Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0015	A. BUILDING: _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

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L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility on April 5 - 12, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 52 and the survey sample included 29 residents. The following Facility Reported Incidents were investigated during this survey: DC00010407, DC00010401, DC00010508, DC00010537, DC00010590, DC00010646, DC00010739, DC00010738, DC00010882, DC00011079, DC00011085, DC00011181, DC000111406, DC00011498, DC00011565, DC00011604,DC00011628, DC00011811, DC00011160, DC00011820. Federal and Local deficiencies were cited related to the investigation of DC00010646. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. 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 B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid	L 000		

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L 000	Continued From page 1	L 000		

Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C - Discontinue
Dl - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight

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L 000	Continued From page 2 N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of	L 051		

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L 051	Continued From page 3 physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 29 sampled residents, the facility staff failed to update a resident's care plan to include goals and approaches to address one resident's Sacral pressure ulcer. Residents' #50. Findings included: Resident #50 was admitted to the facility on 2/22/2023 with diagnoses that included: Hypertension, Hyperlipidemia, Osteoarthritis, Chronic Obstructive Pulmonary Disease, Anemia, Hypertensive Heart Disease, and Major Depressive Disease. A review of the medical record revealed the following: A review of care plans showed a focus area, "[Resident Name] has potential for impairment to skin integrity related to frail/fragile skin, memory impairment, impaired mobility, use of hypertensive medications", initiated on 2/23/2023.	L 051	**L 051 Develop/Implement Comprehensive Plan of Care-Failure to update care plan for pressure ulcer** **1. Immediate Response:** The care plan for admission pressure ulcer was updated on 5/16/23 for resident #50. **2. Risk Identification:** Care plans of all residents who were admitted with pressure ulcers were reviewed to ensure specific goals and interventions to be in place and be followed by staff. All were up to date. **3. Systemic Changes:** Licensed staff were in-serviced on the necessity to update care plans for residents who were admitted with pressure ulcers. **4. Monitoring:** Monthly random sample of care plans of residents admitted with pressure ulcers will be audited by the Director of Nursing or her designee to ensure consistency of planned interventions and the monitoring documentation of these interventions. These findings will be reported at the QAPI quarterly meetings.	5/15/23

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L 051	Continued From page 4 The Admission Minimum Data Set (MDS) dated 3/1/2023 showed in Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "15", indicating an intact cognitive response. Under Section G (Functional Status) - Bed Mobility and Personal Hygiene the resident was coded as requiring extensive assistance with one person's physical assistance from facility staff. In Section M (Skin Condition), M0210 indicated "Does this resident have one or more unhealed pressure ulcers/injuries, the facility staff coded, yes." M0300 indicated, "Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar coded as 1. The number of these unstageable pressure ulcers that were present upon admission/entry or reentry coded as 1." 2/22/2023 18:15 [6:15 PM] Medication Reconciliation Note: "Resident admitted to this nursing facility this afternoon. Reviewed discharged orders with MD. New orders received ... Use Dakin's solution to clean coccyx wound daily and PRN ...." 2/22/2023 20:45 [8:45 PM] (Physician's Order) "Dakin's (1/4 strength) external solution (sodium hypochlorite) Apply to coccyx topically as needed for dressing soiling /lifting. After cleansing with ¼ strength Dakin's solution follow with gauze and cover with foam dressing." 4/5/2023 10:55 Skin/wound notes " ... 87-year-old A [patient] pt seen at bedside earlier today. ... sacral pressure injury ... The sacrum is an unstageable pressure injury that is covered with	L 051		

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L 051	Continued From page 5 40% thin slough and 60% pale granulation around the wound edges. It is surrounded with intact tissue with scant s/s drainage continue the current treatment." 4/10/2023 16:31 Nurses Skilled Notes: " ... Wound still present and with scant slough in bed, no mal odor to the wound while observing for infection ... wound care done and no bleeding observed ..." There was no documented evidence that facility staff updated Resident #50's care plan to reflect the open area found on 2/22/2023. During a face-to-face interview conducted on 4/12/2023, at approximately 9:00 AM with Employee #3 (ADON/Educator), she acknowledged the finding.	L 051		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, facility staff failed to maintain infection prevention and control practices during a wound care dressing change observation for one resident. Resident #50. The findings included: According to the National Library of Medicine, when performing wound care, staff should, "Wash	L 091		

