Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0026	A. BUILDING: _____ B. WING _____	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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L 000	Initial Comments The Annual Licensure Survey was conducted at Sibley Memorial Renaissance Skilled Nursing Facility from April 19, 2021 through April 23, 2021. Survey activities consisted of a review of 17 sampled residents. The following deficiencies are based on observation, record review, resident, and staff interviews. An analysis of the findings determined the facility is not in compliance with Title 22b District of Columbia Municipal Regulations (DCMR) Chapter 32. The resident census during the survey was 23. 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 CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube	L 000		

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L 000	Continued From page 1 HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 2 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for 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 review and staff interview, for one (1) of 17 sampled residents, the charge nurse failed to update/revise the compromised skin integrity care plan to address Resident #20's impaired skin integrity. The findings included ... Resident #20 was admitted to the facility on 03/17/2021, with multiple diagnoses, including Fracture of the Tibial Plateau, Status Post Open Reduction and Internal Fixation, Deep Vein Thrombosis, Rheumatoid Arthritis, and Osteoporosis. Review of the Care Plan (Compromised Skin	L 051	1.Corrective Action for Identified residents: a) The resident's record reviewed and elements for learning and teaching were identified in addition to gaps relative to documentation standards. This information will be used to re-educate the nursing staff. Following the survey resident EHR was audited, inconsistent skin assessment documentation was noted, the care plan was updated to include the following treatment plan administered to the resident included all the following; Heel pressure off loading device put in place, incontinent management followed, airflow under pads was use, foam dressing was applied for protection and moisturizer was applied as ordered and pain was managed. b) The employee identified in this deficiency will be reeducated and coached using our Just Culture policy. 2.Identification of Other residents having the Potential of be Affected: a) Audit was done on EHR of all the current resident in the facility with skin integrity issues and there are no deficient practices identified. b) No direct impact identified to resident from the deficient practice. Policy: "REN-Renaissance Care Plan" [REN053] was reviewed and determined not to require any revisions. Following the survey, review of Electronic Health Records (EHR) of the current resident and there are no additional findings. 3. Systemic Changes to Prevent Recurrence: a) MDS staff will provide comprehensive care plan education to nursing staff with completion by June 5, 2021.	

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L 051	Continued From page 3 Integrity) with a start date of 03/18/2021, revealed the following Interventions: " ...2. Observe and relieve pressure to boney prominences. 3. Avoid sheering. 4. Keep skin clean and dry ...6. Apply or encourage use of lotion/moisturizer on intact skin as indicated ...8. Consult with wound, ostomy and/or continence nurse as needed." Review of the Admission Minimum Data Set (Assessment Reference Date of 03/24/21), documented the following: in Section C0500 (Brief Interview for Mental Status), the resident has a summary score of 14, indicating the resident was cognitively intact. In Section M0300 (Current Number of Unhealed Pressure/Ulcers at Each Stage), "skipped" was documented, indicating Resident #20 did not have a pressure ulcer during the assessment period. Review of the physician's orders dated 03/29/21 at 21:52 (9:52 PM), revealed the following, "Specialized bed therapy ...non-weight bearing to RLE [right lower extremity] now presents with pressure sore of [heels L > R]." The Care Plan (Compromised Skin Integrity) was not updated with goals and approaches to address Resident #20's left heel (pressure) wound identified on 3/29/2021. During a face-to-face interview with Employee #12 on 04/21/2021, at approximately 3:30 PM, she acknowledged the finding and stated, "It's not there."	L 051	L051 con't 4. Monitoring and Incorporation into Quality Assurance and Performance Improvement a)On a monthly basis or weekly, the quality improvement nurse specialist and or his/her designee will conduct an audit of the electronic medical record, with specific review of the care plan to ensure the appropriate documentation is included around the wounds/skin integrity and to ensure that the care plan is comprehensive in nature. Further, the quality nurse specialist and or his/her designee will ensure that an LDA (Line, Drains and Airway) is completed and supportive of the care plan as it relates to wounds/ skin integrity. The audit will be on at least ten (when volume allows) residents with wounds/skin integrity issues. Any instances of non-compliance will be addressed in real-time and the implementation of our Just Culture process will be used. Compliance will be reported monthly to leadership and at each QAPI committee meeting and the audits will remain in effect until compliance is sustained at 100% for three consecutive months. 5.The corrective action will be completed on or by June 22, 2021	6/22/21
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident	L 052		

