 Allergy and Influenza Vaccine** **1. Immediate Response:** Resident's records were reviewed by MD and clarification of influenza allergy was documented. Resident showed no adverse reaction from vaccine. **2. Risk Identification:** All residents' medical records, who have documented allergy to influenza vaccine, were reviewed to ensure they did not receive a contraindicated vaccine. **3. Systemic Changes:** Staff in serviced as to the importance of clarifying influenza vaccine allergies with physician prior to administration of vaccine. **4. Monitoring:** Director of Nursing or designee will conduct quarterly audits of a random sample of medical records of residents receiving flu vaccines to ensure that all allergy precautions are followed. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 334	Continued From page 14 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 29 Stage 2 sampled residents, it was determined that facility staff administered the influenza vaccine to a resident with medical contraindications without physician involvement and/or approval; there was no evidence that staff clarified the extent of Resident #13 ' s documented influenza allergy and there was no evidence that the physician was consulted prior to the administration of an inactivated form of the influenza vaccine.	F 334	**F371 Convection Oven Soiled** **1. Immediate Response:** Convection oven was cleaned immediately after observation. **2. Risk Identification:** All other ovens were checked for burnt food residue and cleaned as appropriate. **3. Systemic Changes:** In serviced staff on cleaning process for convection oven. Convection oven added to weekly master cleaning list and opening and closing checklist. Convection oven to be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the convection oven cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 334	Continued From page 15 The findings include: The facility policy " Influenza/Pneumococcal Immunization, SOP Number: N068; Effective Date: September 2008 stipulates: "... II. Procedures: ... Influenza: 2. ... Influenza immunization will continue to be offered when readily available from October 1st through March 31st annually unless the immunization is medically contraindicated or the resident has already been immunized during this time period." A history and physical dated March 29, 2016 revealed resident had allergies to: " MSO4 (Morphine Sulfate), Aranesp, Hydrocodone [and] Influenza. " The admission record face sheet for Resident #13 allergies included: ... " Influenza Vaccines ... " A physician ' s order signed August 16, 2016 directed, " Flu Vaccine 0.5 ml IM (Intramuscularly) Q (every) year ... Special Instructions: Allergic to Flu Vaccine .... Do Not Administer 02/25/2015- [no end date]. " A review of the comprehensive care plan revealed a focus problem, " Medication Allergies: At risk for injury and discomfort related to Medication allergies: Influenza Vaccines ... "; Goal: Resident will not receive medications listed as causing an allergic reaction, Interventions: Make sure resident ' s allergies are well documented throughout the chart, medication records, in pharmacy computer medication profile and all other pertinent documents ..." A review of the Medication Administration Record	F 334	**F371 Grease Fryer Soiled** **1. Immediate Response:** Grease fryer was cleaned immediately after observation. **2. Risk Identification:** All other cooking appliances were checked for leftover food particles and cleaned as appropriate. **3. Systemic Changes:** In serviced staff on cleaning process for grease fryer. Grease fryer added to weekly master cleaning list and opening and closing checklist. Grease fryer to be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the grease fryer cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 334	Continued From page 16 dated October 2016, Resident #13 received Afluria [an inactivated influenza virus vaccine] Intramuscular Suspension 0.5ml IM on October 27, 2016 at 7:00 PM. There was no evidence in the clinical record that facility staff received medical clearance from the physician to administer the " inactivated " vaccine to Resident # 13. There was no documented evidence that Resident #13 sustained any adverse effect from the vaccine that was administered. A face-to-face interview was conducted with Employees #2, and #3 on August 25, 2016 at approximately 4:00 PM regarding the aforementioned findings. Both acknowledged that the resident was given the influenza vaccine. Further stated that the resident did not have any adverse reactions because the vaccine [he/she] received was not a " live " vaccine. The clinical record was reviewed on August 25, 2016.	F 334	**F371 Dented Pans** **1. Immediate Response:** Identified pans were removed from service area. **2. Risk Identification:** All pans were inspected for dents and removed if appropriate. **3. Systemic Changes:** In serviced staff on identifying pots and pans with excessive wear and tear. Inspection of pans added to opening and closing checklist and will be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the pan inspections will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 17 Based on observations made on August 22, 2016 at approximately 9:15 AM, it was determined that the facility failed to prepare foods under sanitary condition as evidenced by one (1) of one (1) soiled convection oven, one (1) of one (1) soiled grease fryer, two (2) of five (5) dented one-third pans, one (1) of one (1) five-pound container of cottage cheese that was stored beyond its expiration date and one (1) of one (1) soiled coffee brewing machine in the nursing facility kitchen. The findings include: 1. One (1) of one (1) convection oven in the main kitchen was soiled with burnt food residue. 2. One (1) of one (1) grease fryer in the main kitchen was soiled with leftover food particles. 3. Two (2) of five (5) one-third pans in the main kitchen were dented. 4. One (1) of one (1) five-pound container of 1% small curd cottage cheese stored in the milk box in the main kitchen was expired as of August 10, 2016. 5. One (1) of one (1) coffee brewing machine in the nursing facility (NF) kitchen was soiled in several areas. These observations were made in the presence of Employee # 4 who acknowledged the findings.	