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L 091	Continued From page 6 your hands .... Clean the trolley using soap and water, or disinfectant, and a cloth. Start at the top of the trolley and work down to the bottom legs of the trolley using single strokes with your damp cloth. Place the sterile dressing/procedure pack on the top of the trolley. Open the sterile dressing pack on top of the trolley. Open the sterile field using the corners of the paper. Open any other sterile items needed onto the sterile field without touching them. Wash your hands and put on non-sterile gloves (to protect yourself) before removing an old dressing. Dispose of this dressing in a separate dirty clinical waste bag. ... Fold up the dressing/procedure pack and place all contaminated material in a bag designated for clinical waste, making sure all sharps are removed and disposed of in a sharp's container. ...Remove gloves and place them in a waste bag. Wash your hands. (www.ncbi.nlm.nih.gov/pmc/articles/PMC4579997/) During wound care observation for Resident #50's pressure ulcer on 04/06/23 at 11:27 AM Employee #7 was observed cleaning the sacral wound with gauze covered with Dakin solution. He then placed the used unclean gauze on the bedside table with the clean gauze and foam dressing he needed to complete the dressing change. Physician orders dated 02/22/23 at 8:45 PM showed, "Dakin's (1/4 strength) external solution (sodium hypochlorite) Apply to coccyx topically as needed for dressing soiling /lifting. After cleansing with ¼ strength Dakin's solution follows with gauze and cover with foam dressing". During wound care observation on resident #50 4/6/2023 at 11:27 AM Employee #7 was observed	L 091	**L 091 Infection Prevention and control would dressing disposal** **1. Immediate Response:** On 4/6/23 staff properly disposed of soiled gauze dressing. Resident #50 was assessed and there was no harm. **2. Risk Identification:** Dressing change observations were done on all licensed staff to ensure proper disposal of soiled dressings. **3. Systemic Changes:** Licensed staff were in-serviced regarding the correct method of disposing of soiled dressings. **4. Monitoring:** Monthly random audits of dressing change observations will be done and reviewed by the Director of Nursing or their designee. These findings will be reported at the QAPI quarterly meetings.	5/15/23

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L 091	Continued From page 7 cleaning the sacral wound with gauze covered with Dakin solution. He then placed the used unclean gauze on the bedside table with the clean gauze and foam dressing he needed to complete the dressing change. In a face-to-face interview conducted on 4/6/2023 at approximately 11:28 AM, Employee #7 stated, "I did not have a red bag to put it (used soiled gauzed) in." He was able to verbalize the procedure for completing the dressing change. A face-to-face interview was conducted on 4/12/2023, at approximately 9:00 AM with Employee #5 (Infection Control), she acknowledged the finding and stated, "Staff will be trained."	L 091	**L 099Essential Equipment, Safe Operating Condition** **1. Immediate Response:** On 4/5/23, the noted dishwasher was shut down and the dishes were washed in the NF kitchen dishwasher. Dietary Director contacted the vender to repair the dishwasher on 4/5/23. The dishwasher repair was completed on 4/6/23. There was no harm to any resident. **2. Risk Identification:** The other dishwasher onsite was checked to ensure that it was working properly and it was. While checking daily, if dishwasher is found to be not working properly, the dishes will be moved to the other dishwasher and a work order will be placed with the vender. **3. Systemic Changes:** On 4/6/23, the Dietary Director in-serviced the dishwashers and dietary managers on correctly operating the dishwashers and properly checking them to ensure correct temperature is reached. **4. Monitoring:** Dietary Director or designee will check the dishwasher daily for proper operating and temperature. Findings will be reported at the quarterly QAPI meetings.	5/15/23
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by final rinse temperatures from one (1) of two (2) dishwashers that were consistently below 180 degrees Fahrenheit (F) in high heat disinfect mode. The findings include: During observations in dietary services on April 5, 2023, at approximately 12: 45 PM, one (1) of one (1) dishwasher in the main kitchen failed to reach a minimum of 180 degrees Fahrenheit on	L 099		