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L 052	Continued From page 4 receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene,	L 052		

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L 052	Continued From page 5 including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A.Based on observation, record review, and resident and staff interview, facility staff failed to ensure that sufficient nursing time was provided to Resident #20, who was admitted to the facility with a bruise to the left heel received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent a deep tissue injury from developing for approximately 14 days, for one (1) of 17 sampled residents. The findings included ... "Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration - Intact or non-intact skin with localized area or persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature changes often preceded skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full-thickness pressure injury (unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions."	L 052	1. Corrective Action for identified resident: a)Immediate action was taken, review of the identified resident's Electronic Health Record (EHR) was done and inconsistent documentation of skin assessment was found. EHR finding and the importance of appropriately and accurately assessing skin integrity on admission and every shift was addressed in safety huddles after completion of the survey and during Staff Meeting by the DON. Employees #1, #2, #13 and #15 involve will be coached by the Director of Nursing (DON) by June 22, 2021.CWON will be individually counseled about consult and documentation expectations by supervisor by 6/22/21. b)After the survey the following treatment plan was administered to the resident: Skin assessment every shift was done and skin monitoring to prevent additional skin problems. Heel pressure off loading device put in place, incontinent management, airflow under pads, foam dressing applied for protection and moisturizer applied as ordered and pain management included in the plan, dressing change order obtain from the Physician and implemented, CWON and Dietician continue to monitor the resident's progress. Oral supplement added to promote healing. An x-ray and doppler of the left lower extremities were done. 2.Identification of other resident having potential to be affected: Every resident having the potential to be affected by the same deficient practice will be identified on all admissions. EHR of all current residents was reviewed and no deficient practice found. 3.The following systemic changes will be in place to ensure that the deficient practice does not recur: a)All residents who are high risk for pressure injury(ies) and those with existing pressure injury(ies) will be identified upon admission. This will occur by two nurses completing a thorough full body skin assessment and documenting with the smart phrase in EPIC.	

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L 052	Continued From page 6 https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_25_july_20161pdf.pdf?db=web&hash=A8BF4B1E486A6A67DD5210A2F36E0180 Resident #20 was admitted to the facility on 03/17/2021, with multiple diagnoses, including Fracture of the (Right) Tibial Plateau, Status Post Open Reduction and Internal Fixation, Deep Vein Thrombosis, Rheumatoid Arthritis, and Osteoporosis. Review of the Admission Minimum Data Set (Assessment Reference Date of 03/24/21), doucmeted the following: in Section C0500 (Brief Interview for Mental Status), the resident had a summary score of 14, indicating the resident was cognitively intact. In Section M0300 (Current Number of Unhealed Pressure/Ulcers at Each Stage), "skipped" was documented, indicating Resident #20 did not have a pressure ulcer during the assessment period. Review of the resident's medical record revealed the following notes: "03/17/21 at 9:07 PM (Nursing Note) - sole of feet observed with hard skin ..." "03/18/21 at 3:39 PM (Wound/Ostomy Note) - patient seen today for wound care to surgical incision on right leg, s/p (status post) ORIF (open reduction and internal fixation) of right bicondylar tibial plateau ...offloaded heels, heels are dry, no redness noticed. It is sore to touch ..." A review of the Wound Nurse's picture of the Resident's left heel (scan date of 03/18/21)	L 052	L052 con't b)Identified non-compliant nurses will be counseled by Quality Compliance RN. c)All Nurses in the Renaissance Facility will be assigned the Skin Integrity myLearning course. The Director of Nursing will ensure all nurses are signed off on HAPI Prevention skill competency by 6/22/21. d)Residents with pressure injuries and high risk for skin integrity problems will be reported on daily safety huddles by Charge Nurse. Renaissance will have at least one representative at the monthly Skin Integrity Committee and update will be shared in safety huddles. 4.Monitoring and Incorporation into Quality Assurance and Improvement Process: a) The Director of nursing or designee will review LDA (Line Drains and Airway) /flowsheets of newly documented Pressure Injuries and will notify Renaissance leadership when indicated. Root Cause Analyses (RCAs) will be completed within seven days and reported out at the weekly HAPI huddle. Results will be reported at the quarterly Quality Compliance and Performance Improvement meeting. b)On a monthly basis, the Quality Nurse will audit 10 resident records to ensure compliance with the smart phrase and the two-nurse assessment. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to leadership and at each QAPI committee until compliance is sustained for a continuous 3 months.	

