Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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L 000	Initial Comments The Annual Licensure Survey was conducted at Serenity from July 10 through July 20, 2018. Survey activities consisted of a review of 56 sampled residents. 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 ADL- Activities of Daily Living ARD - assessment reference date BID - Twice- a-day BIMS- Bried Interview Mental Status B/P - Blood Pressure cm - Centimeters CMP- Comprehensive Metabolic Panel CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility cc- Cubic Centimeter D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter	L 000	Serenity Rehabilitation and Health Center is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the Facility's written allegation of Compliance for deficiencies cited. However submission of this Plan of Correction does not constitute Admission of facts or conclusions Cited.	10/18/18

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L 000	Continued From page 1	L 000		

DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
GERD- Gastro-esophageal Reflux Disease
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
I/O- Intake and Output
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
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
RP- Responsible party
SCSA Significant change status assessment
Sol- Solution

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L 000	Continued From page 2 S/P- Status Post TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment T4- Thyroxine TSH- Thyroid Stimulating Hormone	L 000		
L 031	3207.6 Nursing Facilities The physician shall prescribe a planned regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindications for the health and safety of the resident; (e)Resident therapeutic activities; and (f)Plans for continuing care and discharge. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 56 sampled resident, the physician failed to review the resident's total program of care for the continuation of eye drops to treat the Resident ' s eye condition (Glaucoma). Resident #96. Findings included ... Resident# 96 was admitted to the facility with diagnoses which include Glaucoma, Anemia Unspecified, Essential (Primary) Hypertension, Low Back Pain, Muscle Weakness, Hypothyroidism (Unspecified).	L 031	**Corrective action for the residents affected:** This facility cannot retroactively correct the deficiency. 1. Eye drops were ordered for resident # 96. Education will be provided to ensure facility staff review hospital discharge summaries for reconciliation of previous medications if not included. **Identification of others with potential to be affected:** 2. Admission orders will be compared to previous orders for missing medications. **Measures to prevent recurrence:** 3. Education will be provided for comparison of previous medication lists. Audits will be completed by DON/designee weekly times four, then monthly. **Monitoring corrective action:** 4. Monthly audits will be completed by DON/designee to ensure facility provides medication as prescribed. Findings will be reported to the QA committee monthly.	10/18/18

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L 031	Continued From page 3 Review of the medical record on 7/13/18 at 9:30 AM showed a physician order dated 9/27/27 "Ophthalmology Consultation for Resident with Glaucoma, Travatan/Benzalkonium, 0.004% eye drop 1 gtt (drop) to both eyes Q HS (every bedtime) DX (diagnosis) Glaucoma, Dorzolamide-Timolol 2%-0.5% eye drop 1 gtt (drop) to both eyes BID (twice a day) Dx Glaucoma." A review of the medical record on 7/13/18 at 10:30 AM showed Medication Administration Record (MAR) "Schedule for September 2017-December 2017" reads "Dorzolamide HC-Timolol Mal Solution 22.3-6.8 MG/ML (milligram/milliliter) one drop in both eyes two times a day for Glaucoma and Dorzolamide-Timolol 2%-0.5% Drops instill 1 drop in both eyes two times a day for Glaucoma" The medication administration showed eye drops were administered to Resident#96 during the months of September 2017, October 2017, November 2017, and December 2017. A further review of the Medication Administration Record on 7/13/18 at 11:30 AM failed to show Resident # 96 received eye drops since December 2017. During an interview on 7/16/18, at 12:30 PM, Employee# 4, stated I see the eye drops are not on the MAR and I don ' t see an order to stop them, let me keep looking." During a telephone interview on 7/16/18, at 1:00 PM with Employee#14 stated the Resident had multiple hospitalizations and that is why he [Resident] may not have had the Ophthalmology	L 031		10/18/18

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L 031	Continued From page 4 Consult, and the order for eye drops check to see if the eye drops are on the discharge hospital paperwork, but I understand that he should have received the order for eye drops, so he [Resident] could have gotten them [eye drops]. Employee #14 could not provide further insight as to why the eye drops were not prescribed for the Resident ' s eye condition (Glaucoma). During an interview with Employee#4 on 7/16/18, at 3:00 PM Employee stated no I could not find that the resident received the eye drops since December of 2017, the Resident did go in and out of the hospital, but as far as I see the Resident did not receive the eye drops at all this year. Facility staff failed to provide evidence that Resident #96 received eye drops for the past seven months to treat eye condition (Glaucoma). A further review of the medical record on 7/17/18, at 2:00 PM showed a physician's order dated 7/17/18, "Latanoprost 0.005% opthamology solution instill 1 drop in both eyes at bedtime and Dorolamide HCL 2% instill 1 drop in both eyes two times a day for Glaucoma. During a face-to-face interview and phone interview on 7/16/18, at 4:00 PM Employee#4 and #14 acknowledged the finding.	L 031		10/18/18
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical	L 051	**Corrective action for the residents affected:** 1.a. Resident #6 careplan was updated to include goals and approaches to care for AV fistula and access site.	

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L 051	Continued From page 5 and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 56 sampled residents, the charge nurse failed to ensure the Minimum Data Set (MDS) coding accurated reflected one (1) resident diagnosis of Anxiety, and one (1) resident with Depression. Resident #111 and 143. Findings included... 1. Resident #111 was admitted on February 9, 2017 with diagnoses to Diabetes Mellitus Type 2, Hypertension, Hyperlipidemia, GERD, Acute Kidney Failure and Anxiety disorder, A review of Resident #111's annual Minimum Data Set dated January 31, 2018, showed Section I Active Diagnosis, under Psychiatric	L 051	1.b. Resident #138 careplan was updated to include goals and approaches for access site blockages and assessment of the AV graft/fistula pre and post dialysis treatment, updated careplan to include goals and approaches to address diagnosis for rehab services,, and updated careplans to include goals and approaches for diagnosis of GERD. 1.c. Resident #38 careplan was updated to include goals and approaches to address the resident's Alzheimer's Disease **Identification of others with Potential to be affected:** 2. A housewide audit of careplans with residents with AV fitulas, diagnosis for rehab services, and Alzheimer's Disease was completed to ensure goals and approaches were addressed. Any issue found during the audit will be addressed. **Measures to prevent recurrence:** 3. Education will be provided to staff to ensure careplans goals and approaches are developed for residents with diagnosis for Alzheimer's Disease, GERD,Rehab services, and AV fistulas. **Monitoring corrective Action:** 4. Audits will be completed weekly times four, then monthly times three by the DON/designee to ensure the facility develops careplans with goals and approaches with residents with diagnosis for Alzheimer's disease, GERD, AV Fistulas, and rehab services. Findings will be reported to the QAPI committee for the next three months.	10/18/18

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L 051	Continued From page 6 /Mood Disorder with a box next to I5700 Anxiety Disorder which was blank left which indicated the condition does not exist. A review of the Psychiatric Assessment dated January 19, 2018, showed diagnoses of Anxiety Disorder, unspecified, Adjustment Disorder with Anxiety, and Unspecified, Dementia without behavioral disturbance. During a face to face interview on July 20, 2018, at approximately 4:00 PM with Employee #20, the Psychiatric Assessment was reviewed. Employee acknowledged the finding. 2. Resident #143 was admitted on May 16, 2014, with diagnoses to include Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia, Hyperparathyroidism, Hypothyroidism and GERD, Cerebral Infarction, and Adult Failure to Thrive. A review of Resident #143's quarterly Minimum Data Set dated June 22, 2018, showed Section I Active Diagnosis, Psychiatric /Mood Disorder with a box next to I5800 Depression was blank left which indicated the condition does not exist. A review of the Physician interim order sheet showed an order dated December 28, 2017, 4:40 PM that directed, "Psych consult for Dementia in other diseases without behavioral disturbance." A review of the Psychologist Assessment dated January 4, 2018, showed diagnosis of Major Depressive disorder, unspecified. During a face to face interview on July 20, 2018,	L 051		10/18/18