F 371	**F371 Expired Cottage Cheese** **1. Immediate Response:** Expired cottage cheese in milk box was disposed of immediately. **2. Risk Identification:** All food stored in refrigerators was checked for expiration dates. **3. Systemic Changes:** In serviced staff on proper monitoring of all refrigerated food items' expiration dates as well as FIFO. Checking expiration dates was added to the opening and closing checklist and will be monitored by management on a daily basis. **4. Monitoring:** Findings of the food items' expiration dates monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 18 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview for	F 441	**F371 Coffee Machine Soiled** **1. Immediate Response:** Coffee maker was cleaned immediately after observation. **2. Risk Identification:** All other coffee makers were checked for cleanliness. **3. Systemic Changes:** In serviced staff on cleaning process for coffee brewing machine. Coffee maker was added to master cleaning list and opening and closing checklist. Coffee maker to be monitored by staff and management on a daily basis. **4. Monitoring:** Findings of the coffee maker cleanliness monitoring will be reported by the Food Service Director and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 441	Continued From page 19 one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to practice hand hygiene in accordance with accepted standards of practice during a dining observation. Resident #27. The findings include: According to Centers for Disease Control and Prevention handwashing guidelines are as follows: " Wet your hands with clean, running water ...Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds ...Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them. " http://www.cdc.gov/handwashing/when-how-handwashing.html Facility staff failed to practice hand hygiene in accordance with accepted standards during a dining observation for Resident #27. During a dining observation conducted on August 22, 2016 at approximately 12:40 PM, the following occurred: Employee # 14 entered the dining room. Removed a handbag from his/her shoulder. Placed the handbag on the chair. Moved a chair bedside the resident and proceeded to feed the resident without first sanitizing his/her hands.	F 441	**F441 Staff Did Not Re-Sanitize Hands** **1. Immediate Response:** Employee involved was immediately in serviced as to the proper protocol for hand washing and feeding a resident. **2. Risk Identification:** The Director of Nursing and her RN designee conducted hand washing observations on all nursing staff to observe for proper handwashing at mealtimes. **3. Systemic Changes:** Nursing staff were re-in serviced on the proper handwashing protocol at mealtimes to control infection. **4. Monitoring:** The Director of Nursing or her designee will conduct random hand washing observations on staff who feed residents on a quarterly basis to ensure proper infection control technique. Observation findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 441	Continued From page 20 A face-to-face interview was conducted with Employee #14 on August 22, 2016 at approximately 2:30 PM. He/she stated, " I did sanitize my hands. " There was no evidence that facility staff sanitized his/her hands prior to feeding the resident.	F 441	**F467 Exhaust Vents Not Functioning** **1. Immediate Response:** Replacement parts were ordered immediately and delivered the following day. Upon delivery the parts were installed and exhaust vents functioning properly. **2. Risk Identification:** All rooms were inspected for properly functioning exhaust vents. **3. Systemic Changes:** Monthly room checks on exhaust vents will be conducted to make sure they are functioning properly. An in-service was held with employees conducting these room checks to ensure all exhaust vents are functioning properly. **4. Monitoring:** Findings of the monthly checks of exhaust vents will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations made on August 22, 2016 at approximately 10:45 AM, it was determined that the facility failed to ensure that adequate outside ventilation by means of windows, or mechanical ventilation, or a combination were functioning as intended in three (3) of 20 resident rooms. The findings include: Exhaust vents in resident rooms #129, #131 and #133 were not functioning in three (3) of 20 resident rooms observed. These observations were made in the presence of Employee # 5 who acknowledged the findings.	F 467		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514		

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F 514	Continued From page 21 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. SThe clinical record must contain sufficient The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 29 sampled Stage 2 residents, it was determined that facility staff failed to ensure that the residents medical record was inclusive of Hospice documents. Resident #49. The findings include: A review of the Physician ' s Order Sheet dated August 2, 2016 directed, "Admit resident to Hospice Services." Further review of Resident #49's medical record lacked evidence of the hospice "Initial Nursing Assessment, and the Consent for Service" documents. A face-to-face interview was conducted on August 25, 2016 with Employees #3 and #6. After review of the aforementioned both acknowledged the	F 514	**F514 Hospice Services not on Medical Record** **1. Immediate Response:** Hospice records were obtained from the Hospice provider and placed on the charts. **2. Risk Identification:** All charts of residents enrolled in hospice were checked to make sure hospice records were present. **3. Systemic Changes:** Hospice RN Case Manager will place a copy of admission assessment and consent for services in all hospice charts within 72 hours of admission. **4. Monitoring:** The Director of Nursing or her designee will audit a random sample of residents enrolled in hospice services and check charts monthly for the inclusion of appropriate hospice records. Audit findings will be reported and tracked at the quality assurance meetings held quarterly. **5. Completion: October 5, 2016**	

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F 514	Continued From page 22 findings. Facility staff failed to ensure that the residents medical record was inclusive of Hospice documents. The record was reviewed on August 29, 2016.	F 514		