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L 052	Continued From page 7 showed a dark area approximately the size of a quarter. Review of the Care Plan (Compromised Skin Integrity) with a start date of 03/18/2021, revealed the following interventions: " ...2. Observe and relieve pressure to boney prominences. 3. Avoid sheering. 4. Keep skin clean and dry ...6. Apply or encourage use of lotion/moisturizer on intact skin as indicated ...8. Consult with wound, ostomy and/or continence nurse as needed." Review of the physician's orders dated 03/29/21 at 21:52 (9:52 PM), revealed the following, "Specialized bed therapy ...non-weight bearing to RLE [right lower extremity] now presents with pressure sore of [heels L > R]." Although the physician ordered a specialized bed for the resident due to pressure sore(s) of heels, there was no doumented evidence of an assessment of the resident's left or right heel to determine the size, characteristic and staging of the pressure ulcer on 03/29/21. Review of the "Nursing Flow" sheet from 03/17/21 at 7:40 PM to 04/01/21 at 9:00 PM revealed the following: -Integumentary section [the form used by the nursing staff to monitor a resident's skin appearance every shift). The section was left blank indicating that nursing staff did not observe any impairment or discoloration to the residents left heel. - Pressure Ulcer Prevention Intervention section documented - "suspend heels off [the] bed and heel pressure-offloading device ..."	L 052	L052 con't c)The Quality Compliance RN will perform chart audit for current residents for consistent documentation of skin assessment for 3 months. The result will be reported to the quarterly QAPI meeting. 5. Corrective action will be completed by 6/22/21	

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L 052	Continued From page 8 "04/01/21 at 10:30 AM (Wound/Ostomy Note): Subjective: pt [patient] said the left heel was burning last night, it feels somebody scraped the heel. The nurse put some cream on it ...gave me some medicine. The pain finally went away... The [left] heel is black, hard to touch, it is very tender to touch. Recommend ...x-ray ...check for any traumatic changes ... pain on left heel when it is touched 9 of 10." Review of the physician's orders dated 04/01/21[not time indicated] revealed, "XR [x-ray] Calcaneus [heel bone] Left Minimum 2VWs [views]." Review of the X-ray dated 04/01/21 at 4:45 PM of the Resident's left heel showed, "Impression Osteopenia without acute osseous findings and degenerative changes." "04/01/21 at 5:49 PM (Physician Progress Note) - Plan #11- Pressure sore to the left heel, low air loss mattress, reposition every 2 hours as needed, ostomy care team following patient, [and] float heels as tolerated." "04/02/21 at 5:54 PM (Wound/Ostomy Note) - Patient seen for pressure injury assessment and care. Location- left heel, stage - deep tissue injury ...the heel has a localized black area, it is tender and firm to touch, skin is intact. It is likely deep tissue injury ...Initial Pressure Injury Staging - Deep Tissue Pressure Injury, Length 3 cm (centimeters), Width 3.5 cm" "04/08/21 at 1:00 PM (Wound/Ostomy Note) - The black discoloration on left heel remains dry and intact. Patient said it feels better, it is not tender anymore. Continue to offload the heels ..."	L 052		