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L 051	Continued From page 7 at approximately 4:00 PM with Employee #20, the Psychologist Assessment was reviewed. Employee acknowledged the finding. B. Based on record review and staff interview for five (5) of 56 sampled residents, the charge nurse failed to develop care plans with goals and approaches to properly care for one (1) resident with arteriovenous (AV) graft and indwelling catheter and one (1) resident with nephrostomy tubes, one (1) resident AV[arteriovascular] graft/fistula access site, one (1) resident for diagnosis Alzheimer Disease, one (1) resident for GERD [Gastroesophageal Reflux Disease], and Rehab services . Residents' #6, 38, 138, 227 and 228. Findings included ... 1.The charge nurse failed develop a baseline care plan with goals and approaches to care for the residents' arteriovenous (AV) graft and indwelling catheter. Resident # 227. Resident #227 was admitted to the facility on July 4, 2018, with diagnoses, which include Chronic Kidney Disease, Pulmonary Hypertension, and Diabetes Mellitus. The resident also had an arteriovenous (AV) graft place on the left forearm for hemodialysis access and an indwelling catheter. According to health note dated July 5, 2018, at 10:58 AM, read, "S/P (status post) AV graft at left forearm with good thrill and bruits ... S/P indwelling Foley [catheter] with amber colored urine." Review of the Admission/Interim Care Plan [Baseline care plan] lacked evidence of goals and	L 051	**Corrective action for the residents affected:** Resident **# 227** careplan was updated to reflect careplan for AV graft and indwelling catheter. Resident **#228** careplan was updated to reflelct careplan for indwelling catheter (nephrostomy tubes). **Identification of others with the potential to be affected:** 2.Housewide audits of newly admitted residents baseline care plans will be completed to ensure the facility develops a baseline careplan with goals and approaches to care for residents admitting diagnosis. Revision of the baseline careplan will be completed to include other devices. **Measures to prevent recurrence:** 3. An audit was conducted of newly admitted residents to ensure baseline careplans included goals and approaches to care for residents admitting diagnosis. **Monitoring corrective action:** **4.** Audits will be conducted weekly times four, then monthly times three by DON or designee to ensure facility develops Baseline careplans with goals and approaches to care for residents' admitting diagnosis. Findings will be reported to the QAPI Committee monthly times three months	10/18/18

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L 051	Continued From page 8 approaches to address the care needs for the left arm with the arteriovenous graft placement (such as, palpate the sight for thrill and using a stethoscope to listen for bruit and no obtaining blood pressure measurements on the residents left arm). Also, to ensure the indwelling catheter has no kinks or twists, empty the drainage bag(s) before they are full, and use of leg straps to securely hold the catheter in place). During a face-to-face interview with Employee #5 on July 17, 2018, at 10:20 AM, the employee reviewed the care plan and acknowledged that it did not include information regarding care of the residents arteriovenous (AV) graft and indwelling catheter. 2. The charge nurse failed develop a baseline care plan with goals and approaches to care for Resident #28's nephrostomy tubes. Resident #228 was admitted to the facility on June 25, 2018, with diagnoses that included obstructive and reflux uropathy, anuroa and oliguria, and ovarian cancer. The resident also had and indwelling catheter (nephrostomy tubes) in place. The admission note dated 7/25/18, at 23:44 [11:44 PM] reads, " ...Bilateral nephrostomy tubing noted patient draining straw color urine with no odor. 110 milliliters on the left drainage bag and 50 milliliters on the right drainage bag." Review of the Admission/Interim Care Plan [Baseline care plan] lacked evidence of goals and approaches to address the care needs to maintain the bilateral nephrostomy tubes (such	L 051		10/18/18

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L 051	Continued From page 9 as, checking the skin at the insertion sites, ensure the tubes have no kinks or twists, empty the drainage bag(s) before they are full, and flushing protocols if ordered). During a face-to-face interview on July 17, 2018, at 5:13 PM, Employee #5 acknowledged the care plan did not address care of the resident's nephrostomy tubes. C. Based on record review and interviews for three (3) of 56 sampled Residents, facility staff failed to develop a care plan that included goals and approaches for assessment of one (1) resident AV[arteriovascular] graft/fistula access site, one (1) Resident for Diagnoses Alzheimer Disease, one (1) Resident for GERD [Gastroesophageal Reflux Disease], and Rehab services. Resident #6, #38, and #138 Findings included... 1. Facility staff failed to develop a care plan that included goals and approaches for one (1) resident AV graft/fistula access site. Resident #6 Resident #6 admission was on July 10, 2015, with diagnoses that include End Stage Renal Stage Disease, Anemia, Hyperlipidemia. Diabetes Mellitus 2, Hypertension, Heart Failure, Peripheral Vascular Disease, and Cataract. A review of the quarterly MDS with ARD date July 6, 2018, section I Active Diagnoses under I8000 Aditional Active Diagnoses show "End Stage Renal Disease" and Section O Special treatments Procedures, and Programs O0100 J "Dialysis	L 051		10/18/18

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L 051	Continued From page 10 while a resident." On July 18, 2018, 11:50 AM a review of the following Nurses Progress Note showed that the Resident#6 AV graft/fistula access site for dialysis treatment located in her left arm clogged twice. "April 11, 2018, 23:39 PM "[Resident name] returned to the facility this afternoon at about 4 PM without being dialyzed [dialyzed], AV [Arteriovascular] graft was blocked." "May 4, 2018, 18:08 PM Resident came back and was not dialyzed secondary to clogged AV graft. Resident scheduled for declogging on May 5, 2018, at 9 am. A review of care plan showed no evidence that staff developed a care plan with goals and approaches that included the Resident's access site blockages, and pre and post dialysis assessment for her AV graft/fistula. The resident's care plan lacked evidence that staff developed a care plan that included the access site blockages and assessment of the AV graft/Fistula pre and post dialysis treatment. During a face-to-face interview on July 19, 2018, Employee#19 reviewed the care plan and acknowledged the findings. 2. Facility staff failed to develop a care plan with goals and approaches for one (1) resident for Alzheimer's Diseases. Resident #38 Resident# 38 admitted on May 24, 2005, with diagnoses to include Alzheimer's Disease, Convulsion, unspecified, Hyperlipidemia,	L 051		10/18/18

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L 051	Continued From page 11 Diabetes Mellitus 2, Hypertension, and Hypothyroidism. A review of the Annual Minimum Data Set dated May 2, 2018, section I Active Diagnoses under I4200 show "Alzheimer's Disease." A review of physicians order dated March 29, 2018, 10:00 AM showed " Psych to evaluate and treat as needed for Alzheimer's Disease, Impulsive disorder. A review of care plan showed no evidence that staff developed a care plan with goals and approaches to address the resident's Alzheimer's Disease. The resident's care plan lacked evidence that staff develops a care plan with goals and approaches to address diagnoses of Alzheimer's Disease. During a face-to-face interview on July 19, 2018, Employee#19 reviewed the care plan and acknowledged the findings. 3A. Charge Nurse failed to develop a care plan with goals and approaches for one (1) Resident diagnoses GERD. Resident# 138 admitted on September 6, 2016, with diagnoses to include Gastro-esophageal Reflux Disease, Hyperlipidemia, Diabetes Mellitus 2, Hypertension, Major Depressive Disorder, Anemia and Peripheral Vascular Disease. A review of the Quarterly MDS with ARD date June 19, 2018, section I Active Diagnoses under I8000 H show "Gastro Esophageal Reflux Disease without Esophagitis."	L 051		10/18/18