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L 099	Continued From page 8 numerous consecutive occasions. Two (2) of two (2) trays of dishes and utensils that had been washed were rewashed in the chemical disinfect dishwasher located in the resident's small kitchen, on the Long-Term Care unit. When tested, the chemical disinfect solution from that dish machine was at 200 PPM. Employee #10 confirmed the findings on April 10, 2023, at approximately 11:00 AM.	L 099	**L 128 Pharmacy Services-Procedures for records/documentation of disposition of controlled substances** **1. Immediate Response:** The pharmacy record for accounting of controlled substances were corrected to be accurate on 4/6/23 for resident #6 and on 4/11/23 for resident #23. **2. Risk Identification:** On 4/13/23 Pharmacy controlled substance records on all medication carts were checked for correct documentation and all were found accurate. **3. Systemic Changes:** All licensed staff were in-serviced regarding proper documentation procedures for dispensing controlled substances. **4. Monitoring:** The Director of Nursing or designee will conduct monthly random audits of medication carts for controlled substances count and corresponding documentation on the pharmacy dispensing sheet. Any inconsistencies found will be corrected at the time of audit. Findings will be reported at the quarterly QAPI meetings.	**5/15/23**
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at 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	L 128		

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L 128	Continued From page 9 that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of 29 sampled residents, facility staff failed to account for the dispensing of a controlled medications. Residents' #6 and #23. The findings included: 1. Facility staff failed to account for the dispensing of Resident #6's ordered Tramadol (narcotic pain reliever). Resident #6 was admitted to the facility on 07/18/20 with diagnoses that included: Polyosteoarthritis, Idiopathic Peripheral Autonomic Neuropathy and Dementia. Review of Resident #6's medical record revealed: A physician's order dated 08/25/22 that directed, "Tramadol HCl (hydrochloride) Tablet 50 MG Give 0.5 tablet by mouth everyday shift for pain control..." During a narcotic count conducted on 04/06/23 at 10:16 AM of the Team A medication cart with Employee #7 (Licensed Practical Nurse), it was noted that Resident #6's inventory sheet for Tramadol (narcotic pain reliever) 50 mg (milligrams) ½ (half) tablets documented "21" remaining, however, the blister packet was observed to have 20 half tablets remaining. Review of the Medication Administration Record (MAR) for April 2023 showed that Employee #7 initialed to indicate that Resident #6 was administered Tramadol 25 MG on 04/06/23 for "day" shift.	L 128		

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L 128	Continued From page 10 During a face-to-face interview conducted at the time of the observation, Employee #7 acknowledged the findings and stated, "I gave it to [resident] this morning and forgot to sign it out." 2. Facility staff failed to account for the dispensing of Resident #23's ordered Lorazepam (anti-anxiety medication). Resident #23 was admitted to the facility on 09/21/16 with multiple diagnoses that included: Dementia with Anxiety, Hallucinations and Hypertensive Heart Disease. A physician's order dated 07/20/21 that directed, "Ativan tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 6 hours for anxiety." Review of the Medication Administration Record (MAR) for April 2023 showed that Employee #8 initialed to indicate that Resident #23 was administered Lorazepam 0.5 mg tablet at 1:00 PM. During a narcotic count on 04/11/23 at 1:08 PM of the Team A medication cart with Employee #8 (Licensed Practical Nurse), it was noted that Resident #23's inventory sheet for Lorazepam 0.5 mg tablets documented "6" remaining, however, the blister packet was observed with 5 tablets remaining. During a face-to-face interview conducted at the time of the observation, Employee #8 acknowledged the findings and stated, "I know to sign out the narcotic medications when I give it. I don't know what happened."	L 128		

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L 201	Continued From page 11	L 201		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition;	L 201	**L 201 MDS Section L** **1. Immediate Response:** On 4/12/23, the MDS for resident #21 was corrected and the MDS section L0200 modification was completed and submitted. **2. Risk Identification:** On 4/12/23, the MDS section L was checked for accuracy for all 14 residents who are edentulous and all were correct. **3. Systemic Changes:** MDS Coordinator and their substitutes were in-serviced regarding proper coding of section L0200 of the MDS. **4. Monitoring:** Monthly random sample of MDS assessments section L of residents who are edentulous will be audited by the Director of Nursing or her designee to ensure accurate coding. These findings will be reported at the QAPI quarterly meetings.	5/15/23

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L 201	Continued From page 12 (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 29 sampled residents,	L 201		

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	HFD02-0015	A. BUILDING: _____ B. WING _____	C 04/12/2023