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L 052	Continued From page 9 "04/19/21 at 4:10 PM (Wound/Ostomy Note) - patient seen today ...assess DTI (Deep Tissue Injury) on left heel ...dry black eschar ..." A face-to-face interview was conducted with Resident #20 in her room on 04/21/2021, at approximately 5:00 PM. During this time, the resident was observed sitting up in the bed eating dinner and reported that there was pain to her left heel. An observation of Resident #20's left heel was conducted and revealed a darkened area that covered the resident's left heel. The area was intact and did not have drainage or smell. A cushion used to elevate the resident's feet/heel(s) was observed at the foot of the bed. At the time of the observation, the resident's heel was not on the cushion as the resident was eating dinner. During a face-to-face interview on 04/23/21 at 9:39 AM, the Director of Nursing (Employee #2), stated that nursing staff assess all resident's skin every shift and document findings on the flowsheets. There was no evidence that facility staff noted and treated the darkened area to Resident #20's left heel for approximately 14 days (3/29/2021) when there was an order for a Specialized bed therapy due to the resident presenting with pressure sore of [heels L > R]. Four (4) days later on 04/02/21, the wound/ostomy nurse documented that the resident had an "Initial Pressure Injury Staging - Deep Tissue Pressure Injury, Length 3 cm (centimeters), Width 3.5 cm" The Care Plan/Compromised skin integrity was not updated with goals and approaches to address Resident #20's left heel (pressure) wound identified on 3/29/2021.	L 052		

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L 052	Continued From page 10 During a face-to-face interview conducted on 04/23/2021, at approximately 1:00 PM, Employee #13 stated that she observed a bruise on Resident #20's left heel during her initial assessment on 03/18/2021. However, she did not inform staff about the bruise to the resident's left heel, but she did start the resident on Heelz Up (a pressure-relieving device). Employee #13 also said although she performed wound care to Resident #13's right knee surgical wound twice a week starting on 03/18/21, she did not re-assess the resident's left heel "bruise" again until 04/01/21 (15 days after her initial assessment) when the resident complained of pain. The left heel was staged as a deep tissue injury on 04/02/21. Employees #'s 1, 2, 13, and 15, acknowledged the finding. B. Based on observation, record review and staff interview, for one (1) of 17 sampled residents, facility staff failed to ensure that sufficient nursing time was provided to treat a resident with an indwelling catheter with respect and dignity as evidenced by his urinary collection bag being exposed while walking in the hallway. Resident #284. The findings included ... Resident #284 was admitted to the facility on 04/14/2021, with diagnoses that included: Left hip postop wound infection, Deep Vein Thrombosis (DVT), Post-Operative Pain, Difficulty Urinating due to Benign Prostatic Hypertension and Insomnia. Review of the admission Minimum Data Set (MDS) dated 04/14/2021, revealed in Section H (Bowel and Bladder) "16 Fr [French] Catheter	L 052	L052 1.Corrective action for Resident #284 was corrective immediately after the deficiency was discovered by covering the indwelling collection bag with privacy cover and remained in placed until the resident discharge the deficiency was noted and addressed in staff meetings by the Director of Nursing on May 17, 2021. 2. Identification of Other residents having the Potential of be Affected: All residents with indwelling catheters having the potential to be affected by the same deficient practice will be identified on admission. All residents on the REN during the time of survey were observed to ensure the indwelling foley catheter had privacy covers. There were no findings. 3. Systemic Changes to Prevent Recurrence: The following systemic changes will be put in place to ensure deficient practice will not recur. a.Nursing staff was educated immediately in safety huddles following the survey on the deficiency and requirements of treating residents with dignity respect during staff meetings by the Director of Nursing on May 17th, 19thand 21st 2021.	