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L 051	Continued From page 12 A review of the Physician orders showed Famotidine Tablet 20mg give one tablet by mouth one time a day for GERD [Gastro-esophageal Reflux Disease]. A review of care plan showed no evidence that staff developed a care plan with goals and approaches that included the Resident's diagnoses of GERD. The Resident's care plan lacked evidence that staff develops a care plan with goals and approaches to address diagnoses of GERD. During a face-to-face interview on July 19, 2018, Employee#19 reviewed the care plan and acknowledged the findings. 3B. Facility staff failed to develop a care plan with goals and approaches for one (1) Resident for a resident Rehab Services. Resident#138 Resident# 138 admitted on September 6, 2016, with diagnoses to include Anemia. Hyperlipidemia, Diabetes Mellitus, Hypertension, Gastroesophageal Reflux Disease, Peripheral Vascular Disease and Major Depressive Disorder. A review of the Quarterly MDS dated June 19, 2018, showed Section O0400 Therapies B. Occupational therapy started March 20, 2018, and therapy ended May 7, 2018. A review of care plan showed no evidence that staff developed a care plan with goals and approaches to address Resident Rehab Services. The Resident's care plan lacked evidence that	L 051		10/18/18

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L 051	Continued From page 13 staff develops a care plan with goals and approaches to address diagnoses for Resident on Rehab. During a face-to-face interview on July 19, 2018, Employee#19 reviewed the care plan and acknowledged the findings. D. Based on observations, record reviews and staff interview for three (3) of 56 sampled Residents, the charge nurse failed to update the care plan to include goals and approaches to address one (1) resident with a low albumin level, one (1) resident nutritional diet change, and one (1) resident that sustained a fall. Resident #6, #158 and #327. Findings included... 1. The charge nurse failed to update the care plan to include goals and approaches to address Resident #6 low albumin level. Resident #6 admission was on July 10, 2015, with diagnoses that include End Stage Renal Stage Disease, Anemia, Hyperlipidemia, Diabetes Mellitus 2, Hypertension, Heart Failure, Peripheral Vascular Disease, and Cataract. A review of the quarterly Minimum Data Set July 6, 2018, section I Active Diagnoses under I8000 Additional Active Diagnoses showed "End Stage Renal Disease" and Section O Special treatments Procedures, and Programs O0100 "Dialysis while a resident."	L 051	**Corrective action for the residents affected:** 1.a. Resident #6 careplan was updated to include goals and approaches to care for AV fistula and access site. 1.b. Resident #138 careplan was updated to include goals and approaches for access site blockages and assessment of the AV graft/fistula pre and post dialysis treatment, updated careplan to include goals and approaches to address diagnosis for rehab services,, and updated careplans to include goals and approaches for diagnosis of GERD. 1.c. Resident #38 careplan was updated to include goals and approaches to address the resident's Alzheimer's Disease. QAPI committee for the next three months. **Identification of others with Potential to be affected:** 2. A housewide audit of careplans with residents with AV fitulas, diagnosis for rehab services, and Alzheimer's Disease was completed to ensure goals and approaches were addressed. Any issue found during the audit will be addressed. **Measures to prevent recurrence:** 3. Education will be provided to staff to ensure careplans goals and approaches are developed for residents with diagnosis for Alzheimer's Disease, GERD,Rehab services, and AV fistulas. **Monitoring corrective Action:** 4. Audits will be completed weekly times four, then monthly times three by the DON/designee to ensure the facility develops careplans with goals and approaches with residents with diagnosis for Alzheimer's disease, GERD, AV Fistulas, and rehab services. Findings will be reported to the QAPI committee for the next three months.	10/18/18

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L 051	Continued From page 14 Observation on July 11, 2018, 10:30 AM showed Resident #6 on the way to dialysis, accompanied by a staff member with the communication medical record binder. Review of the "Nutrition Progress Note" on April 20, 2018, at 3:00 PM showed the RD [Registered Dietitian] received a consult notice from RNP [Registered Nurse Practitioner] and dialysis regarding marginally low albumin reading. Resident's albumin was 3.4 gram per deciliter on a 3.5-5.5 gram scale. Dialysis goal is 4 gram. The resident will receive 30 milliliters of Pro Source by mouth every day until the next albumin reading. A review of the resident's Nutrition/Dialysis care plan lacked evidence that the charge nurse updated the care plan with goals and approaches to reflect a low albumin level. During a face-to-face interview on July 19, 2018 at 3:15 PM, Employee#19 reviewed the care plan and acknowledged the findings. 2. The charge nurse failed to update the care plan to include goals and approaches for Resident #158 nutritional diet change. Resident #158 admission was on June 12, 2016, with diagnoses that included Hyperlipidemia, Hypertension, Peripheral Vascular Disease, Generalized Muscle Weakness, Cerebral Infarction, Dysarthria and Gastroesophageal Reflux Disease. A review of the Admission Minimum Data Set dated June 19, 2018, Section K0310 Nutritional	L 051		10/18/18

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L 051	Continued From page 15 Approaches under "C" showed Mechanically altered diet - require a change in the texture of food or liquids. A review of physician order dated June 20, 2018, 11:00 PM directed, "Regular diet, Regular texture, Nectar consistency, Nectar thick liquids Double Portion entrée per meal every shift" A review of the Resident's care plan showed a care plan for Nutrition Problem: Mastication difficulty related to medical state as evidenced by mechanical soft diet order date initiated June 15, 2018. The Resident's care plan lacked evidence that the facility updated the care plan with goals and approaches to reflect Regular diet, Regular texture, Nectar consistency, Nectar thick liquids Double Portion entrée per meal every shift when the diet order changed on June 20, 2018. During a face-to-face interview on July 19, 2018, at 3:15 PM, Employee#19 reviewed the care plans and acknowledged the findings. 3. The charge nurse failed to update the care plan to include goals and approaches to address Resident #327 fall. Resident #327 initially admitted on May 4, 2018, and hospitalized briefly. On July 7, 2018, Resident #327 was readmitted with diagnoses that included Malignant Larynx, Hyperlipidemia, Hypertension, Hypothyroidism, Peripheral Vascular Disease, Generalized Muscle Weakness, Atherosclerotic Heart Disease, Cerebral Infarction, Diabetes Mellitus Type 2,	L 051		10/18/18

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L 051	Continued From page 16 Acute Kidney Failure and Gastroesophageal Reflux Disease. During a resident representative interview on July 11, 2018, at 3:33 PM, the resident responsible party stated the staff told her that the resident had fallen and has a bruise on the back and left arm. Review of the admission Minimum Data Set dated May 11, 2018 showed Resident #327 was severely cognitively impaired as coded in Section B Cognitive Status C0500. Brief Interview for Mental Status (BIMS) Summary Score of three (3). In addition, the resident's self-performance required extensive assistance (resident involved in activity, staff provide weight-bearing support) with bed mobility, transfer, dressing, toilet use and personal hygiene as coded in Section G Functional Status Activities of Daily Living Assistance (ADLs) as three (3); and support from staff for activities of daily living provided by staff was coded as one (1) one person physical assist. A review of Nursing Notes showed Resident #327 fell on July 9, 2018, at 9:15 AM, in dayroom and was later observed on the floor of his room at 11:00 AM. A review of the resident's care plan showed a care plan for Potential risk for falls related to limited mobility initiated May 7, 2018. However, Resident #327's care plan lacked evidence that the facility updated the goals and approaches to address the falls Resident #327 sustained on July 9, 2018. During a face-to-face interview on July 19, 2018, at 3:15 PM, Employee#19 and Employee #3 acknowledged the findings.	L 051		10/18/18

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L 051	Continued From page 17 Based on medical record review, policy review, and staff interview, the charge nurse failed to ensure the provision of necessary care and treatment with an acute change in condition as evidenced by the failure to monitor, assess, evaluate and implement interventions, in accordance with professional standards of care, for one (1) resident with a history of dysphagia that experienced a choking episode. (Resident #158) Findings included ... Resident #158 was admitted to the facility on 6/8/18, with diagnoses to include Cerebrovascular Accident, Hypertension, Peripheral Vascular Disease, Dysphagia, Oropharyngeal phase and Dysarthria. The Speech Evaluation and Plan of Treatment dated June 13, 2018 at 4:38 PM showed reason for referral: "Resident referred to SLP [Speech Language Pathology] evaluation due to difficulty speaking and coughing while eating. The speech evaluation included recommendations for mechanical soft textures, mechanical soft/ground textured solids; nectar thick liquids with "close supervision" for oral intake. Swallowing strategies included "seated in chair or edge of bed for all PO [oral] intake. Liquids consumed with head posture chin down." Review of medical record on 7/18/18, at 10:00 AM showed an Admission Minimum Data Set (MDS) dated 6/19/18. Review of the MDS Section C showed the Brief Interview for Mental Status score was coded as 13, which indicates the resident is "cognitively intact". Section G0110 Eating resident was coded as 1 which indicates set up help only. Section K0510 [Nutritional	L 051		10/18/18