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L 201	Continued From page 13 facility staff failed to accurately code one resident's dental status in the Significant Change Minimum Data Set (MDS). Resident #21. The findings included: Resident #21 was admitted to the facility on 05/14/21 with diagnoses that included: Mixed Hyperlipidemia, Vesicointestinal Fistula, and Long Term use of Anticoagulants. Review of Resident #21's medical record revealed: 12/31/22 at 11:33 [Nutrition Assessment] " ...Oral/Dental Condition: Dentures- full upper; Dentures- full lower." A Significant Change MDS dated 01/09/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 11, indicating moderate impaired cognition. Section L0200 (Dental), directed "check all that apply", which included, "No natural teeth or tooth fragments (edentulous)". The MDS showed facility staff documented an "X" at the line "None of the above were present." During a face-to-face interview conducted on 04/05/23 at 2:59 PM, Resident #21 was noted to have no upper or lower teeth. Resident #21 stated, "I wear dentures." The resident's assigned Certified Nurse Aide (CNA) showed the surveyor a small, white container that contained a set of full upper and lower dentures. During a face-to-face interview conducted on 04/12/23 at 9:55 AM, Employee #6 (MDS Coordinator) reviewed the MDS and stated, "You are correct. I was on vacation and someone else	L 201		

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L 201	Continued From page 14 did this MDS."	L 201	**L 204 Investigate/Prevent/Correct Alleged Violation** **1. Immediate Response:** Eight staff providing direct care to resident #41 for the two days prior to the reported incident were reinterviewed from 5/12/23 through 5/15/23 and written statements were added to the investigation. The outcome of the investigation did not change and no abuse was found. On 3/23/23 a throat culture was obtained and symptomatic treatment was ordered; vital signs were monitored and resident did not have trouble with swallowing food or liquid. A negative throat culture result was reported on 3/25/23. **2. Risk Identification:** All incident reports with corresponding investigations of alleged abuse were reviewed for the past year. All identified investigations were found to follow facility policy for staff interview timeline and written statement requirements. **3. Systemic Changes:** All licensed staff were in-serviced on the policy for abuse investigations and the taking of witness statements. The facility administration reviewed the policy to assure regulatory compliance and allow for appropriate time to investigate allegations of abuse.	
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within 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, for one (1) of 29 sampled residents, facility staff failed to have documented evidence that an allegation of abuse was thoroughly investigated. Resident #41. The findings included: Review of the facility policy titled "[Facility Name] Abuse Investigation Protocol", not dated, documented, "...The individual conducting the investigation will, as a minimum... Conduct all interviews in the presence of a witness; Make every effort to interview staff members giving direct care to the resident for two days prior to the incident ... Interview any staff members or others who may have knowledge of the incident ... The	L 204		

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L 204	Continued From page 15 following guidelines will be used when conducting interviews...Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports..." Resident #41 was admitted to the facility on 12/29/21 with diagnoses that included: Vascular Dementia, with Anxiety, Chronic Pain and Muscle Weakness. Review of Resident #41's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 02/18/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 04, indicating severe cognitive impairment; no indicators of psychosis or behavior issues; required extensive assistance with one person physical assist for bed mobility, transfers, dressing, toilet use and personal hygiene. 03/21/22 at 2:47 PM [Psychosocial Note Late Entry] "Care conference held on 3/17/2022 for quarterly review. Resident participated in assessment but did not wish to attend meeting. RP (representative) ...notified of meeting but declined to attend. Care plan reviewed. Resident scored 4/15 on BIMS assessment. [Resident] was able to repeat 2/3 test words, could not recall test words with cueing, and was able to accurately state the month, but not day of the week or year. Resident is generally oriented to self, others, and place, although she shows deficits in short-term memory as evidenced by repeating conversations and difficulty accurately recalling events ..." 03/23/22 at 4:42 AM: [Nurses General Note]	L 204	**4. Monitoring:** The Director of Nursing will review all incident reports and the corresponding investigation on a quarterly basis to assure compliance with the facility's policy. Findings will be reported at the quarterly QAPI meetings.	5/15/23