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L 052	Continued From page 11 Balloon size 10mL (milliliters) Placement 4/8/2021 by urology." Review of the care plan dated 04/14/2021, revealed for the problem, "Indwelling Catheter Maintenance", intervention #12, "Nursing staff will ensure resident's Foley bag is covered when out of resident's room to ensure resident dignity" During a tour of unit 3 south on 04/20/2021, at 11:56 AM, Resident #284 was observed walking in the hallway with Employee #7 with his urinary catheter drainage bag not covered, exposing the contents of the drainage bag. During a face-to-face interview conducted with Employee #7 on 04/20/2021, at approximately 11:56 AM, she acknowledged the finding and stated, "I am not sure about any privacy covering for the regular drainage bag."	L 052	L052 b.Education provided to both Rehab and Nursing around resident dignity and respect to include use of privacy cover for Foley catheter. c.Supply of privacy cover for indwelling catheter and drains are now available for Nursing and Rehab and location of supply has been communicated during the safety huddles. d.Management of Residents with Indwelling Urinary catheter Policy (REN063) was reviewed and updated to maintain the respect and dignity of resident. 4.Monitoring and Incorporation into Quality Assurance and Performance Improvement Process: a)Nursing Leadership will conduct randomized observations monthly to ensure compliance of privacy cover for resident identified with indwelling catheter and or drain. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5. Corrective date will be completed by 6/22/21	
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 prepare and distribute foods under sanitary conditions as evidenced by one (1) of two (2) soiled convection oven in the bake shop area, two (2) of two (2) soiled convection ovens in the patient hotline area, and 32 of 33 food service trays that were cracked at both handles. Findings included ...	L 099		

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L 099	Continued From page 12 During a walkthrough of dietary services on 04/19/2021, at approximately 11:15 AM, the following were observed: 1. One (1) of two (2) convection ovens in the bake shop area was soiled with burnt food residue. 2. Two (2) of two (2) convection ovens in the patient hotline area were soiled with burnt food residue. 3. 32 of 33 food service trays stored for use in the dishwashing machine area were cracked at both handles. Employee #4 confirmed the findings during the walkthrough on 04/19/2021, at approximately 2:00 PM.	L 099	L099 1.There was no direct harm to our residents from this deficient practice. All identified findings were immediately addressed on 4/19/21. 2. No additional residents were identified to be affected by this deficient practice. On 5/11/21 the Director of Food Services submitted an order of new food service trays. 3. On 5/20/21 the Food Services Director will re-educate employees on the importance of convection oven cleaning ,food tray storage including F 812 Food Procurement, Store/Prepare/Serve-Sanitary requirements. An audit will be conducted on soiled convection ovens and food trays. 5/17/21 4. On a monthly basis, the Food Services Director or designee will conduct weekly audits to ensure convection oven cleanliness and food trays are not cracked. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to the leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5.Corrective Action will be completed by 6/22/21	
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on one (1) of one (1) medication storage observation, facility staff failed to ensure that a syringe containing Neurontin (an anti-epileptic drug) was not stored for use beyond the expiration date. Findings included ... During an observation of the 3 south medication refrigerator on 04/20/2021, at approximately 10:45 AM, it was observed that one (1) of one (1) syringe labeled, "Neurontin 250 mg (milligrams)/5 ml (milliliters) solution 300 mg dose = 8 ml expiration date 4/18/21" was stored for use.	L 161	L161 1. There was no direct harm to our residents from this deficient practice. All identified findings of expired medication was immediately removed on 4/20/21. 2. No additional patients/residents were identified as being negatively impacted by this deficient practice. Pharmacist or designee will conduct a full in-house Renaissance audit by 5/22/21.	