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L 051	Continued From page 18 Approaches] the resident is coded as requiring a mechanically altered diet (requires change in texture of food or liquids, e.g. pureed food, thickened liquids). Speech Therapy Treatment Encounter note dated 6/21/18 at 5:42 PM, showed "regular nectar thin liquids presented mild cues for head posture chin down during liquid intake." The Nurse's Note dated July 17, 2018, at 11:15 PM showed that Resident #158 was in the Day Room with other residents eating a "steak and cheese" sub from a local carry out when a staff member yelled for help at about 9:40 PM. Upon entering the Day Room, the nurse observed the resident sitting in his wheelchair "coughing/choking and his eyes rolling backward." The nurse called for help and performed five (5) "back blows on each shoulder blades." Resident #158 coughing increased. In addition, the Nurse's Note showed abdominal thrusts were performed three (3) times "but the resident condition is not improved. He went into code and CPR (Cardiopulmonary Resuscitation) was initiated and 911 was called, resident was intubated and then transferred to [Hospital Name]." Further review of the medical record showed an "eInteract Change of Condition Evaluation Form" dated July 17, 2018, at 9:59 PM. The form showed Resident #158's diagnosis of Dysphagia, Oropharyngeal phase, on Plavix (a platelet inhibitor which prevents blood clotting). The most recent vital signs recorded as "7/17/18 at 9:40 AM"- 138/90, pulse- 78 beats per minutes, respirations- 20 breaths per minutes, and the most recent temperature recorded as 98.4	L 051	**Corrective action for the residents affected:The facility cannot retroactively correct the deficiency:** 1. a. **Resident #6** Care Plan was updated to include goals and approaches to address the low albumin level. 1. b. **Resident #158** care plan was updated to include goals and approaches to address a nutritional diet change, and approaches to reflect regular diet, regular texture, nectar consistency, nectar thick liquids and double portion entrée per meal every shift. 1.c. **Resident #327** careplan was updated to include goals and approaches to address the resident's fall. Education will be provided to nursing staff to ensure timely updates of careplans to address nutritional diet changes and falls. **Identification of others with potential to be affected.** All residents in the facility have potential to be affected. 2. A house wide care plan audit will be done on residents with nutritional diet changes, and falls, to ensure goals and approaches are addressed. Any issue found during the audit will be addressed. **Measures to prevent recurrence:** 3. Education will be provided to ensure staff addresses goals and approaches to address nutritional diet changes and falls. **Monitoring corrective action;** 4. Audits will be completed by the DON/designee weekly times four then monthly times three. Findings will be reported to the QAPI committee for the next three months.	10/18/18

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L 051	Continued From page 19 degree Fahrenheit orally at 2:28 PM on July 17, 2018. The most recent oxygen saturation recorded as 98% (percent) on July 16, 2018 at 11:03 PM. The physical assessment showed Resident #158 had no observed neurological changes but was also unresponsive, and choking. Under section summarize your observations and evaluation: "Resident was eating outside food steak and cheese sandwich when he began choking." The interventions documented were "911 was called and CPR continued, resident was transported via 911." During a face-to-face interview on 7/18/18 with Employee #26 at 4:21 PM regarding "the resident change in condition, I completed the Nursing Home to Hospital Transfer Form on 7/17/18 and I assisted with CPR (cardiopulmonary resuscitation) for Resident# 158. When I came in the dayroom I saw the resident trying to stick his hand down his throat , we [staff] were trying to get him to stand and he could not stand he was conscious and I was telling him to cough and Employee# 25 did the back slaps over his shoulder blades, he had cup of water he was trying to drink it and it was coming out of his mouth, then he could not breathe he was shaking and he became stiff and he was not breathing and we started CPR we called a code and 911, the supervisor [Employee# 27] came to the floor and took over CPR." During a telephone interview on 7/19/18 at 5:35 PM, Employee# 24, stated "I was in the dayroom but I was not assigned to the resident and three	L 051		10/18/18

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L 051	Continued From page 20 residents came in with food from the outside; Resident#158 and two other residents. I was not too far away and he asked for sips of water, thickened water. While they were eating I gave him the thickened water and then I asked him if he was choking. He said yes, he only took a few bites before he started choking. It was not a long time at all, if ten minutes, before he started choking. He had a lot of sandwich left. I saw staff in the hall way and called for help they came in and started working on him." During a face-to-face interview with Employee #27 on 7/20/18 at 5:00 PM, "they called a medical emergency and I came from the first floor and I met the Resident# 158 holding his throat he said that he just choked he stood up and we supported him I did the Heimlich Maneuver and then we placed him on the floor and I took over CPR, oxygen and suction with a Yankeur (oral suction tool), by now 911 had arrived and his SP02 [oxygen level] was 62% they [911] took over chest compressions with an automatic chest compression system they [staff] pulled out a big piece of meat, he was alive when he left the floor he was to go [hospital name] but he went to [hospital name]." Review of the facility policy titled "Serenity Rapid Response Team" dated April 27, 2018, showed that staff are to response to all emergencies to include a licensed nurse from each unit and the Director of Nursing/Nursing Supervisor, and Nurse Practitioner , if available. The Director of Nursing/Nursing Supervisor is responsible for bringing the AED (Automated External Defibrillator). Review of the "American Heart Association	L 051		10/18/18

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L 051	Continued From page 21 Guidelines 2015/ CPR & ECC" for "Choking Relief in a Responsive Adult" includes positioning self behind the choking victim and wrap arms around the victim's midsection and search for their bellybutton. Make a fist with one hand and grasp it with the other hand and thrust both hands inward and upward, until the blockage comes out. If the patient loses consciousness and the blockage remains, lower the patient to the floor. Open the mouth with the head tilt/ chin lift and look inside for the item and begin chest compressions. Reassess for expelled object and pulse until paramedics arrive. The charge nurse failed to show all interventions implemented to include complete vital signs, administration of oxygen, suctioning, the performance of a comprehensive assessment, cardiovascular assessment, respiratory assessment, and neurological assessment at and during the change of condition. In addition, review of the interventions provided during the choking episode showed the interventions taken were inconsistent with acceptable professional standards for care of choking resident. During a face-to face-interview on July 20, 2018, Employee #1 and 2 acknowledged the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:	L 052	**Corrective action for the residents affected:** 1. This facility cannot retroactively correct the deficiency. Resident # 112 care needs were met by providing nail care.	10/18/18

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L 052	Continued From page 22 (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, including oral acre; and	L 052	**Identification of others with potential to be affected:** 2. All residents in the facility have potential to be affected. Audits of residents will be completed to ensure the facility provides adequate grooming services. **Measures to prevent recurrence:** 3. Staff will be educated /trained on personal care needs to include showers and nail care. **Monitoring corrective action:** 4. Audits will be completed by DON/designee weekly times four, then monthly times three. The results of the audits will be presented in the monthly QAPI meeting times three months.	10/18/18

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L 052	Continued From page 23 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 for one (1) of 56 sampled residents, the facility failed to ensure the sufficient nursing time to provide adequate grooming services by failing to provide nail care for one (1) resident who was totally dependent on staff for all of his care. Resident #112. Findings included... Resident #112 was admitted to the facility on March 18, 2018 with diagnoses which included Anemia, Renal Insufficiency, Dementia, Hypertension, and Peripheral Vascular Disease. Observation on July 12, 2018 showed Resident #112 lying in bed. The resident's nail edges were broken and jagged with black material underneath the nailbeds. Review of Resident #112's medical record showed an admission Minimum Data Set (MDS) with an assessment reference date (ARD) of March 27, 2018. Section G (Functional Status) G0110 activities of daily living (ADL) assistance, the resident was coded as a three (3) for bed mobility, transfer, toilet use, dressing and locomotion, indicating the need for extensive assistance in all of the aforementioned areas. The support level coding for the ADLs was coded as a two (2), indicating the need for one (1) person's physical assistance to perform the activities, except in transfer, where it was coded as a three (3), indicating the need for physical assistance from two or more persons for transfer.	L 052		10/18/18