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L 204	Continued From page 16 "Resident continue c/o (complain of) throat discomfort. Throat culture collected, awaiting technician to pick it up. Resident remain afebrile. No coughing ...Lung sounds clear on auscultation." 03/25/22 at 8:40 AM: [Psychosocial Note] "On 3/22/22, at Resident Council, resident reported concerns to include [resident] is treated "roughly" by staff and had a sore throat that was not addressed by staff. Staff investigated reports and RP ... notified about concerns. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred on ...Staff interviewed. No unusual incidents observed. Staff to monitor resident for additional reports. Investigation closed at this time." A Facility Reported Incident (FRI), DC00010646, received by the State Agency on 03/28/22 documented, "On 3/22/22, at Resident Council, resident reported concerns to include [resident] is treated "roughly" by staff and had a sore throat that was not addressed by staff. Staff investigated reports. Resident interviewed. Unable to give details of staff treatment such as which staff, which day or which shift the treatment occurred ..." Review of the facility's investigation documents provided to this surveyor on 04/06/23 showed a typed document dated "March 22, 2022" that documented, "Investigation of Claims of "Rough Handling"- Resident Council. DN (Director of Nursing) interviewed [Resident #41] following resident council ... DN verbally interviewed the following staff who are usual caregivers. [Names of four (4) staff members]. No unusual incidents observed ...There is no evidence of abuse.	L 204		

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L 204	Continued From page 17 Investigation concluded." The 4 employee names who the DN documented she verbally interviewed were cross-referenced to the facility's assignment sheets for dates 03/20/22 and 03/21/22 (the two days prior to the incident/allegation being reported) and it should be noted that two (2) of those employees did not provide direct care to Resident #41 in that time frame. The assignment sheets also revealed that there were six (6) employees who did provide direct care to Resident #41 during that time frame (03/20/22 to 03/22/22) for which there was no documented evidence of an interview or that they provided a signed and dated witness report/statement regarding Resident #41's allegation of being roughly handled. The evidence showed that the facility staff who conducted the investigation of Resident #41's allegation of abuse failed have documented evidence that an allegation of abuse was thoroughly investigated by failing to: 1. Make every effort to interview all staff members giving direct care to the resident for two days prior to the incident being reported; 2. Obtain signed and dated written witness reports/statements. During a face-to-face interview conducted on 04/12/23 at 12:39 PM, Employee #2 (Director of Nursing), who conducted the investigation of this allegation of abuse stated, "I interviewed her [Resident #41]. Had a lot of paranoia and documented memory problems." When asked why none of the staff members interviewed provided a signed and dated written report/statement, Employee #2 stated, "There	L 204		

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L 204	Continued From page 18 weren't any witnesses; (Resident #41) couldn't tell us who did it or when. I just interviewed the regular staff who took care of [resident] ." Employee #2 was then asked if any these interviews (resident and staff) were conducted in the presence of a witness, to which she stated, "No." When asked why all the staff who cared for Resident #41 in the two days prior to the allegation being reported were not interviewed or provided a written report/statement, Employee #2 stated, "[Resident #41] was not able to tell me when this occurred. That would've meant having to interview and get statements from almost all the staff. We didn't have time for that."	L 204	**L 442 Food Safety Requirements** **1. Immediate Response:** On 4/5/23, the noted dishwasher was shut down and the dishes were washed in the NF kitchen dishwasher. Dietary Director contacted the vender to repair the dishwasher on 4/5/23. The dishwasher repair was completed on 4/6/23. There was no harm to any resident. **2. Risk Identification:** The other dishwasher onsite was checked to ensure that it was working properly and it was. While checking daily, if dishwasher is found to be not working properly, the dishes will be moved to the other dishwasher and a work order will be placed with the vender. **3. Systemic Changes:** On 4/6/23, the Dietary Director in-serviced the dishwashers and dietary managers on correctly operating the dishwashers and properly checking them to ensure correct temperature is reached. **4. Monitoring:** Dietary Director or designee will check the dishwasher daily for proper operating and temperature. Findings will be reported at the quarterly QAPI meetings.	5/15/23
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by final rinse temperatures that were below 180 degrees Fahrenheit (F) on April 4, 2023, at approximately 12:45 PM. The findings include: During observation in dietary services on April 5, 2023, at approximately 12:45 PM, final rinse temperatures from one (1) of one (1) dishwasher in the main kitchen did not reach a minimum of 180 degrees Fahrenheit as required. Facility staff attempted to use the dishwasher in chemical disinfect mode. However, when tested, the chlorine disinfect solution failed to reach the	L 442		

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L 442	Continued From page 19 minimum requirement of 50 Parts per Million (PPM). Employee #10 confirmed the findings on April 10, 2023, at approximately 11:00 AM	L 442		