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L 052	Continued From page 24 During a face-to-face interview on July 16, 2018 at approximately 2:30 PM, Employee #5 reviewed Resident #112's nails and stated the resident is very noncompliant with grooming and refuses care. A review of Interdisciplinary Team Meeting notes of March 27, 2018 showed that the Resident #112's Responsible Party (RP) was informed of the elongated nails which were "digging into his skin." RP was informed of the plan to initiate psychiatric consult. The medical record lacked documented evidence of follow-up interventions provided related to refusal to have nails trimmed and cleaned for a resident totally dependent for all care needs. Employee #5 acknowledged the finding on July 16, 2018.	L 052		10/18/18
L 065	3213.2 Nursing Facilities Each nursing employee shall provide restorative nursing in his or her daily care of residents, which shall include the following: (a)Maintaining good body alignment and proper positioning of bedridden residents; (b)Encouraging and assisting bedridden residents or those residents that are confined to a chair to change position at least every two (2) hours or more often as the resident's condition warrants,	L 065		

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L 065	Continued From page 25 day and night, to stimulate circulation; prevent bed sores, pressure ulcers and deformities; and to promote the healing of pressure ulcers; (c)Encouraging residents to be active and out of bed for reasonable periods of time, except when contraindicated by physician's orders; (d)Encouraging residents to be independent in activities of daily living by teaching and explaining the importance of self-care, ensuring and assisting with transfer and ambulating activities, by allowing sufficient time for task completion by the residents, and by encouraging and honoring resident's choices; (e)Assisting residents to adjust to their condition and to their use of prosthetic devices; (f)Achieving good body alignment and balance for residents who use mechanical supports, which are properly designed and applied under the supervision of a licensed nurse; (g)Identifying residents who would benefit from a bowel and bladder training program and initiating such a program to decrease incontinence and unnecessary use of catheters; and (h)Assessing the nature, causes and extent of behavioral disorientation difficulty and implementing appropriate strategies and practices to improve the same. This Statute is not met as evidenced by: Based on observations, record review and staff interviews for two of (2) of 56 sampled residents, facility staff failed to ensure restorative nursing	L 065		10/18/18

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L 065	Continued From page 26 applied hand splints to prevent contractures for residents with an identified limited range of motion and to provide a shoulder sling for the residents. Residents' #68 and #478. Findings included... 1. Resident# 68 was admitted to the facility with diagnoses which include Major Depressive Disorder, Essential Primary Hypertension, Aphasia following Cerebrovascular Disease, Gastro-Esophageal Reflux Disease, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side and End Stage Renal Disease. During an observation on 7/10/18 at 10:00 AM showed Resident #68 lying on her bed holding her left arm close to her torso. A subsequent observation on 7/10/18, at 4:20 PM showed Resident #68 in resident's room listening to music with left arm close to her body. During a Resident interview on 7/11/18 at 10:00 AM the Resident stated that a sling used to support the left arm. However, staff is not applying the sling. The splint was observed in a plastic bag pinned in the wall in the resident's room. Review of the medical record on 7/11/18, at 11:30 AM showed a physician's order was obtained by Occupational Therapy dated 4/19/18 obtained for Physical Therapy "consult to order left shoulder sling use during daytime: (on at 8 AM off at 8 PM) to control pain secondary to Cerebrovascular Accident."	L 065	**Corrective action for the residents affected:** The facility cannot retroactively correct the deficiency. 1. **a. Resident #68 received referral for reevaluation for use of splint/sling.** b. Resident #478 received referral for reevaluation for use of splint. **Identification of others with potential to be affected:** All residents residing in the facility have potential to be affected. 2. Housewide audit will be completed to ensure facility staff applies splints and slings to residents with limited range of motion, per rehab recommendations. Any issue found during the audit will be addressed. **Measures to prevent recurrence:** 3. Audits will be conducted weekly times four, and then monthly times three by DON/designee. Education will be provided to staff on timely splint application. **Monitoring of corrective action:** 4. Monthly audits will be completed by DON/designee to ensure facility applies slings splints to residents as recommended. Findings will be reported to the QAPI committee monthly for the next three months.	10/18/18

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L 065	Continued From page 27 A further review of the medical record on 7/11/18 at 11:30 AM showed an Occupational Therapy phone order dated 4/19/18, "Left Upper Extremity hand and wrist splint provided for positioning, Treatment 3-5x\week x 83 days as tolerated. A further review of the medical record on 7/11/18 at 11:30 AM showed a Rehabilitation Daily Note dated 6/21/18 "patient seen and examined by the bedside, she states that no one has stretched her LUE (left upper extremity) in three weeks or put her brace on." The medical record lacked documented evidence the left hand, and wrist splint and left arm sling were applied as ordered. During a face-to-face interview with Employee #4 on 7/11/18, at 3:30 PM, the employee stated the restorative aide was on vacation and is normally responsible for applying the resident ' s splint. During an interview with Employee #16 on 7/12/18 at 11:37 AM, the employee stated that if the resident refuses or complains of hand pain, the splint is not applied. However, when asked for documentation of the refusal, Employee #16 stated it was not available. 2. Resident # 478 was admitted to the facility with diagnoses which include Type II Diabetes Mellitus without complications, Chronic Kidney Disease, Peripheral Infarction, Contracture of Left Hand and Unspecified Glaucoma. An observation on 7/10/18, at 1:00 PM showed Resident #478 sitting in Geri-chair with left-hand fingers tightly held in place. A subsequent observation on 7/12/18, at 11:30 AM showed	L 065		10/18/18

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L 065	Continued From page 28 Resident #478 sitting in Geri-chair with left-hand slight bent and fingers tightly fixed. During a Resident interview on 7/12/18, at 1:00 PM the Resident was asked what are staff doing to help with your limited motion? The resident responded, "I have a splint it' s in the back of my wheelchair look back there you will see it," (observed splint device in the back of the resident ' s wheelchair). Review of the medical record on 7/12/18, at 3:00 PM showed a physician ' s order dated 1/12/18, "Resident to wear resting hand splint on left upper extremity up to 8 hours after AM care." During an interview with Employee #4 on 7/12/18, the Employee stated: "our Restorative Aide is on vacation she would normally make sure the splints are applied daily." Employee# 4 could not provide further insight into the failure of the hand splint to be applied as per the physician's order. During a face-to-face interview with Employee #4 on 7/12/18, at 4:00 PM, present at the time of the observation and record review acknowledged the finding.	L 065		
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 observations and staff interview, the	L 091	**Corrective action for resident affected** 1. The identified two (2) of three (3) washing machines with steadily leaking fluid through the bottom of the access door, all three inspected and the door glass resealed on the 2 leaking seal machines.	10/18/18

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L 091	Continued From page 29 facility failed to maintain laundry equipment in safe condition as evidenced by two (2) of three (3) washing machines in the laundry room that continuously leaked through their access door. Findings included ... During observations in the laundry room on July 11, 2018, at 3:10 PM, two (2) of three (3) washing machines were steadily leaking through the bottom of the access door. During a face-to-face interview on July 17, 2018, Employee #13 acknowledged these findings.	L 091	**Identification of others with the potential to be affected** 2. Laundry staff will conduct daily observations of washing machines. **Measure to prevent recurrence** 3. Monthly checks will be conducted by Maintenance director/or designee, X3 months. **Monitoring Corrective action** 4. Results of monthly checks will be reported during the monthly QA meeting. The Quality Assurance Committee will determine the need for further audits or actions after 3 months.	10/18/18
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, the facility failed to prepare, distribute and serve foods under sanitary conditions as evidenced by greasy hood baffles over the grease fryer, expired milk on 42 of 91 observations, staff failure to wear gloves while handling utensils, staff failure to wear a beard net on the tray line, two (2) of three (3) soiled air curtains from the dishwashing machine, undocumented dishwashing machine temperatures, and failure of staff to correctly articulate critical dishwashing machine wash and rinse temperatures. Findings included ... During observations and record review on July 10, 2018, at approximately 9:30 AM:	L-099	**Finding 1** **Corrective action for resident affected** The identified soiled hood baffles were cleaned by Akleen Hood on 8/14/18. **Identification of others with the potential to be affected** A full kitchen inspection was conducted to inspect all baffles. Any issue found, during inspection, was corrected and soiled equipment cleaned. **Measure to prevent recurrence** Food Service Director or designee will conduct random equipment checks weekly. This will be done to ensure overall cleanliness of equipment. **Monitoring Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18

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L 099	Continued From page 30 1. Dust and grease were visible on three (3) hood baffles located above the fryer. 2. Forty-two (42) of 91 half-pint containers of regular milk were expired as of July 8, 2018. 3. Dietary staff setting up resident trays during the lunch period on July 10, 2018, at approximately 12:30 PM, failed to wear gloves and touched exposed and unwrapped plastic utensils such as forks and spoons with bare hands. 4. Dietary staff with beard failed to wear a beard net while serving foods from the tray line on July 10, 2018, at approximately 12:30 PM. 5. Food temperatures from the tray line were not recorded on July 9, 2018. 6. Cold food temperatures were not adequately maintained on July 13, 2018, at approximately 1:52 PM as cold food such as chicken salad was tested at 54.5 degrees Fahrenheit. 7. Two (2) of three (3) air curtains from the dishwashing machine were soiled. 8. A review of the Dishwashing/Warewashing Machine Temperature Log on July 10, 2018, at approximately 12:30 PM, revealed that wash and rinse (final) temperatures were inconsistently recorded. Dishwashing machine temperatures for the month of May 2018, were not documented	L 099	**Finding 2** **Corrective action for resident affected** The identified 42 (½) pints of expired milk were immediately disposed of and placed in garbage. **Identification of others with the potential to be affected** A full inspection of the kitchen was conducted to check expiration dates of all milk. Any issue found, during inspection, was corrected and soiled equipment cleaned. **Measure to prevent recurrence** Food Service Director or designee will conduct random equipment checks weekly. This will be done to ensure proper rotation of product and removal of expired product. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly. **Finding 3** **Corrective action for resident affected** The identified employees were removed from the line, instructed in proper handwashing and glove usage. **Identification of others with the potential to be affected** An in service was conducted (w/ signatures) on handwashing and glove usage on 8/8/18, by the Assistant Food Service Director. **Measure to prevent recurrence** Food Service Director or designee will conduct random handwashing/ glove checks weekly. **Monitoring Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18 10/18/18

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L 099	Continued From page 31 for 18 of 31 days. Dishwashing machine temperatures for the month of June 2018, were not documented for 19 of 30 days. Dishwashing machine temperatures for the month of July 2018, were not documented for 9 of 10 days. 9. Dietary staff failed to correctly articulate Wash and Rinse Dishwashing machine temperatures on July 10, 2018, between 11:45 AM and 12:07 PM. Dishwashing machine wash and rinse (final) temperatures were observed to be below 150 degrees Fahrenheit and 180 degrees Fahrenheit respectively between 10:10 AM and 11:02 AM on July 10, 2018. Those temperatures were not recorded on the morning of July 10, 2018. A face-to-face interview was conducted with dietary staff members (4) assigned to dishwashing duties on the morning of July 10, 2018. One employee stated that she turns the machine on at approximately 10:30 AM to start cleaning dishes but did not check the dishwashing machine temperatures at all the morning of July 10, 2018. Another employee is new (April 2018) and has not been assigned or trained to observe and monitor dishwashing machine temperatures.	L 099	**Finding 4** **Corrective action for resident affected** The identified employee was removed from the line, instructed in proper handwashing and hair restraints usage. **Identification of others with the potential to be affected** An in service was conducted (w/ signatures) usage of hair restraints usage on 8/8/18, by the Assistant Food Service Director. **Measure to prevent recurrence** Food Service Director or designee will conduct random hairnet/ beard guard checks weekly. **Monitoring Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly. **Finding 5** **Corrective action for resident affected** The identified incomplete temp logs were noted, employees counseled on temp taking, and write- ups were issued. **Identification of others with the potential to be affected** A full inspection of all kitchen temp logs was conducted. **Measure to prevent recurrence** An in service was conducted (w/ signatures) usage on proper temperature recording. This was done on 7/11/18, by the Assistant FSD. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18 10/18/18

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L 099	Continued From page 32 The third employee stated that the wash temperature should be 365 degrees Fahrenheit and the rinse temperature should be 398 degrees Fahrenheit. The fourth employee stated that the wash temperature should be greater than 180 degrees Fahrenheit and the rinse temperature less than 160 degrees Fahrenheit. During a face-to-face interview on July 17, 2018, Employee #10 and/or Employee #11 acknowledged these findings.	L-099	**Finding 6** **Corrective action for resident affected** The identified chicken salad was removed from service and fresh chicken salad was made and properly cooled, prior to service. **Identification of others with the potential to be affected** All chicken salad, above proper temp was removed and discarded. **Measure to prevent recurrence** An in service was conducted (w/ signatures) usage on proper temperature recording. This was done on 7/11/18, by the Assistant Food Service Director. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by several remote bed controllers cords that were frayed in six (6) of 34 resident's rooms. Findings included ... During observations throughout the facility on July 11, 2018, between 11:15 AM and 3:00 PM, remote bed controller electrical cords were frayed in resident room #128 (A and B beds), 131, 222B, 229A, 313 (A and B beds), 322A, six (6) of 34 resident's rooms surveyed. The uncovered, exposed electrical wires created	L-214	**Finding 7** **Corrective action for residents affected** The identified air curtains were cleaned and properly re-installed. **Identification of others with the potential to be affected** A full inspection of the dish machine was conducted to ensure, both, cleanliness and proper installation of air curtains.. Any issue found, during inspection, was corrected and soiled equipment cleaned and re-installed. **Measure to prevent recurrence** Food Service Director or designee will conduct dishwasher checks weekly. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18

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L 214	Continued From page 33 a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on June 11, 2018, Employee #12 acknowledged these findings at the time of observation.	L-214	**Finding 8** **Corrective action for residents affected** The identified incomplete temp logs were noted, employees counseled on temp taking, and write ups were issued. **Identification of others with the potential to be affected** A full inspection of all kitchen temp logs was conducted. **Measure to prevent recurrence** An in service was conducted (w/ signatures) usage on proper temperature recording. This was done on 7/11/18, by the Assistant Food Service Director. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18
L 265	3239.12 Nursing Facilities Each ventilation and exhaust system shall be maintained in good operating order. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled exhaust vents in three (3) of 34 resident rooms. Findings included ... During an environmental tour of the facility on July 11, 2018, between 11:15 AM and 3:00 PM, the following were observed: Three (3) of 34 exhaust vents in resident's rooms (Rooms #313, 338, 344) soiled with dust particles. During a face-to-face interview on July 11, 2018, Employee #12 acknowledged the findings.	L-265	**Finding 9** **Corrective action for residents affected** The identified incomplete temp logs were noted, employees counseled on temp taking, and write ups were issued. **Identification of others with the potential to be affected** A full inspection of all kitchen temp logs was conducted. **Measure to prevent recurrence** An in service was conducted (w/ signatures) usage on proper temperature recording. This was done on 7/11/18, by the Assistant Food Service Director. **Monitor Corrective Action** Random audits will be conducted by the FSD or designee 3x's weekly for 30 days, then weekly for the second thirty and continue, ongoing, thereafter. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	10/18/18
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by			

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L 306	Continued From page 34 residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 34 resident rooms that failed to alarm when tested and a call bell without a pull cord in one (1) of 34 resident rooms. Findings included... During observations on the second and third-floor nursing units on July 11, 2018, between 11:15 AM and 2:35 PM, call bells in two (2) of 34 resident rooms (#210 and #330), did not alarm when activated. Also, the pull cord from the call bell located in the bathroom of resident room #346 one (1) of 34 resident rooms was missing. A breakdown in the communication system could prevent or delay the resident, staff or the public from alerting staff. During a face-to-face interview on July 11, 2018, Employee #12 acknowledged these findings at the time of observation.	L-306	**L-214** **Corrective action for resident affected** The identified bed remotes/bed controller that electrical cords were frayed were replaced in rooms 128 A&B, 131, 222B, 229A, 313 A&B, 322A immediately when notified. **Identification of others with the potential to be affected** A full house inspection throughout the facility was conducted to inspect any frayed bed remotes. Any frayed remotes found during the inspection was corrected as well defective equipment replaced. **Measure to prevent recurrence** Maintenance Director/ or designee will conduct random room checks weekly. To ensure all remotes are frayed free and working correctly in residents' room. **Monitoring Corrective action:** Random audits will be conducted by the Maintenance Director/or designee weekly for the next 3 months. Finding will be reported in the monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after the 3 months. **L-265** **Corrective action for resident affected** 1. The exhaust vents found soiled with dust particles in rooms 313, 338, 344 were cleaned. **Identification of others with the potential to be affected** 2. Complete in house audit of exhaust vents conducted and areas of concern corrected. **Measure to prevent recurrence** 3. Random room audits of exhaust vents will be conducted monthly x3 by Maintenance Director/or designee.	10/18/18 10/18/18

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L 314	3246.5 Nursing Facilities If the room is not for single occupancy, each bed shall have flameproof ceiling suspended curtains which extend around each bed in order to provide the resident total visual privacy, in combination with adjacent walls and curtains. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by privacy curtains that were not secured in six (6) of 34 resident rooms. Findings included ... During an environmental tour of the facility on July 11, 2018, between 11:15 AM and 3:00 PM, the following were observed: 1. Six (6) of 34 privacy curtains in resident's rooms (Rooms #113A, 144A, 309, 313B, 329A, 338A) hanging loose and detached from the curtain tracks which could impede the resident from closing the privacy curtains for full privacy. During a face-to-face interview on July 11, 2018, Employee #12 acknowledged the findings.	L 314	**F265** **Monitoring Corrective action:** 4. Results of monthly audits will be reported in monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months. **L-306** A. **Corrective action for resident affected** 1. The call bells cords in rooms 210 and 330 that did not alarm when activated were replaced. **Identification of others with the potential to** 2. Complete in house audit of call bell cord were conducted and areas of concern cor **Measure to prevent recurrence** 3. Random room audits of call bell cords will be conducted monthly by Maintenance Director/ or designee, x3 months. **Monitoring Corrective action:** 4. Results of monthly audits will be reported in Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months. **L-306** B. **Corrective action for resident affected** 1. 1. The pull cord missing from the bathroom in resident room 346 was replaced. **Identification of others with the potential to be affected** 2. Complete in house audit of pull cords were conducted and areas of concern corrected. **Measure to prevent recurrence** 3. Random room audits of pull cords will be conducted monthly by Maintenance Director/ or designee, x3 months.	10/18/18 10/18/18 10/18/18
L 315	3246.6 Nursing Facilities Each bedroom shall be equipped for each resident with the following minimum items:	L 315		

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L 315	Continued From page 36 (a)A separate bed of proper size and height for the convenience of the resident and appropriate to the resident's physical condition; (b)A clean, comfortable mattress; (c)Bedding appropriate to the weather and climate; (d)Functional furniture appropriate to the resident's needs and individual closet space with clothes racks and shelves accessible to the resident; (e)A call system meeting the requirements of section 3245.10; (f)A bedside table or cabinet with some lockable storage; and (g)One (1) chair. This Statute is not met as evidenced by: Based on observation, medical record review and interviews, the facility staff failed to provide resident with a bed mattress to meet the residents preferred comfort level to facilitate a restful night sleep. Resident# 478. Findings included.... Resident# 478 was admitted to the facility on 5/28/14, with diagnoses which include Type II Diabetes Mellitus without complications, Chronic Kidney Disease, Peripheral Infarction, and Unspecified Glaucoma. During a resident interview on 7/12/18, at 10:30	L 315	**Monitoring Corrective action:** 4. Results of monthly audits will be reported in Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months. **L-314** **Corrective action for resident affected** Privacy curtains that were found loosed and detached from the curtain tracked in rooms 113A, 144A, 309, 313B, 329A, which could impede the resident from closing for full privacy were checked and hooks added to ensure proper operation. **Identification of others with the potential to be affected** Complete in house audit conducted and areas of concern corrected. **Measure to prevent recurrence** Random room audits of privacy curtains will be conducted weekly, X3 months by EVS Director/or designee. **Monitoring Corrective action:** Results of audits will be reported in monthly Quality Assurance meetings. The Quality Assurance committee will determine the need for further audits or action after 3 months. **L-315** **Corrective action for the residents affected** 1. Resident #478 was re-assessed. Resident suffered no negative outcome. Resident was provided an appropriate mattress to facilitate comfort. **Identification of others with potential to be affected.** All resident residing in the facility have potential to be affected.	10/18/18 10/18/18 10/18/18

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L 315	Continued From page 37 AM the resident stated staff provides pain medication for pain experienced because the "bed is too hard" and it feels like someone is poking her and nothing has been done about the issue. An observation of the mattress on 7/12/18, at 10:30 AM showed the mattress to be inflated and the blower based pump (located at the foot of the bed) was operational. Review of the Comprehensive Minimum Data Set dated 5/1/18, showed Section C [Cognitive Patterns] C0500-Brief Interview Mental Score [BIMS] of 15 [indicating the resident is cognitively intact]. Section G [Functional Status] G0400-Functional Limitation in Range of Motion Resident was coded as 1 which indicates impairment on one side (upper extremity) and coded as 2 which indicates impairment on both sides (lower extremity). A review of the medical record on 7/12/18, at 11:30 AM showed a Social Work Progress Note dated 5/3/18, read "Resident expressed concern with the shower chair is too hard to set on, shower bed unable to fit on due to her size [sic]." During an interview on 7/12/18, at 1:00 PM with Employee# 4, confirmed that the resident had concerns about the bed mattress. Employee#4 further stated that the facility stopped using the Hoyer lift and follow-up on the mattress was pending. However, the Employee was not aware of the resident's concern about the shower chair or shower bed. The medical record lacked documented evidence that the facility addressed Resident #478's concern of a hard mattress which caused back	L 315	2. A house-wide audit was completed to ensure the residents' mattresses met their preferred comfort level to facilitate a restful night sleep. Any issues found during that audit were corrected immediately.. **Measures to prevent recurrence:** 3. Resident's mattresses/equipment will be checked to ensure proper working order and comfort bi-monthly. **Monitoring corrective action:** 4. Random audits and Observations will be conducted on a weekly basis. The results of the audits will be reported to the Quality Assurance Performance Improvement (QAPI) meeting monthly x 3 months.	10/18/18

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L 315	Continued From page 38 pain. During a face-to-face interview on 7/12/18 at 2:00 P, Employees #2 and #4 acknowledged the finding.	L 315		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by privacy curtains that were not secured in six (6) of 34 resident's rooms, soiled exhaust vents in three (3) of 34 resident's rooms and a call bell with no pull cord in one (1) of 34 resident's bathrooms. Findings included ... During an environmental tour of the facility on July 11, 2018, between 11:15 AM and 3:00 PM, the following were observed: 1. Privacy curtains in six (6) of 34 resident's rooms (Rooms #113A, 144A, 309, 313B, 329A, 338A) were hanging loose and detached from the curtain tracks which could impede the resident from closing the privacy curtains for full privacy. 2. Exhaust vents in three (3) of 34 resident's rooms (Rooms #313, 338, 344) were soiled with	L 410	**L- 410** A. **Corrective action for resident affected** 1. Privacy curtains that were found loosed and detached from the curtain tracked in rooms 113A, 144A, 309, 313B, 329A, which could impede the resident from closing for full privacy were checked and hooks added to ensure proper operation. **Identification of others with the potential to be affected** 2. Complete in house audit conducted and areas of concern corrected. **Measure to prevent recurrence** 3. Random room audits of privacy curtains will be conducted weekly, X3 months by EVS Director/or designee. **Monitoring Corrective action:** 4. Results of audits will be reported in monthly Quality Assurance meetings. The Quality Assurance committee will determine the need for further audits or action after 3 months. **B.** **Corrective action for resident affected** 1. The exhaust vents found soiled with dust particles in rooms 313, 338, 344 were cleaned. **Identification of others with the potential to be affected** 2. Complete in house audit of exhaust vents conducted and areas of concern corrected. **Measure to prevent recurrence** 3. Random room audits of exhaust vents will be conducted monthly x3 by Maintenance Director/or designee.	10/18/18 10/18/18

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L 410	Continued From page 39 dust particles. 3. The call bell cord in the bathroom of resident room #346 was missing, one (1) of 34 resident's rooms. During a face-to-face interview on July 11, 2018, Employee #12 acknowledged these findings.	L 410	L 410 **Monitoring Corrective action:** 4. Results of monthly audits will be reported in monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months. C. **Corrective action for resident affected** 1. The call bell cord found missing in room 346 was replaced. **Identification of others with the potential to be affected** 2. Complete in house audit of call bell cords was conducted and areas of concern corrected. **Measure to prevent recurrence** 3. Random audits of call bell cords will be conducted monthly by Maintenance director/or designee, X3 months. **Monitoring Corrective action:** 4. Results of monthly audits will be reported in monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months.	10/18/18
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations the facility failed to maintain an effective pest control program as evidenced by flying pests seen in the main kitchen from July 10, 2018 through July 19, 2018. Findings included ... Numerous flying insects were observed throughout the facility during the survey period from July 10, 2018, through July 19, 2018, in several areas including the Kitchen, the first, second and third floor. During a face-to-face interview on July 17, 2018, Employee #10 and/or Employee #11 acknowledged these findings.	L 426	**L-426** **Corrective action for resident affected** 1. The Identified flying insects that were observed throughout the facility were treated by a pest control company. They were contacted to re-examine the facility and found items in the dietary janitor closet where they were breeding and removed them and cleaned thoroughly. **Identification of others with the potential to be affected** 2. Pest Control Company will treat all areas of concern.	10/18/18
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	L 442		

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L 442	Continued From page 40 This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to provide an environment free from accident hazards as evidenced by several remote bed controllers cords that were frayed in six (6) of 34 resident rooms. The facility also failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) high temperature dishwashing machine that failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit and two (2) of three (3) washing machines that were leaking in the laundry room. Findings included ... 1.The facility failed to provide an environment free from accident hazards as evidenced by several remote bed controllers cords that were frayed in six (6) of 34 resident rooms. During observations throughout the facility on July 11, 2018, between 11:15 AM and 3:00 PM, remote bed controller electrical cords were frayed in resident room #128 (A and B beds), 131, 222B, 229A, 313 (A and B beds), 322A, six (6) of 34 resident's rooms surveyed. The uncovered, exposed electrical wires created a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on June 11, 2018, Employee #12 acknowledged these findings at the time of observation. 2.The facility failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) high temperature dishwashing machine that failed to reach a minimum final rinse	L 442	**L-426** **Measure to prevent recurrence** 3. Environmental rounds will be made weekly, X3 months to observe for insect presence by the EVS Director/or designee. **Monitoring Corrective action:** 4. Results of rounds will be reported at the monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after 3 months. **L-442** **Corrective action for resident affected** The identified bed remotes/bed controller that electrical cords were frayed were replaced in rooms 128 A&B, 131, 222B, 229A, 313 A&B, 322A immediately when notified. **Identification of others with the potential to be affected** A full house inspection throughout the facility was conducted to inspect any frayed bed remotes. Any frayed remotes found during the inspection was corrected as well defective equipment replaced. **Measure to prevent recurrence** Maintenance Director/ or designee will conduct random room checks weekly. To ensure all remotes are frayed free and working correctly in residents' room. **Monitoring Corrective action:** 4.Random audits will be conducted by the Maintenance Director/or designee weekly for the next 3 months. Finding will be reported in the monthly Quality Assurance meeting. The Quality Assurance committee will determine the need for further audits or action after the 3 months.	10/18/18 10/18/18

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L 442	Continued From page 41 temperature of 180 degrees Fahrenheit and two (2) of three (3) washing machines that were leaking in the laundry room. The high-temperature Dishwashing machine failed to reach a minimum of 180 degrees Fahrenheit between 10:10 AM and 11:02 AM on July 10, 2018, when staff was in the process of cleaning trays, dishes, bowls and utensils that were used for breakfast. Facility used paper plates and plastic utensils for lunch and dinner meals on July 10, 2018. During a face-to-face interview on July 17, 2018, Employee #10 and/or Employee #11 acknowledged these findings. During observations in the laundry room on July 11, 2018, at 3:10 PM, two (2) of three (3) washing machines were steadily leaking through the bottom of the access door. During a face-to-face interview on July 17, 2018, at approximately 4:30 PM, Employee #13 acknowledged these findings.	L 442	**Identification of others with the potential to be affected** 1. Dietary staff will monitor and document daily the dish machine temperature. 2. a **Identification of others with the potential to be affected** . Dish machine fuse and temperature probe replaced. **Measure to prevent recurrence** 3. Weekly preventive maintenance will be performed on dish machine by Maintenance Director/or designee, X3 months. **Monitoring Corrective action:** 4. Results of preventive maintenance will be reported during the monthly QA meeting. The QA committee will determine the need for further audits or action after 3 months.	10/18/18
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on observation and interview for one (1) of 56 sampled residents, the facility staff failed to treat resident with respect and dignity by entering the resident's room without knocking and announcing self before entering the resident's	L 521	**Corrective action for the residents affected** 1. Employee #15 was counseled on properly enter a resident's room "Resident Rights and Dignity.	10/18/18

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L 521	Continued From page 42 room. Resident# 124. Findings included ... An observation on 7/10/18, at 12:30 PM of Resident# 124 room door showed a sign posted which reads "knock please." Resident# 124 was admitted to the facility with diagnoses to include Ventricular Tachycardia, Chronic Congestive Heart Failure, and Acute Kidney Failure. During an interview on 7/10/18, at 12:30 PM with Resident #124 Employee#15 was observed to walk into the Residents' room walk toward the sink and then exit the room without knocking or announcing request to enter. Employee#15 failed to knock on the Residents' door before entering the room, and after entering the room, she did not address the Resident or the Residents' roommate. After Employee#15 exited, Resident# 124 stated I did not hear a knock at all no she [Employee# 15] did not say anything after she came into the room. During an interview on 7/10/18, at 12:35 PM with Employee#15, the television was on so I came in I did not say anything because I saw you talking to the Resident. During a face-to-face meeting, Employee# 15 acknowledged the finding,	L 521	**Identification of others with potential to be affected.** All resident residing in the facility have potential to be affected. 2. Observations were conducted by the Charge Nurse and Team leader daily to ensure staffs are in compliance with the Resident Rights and Maintenance of Dignity. **Measures to prevent recurrence:** 3. In-service /Training will be conducted with staff on --- to ensure staff treat residents with respect and dignity by entering the resident's room without knocking and announcing self before entering the resident's room. **Monitoring Corrective action:** 4. Random audits and Observations will be conducted on a weekly basis. The results of the audits will be reported to the Quality Assurance Performance Improvement (QAPI) meeting monthly x 3 months.	10/18/18