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L 161	Continued From page 13 Employee #9 acknowledged the finding at the time of the observation and stated that the resident had been discharged and that the medication should have been removed from the unit by the pharmacy technician during their rounds.	L 161	3. Pharmacy Leadership reviewed and updated policy: "Medication Preparation, Dispensing and Distribution" [PHAR-POL008] to delineate expectation that upon discharge of patient/resident, nursing is to remove all medications from the patient/ resident's bin, place in a bag to include the patient/ resident's name and place in the "Return to Pharmacy" bin for pick up on the next scheduled delivery by pharmacy. Policy was approved at Pharmacy and Therapeutics Committee on 5/18/2021.	
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to maintain essential equipment in good working condition as evidenced by two (2) of six (6) convection ovens with a loose door handle, and one (1) of two (2) steam kettles that intermittently blew out steam from its connection valve in the patient hotline area. The findings included... During a walkthrough of dietary services on 04/19/2021, at approximately 11:15 AM, essential pieces of equipment were not functioning as intended: 1. One (1) of two (2) convection ovens in the bake shop area had a loose door handle. 2. One (1) of four (4) convection ovens at station #6 had a loose door handle. 3. The connection valve located at the bottom of one (1) of two (2) steam kettles kept releasing occasional bursts of steam in the patient hotline	L 359	Reeducation of Nursing staff to remove and bag medications of discharged residents from the resident specific bin and place in "Return to Pharmacy" bin for pick up by a Pharmacy Technician on next scheduled delivery will occur at the staff meetings scheduled for 5/17/21-5/21/21. Email education will also be provided to all Renaissance nursing staff on 5/21/21 to ensure staff not in attendance at the staff meetings are reeducated. Reeducation of Pharmacy Technicians, including process to be followed for checking all bins each day at 24-hour cart exchange to remove any medications of discharged patients/residents occurred during a Pharmacy Technician meeting on 5/17/21. Email education has also been provided to all Pharmacy Technicians on 5/17/21 to ensure staff not in attendance at Pharmacy Technician meeting are reeducated. 4. On a monthly basis, Pharmacy will conduct audits to observe for expired medications. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5. Corrective action will be completed by 6/4/21.	

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L 359	Continued From page 14 area. Employee #4 acknowledged the findings during the walkthrough on 04/21/2021, at approximately 2:00 PM.	L 359	L359 1. There was no direct harm to our residents from this deficient practice. All identified findings were immediately addressed on 4/19/21 with work orders #138771 & 138770. 2. No additional residents were identified to be affected by this deficient practice. 3. On 5/20/21 the Food Services Director will re-educate employees on the importance of maintaining essential equipment in good working condition such as oven door handles and steam kettles including F 908 Essential Equipment, Safe Operating Condition requirements. An audit will be conducted for convection oven door handles and	
L 419	3256.10 Nursing Facilities The facility shall develop policies and procedures relating to the operation of housekeeping and maintenance services. This Statute is not met as evidenced by: Based on observation and interview, facility staff failed to maintain building equipment in good working condition as evidenced by walls that were marred in nine (9) of 12 resident's rooms, and a damaged floor in one (1) of 12 resident's rooms. The findings included... During an environmental walkthrough of the facility on 04/21/2021, at approximately 1:00 PM: 1. Walls in resident room #302, #306, #307, #311, #313, #318, #320, #326, and #331, were marred in several areas, nine (9) of 12 resident's rooms. 2. The floor was damaged with a hole located in front of the closet in resident room #302, one (1) of 12 resident's rooms surveyed. Employee #5 acknowledged the findings during the walkthrough on 04/21/2021, at approximately 2:00 PM.	L 419	steam kettles. 4. On a monthly basis, the Food Services Director or designee will conduct monthly audits to ensure convection oven handles and steam kettles are in safe operating condition. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to the leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5. All corrective action will be completed by 6/22/21 L419 1.There was no direct harm to our residents from this deficient practice. All identified Rooms 302, 304, 306, 307, 311, 314, 318, 320, 326 and 331 findings were corrected on 4/21/21. 2. No additional residents were identified to be affected by this deficient practice. 3. The Engineering Director re-educated staff on the importance of maintaining resident rooms A full resident room audit will be conducted by 5/28/21 to ensure all rooms are in good working condition. 4. On a monthly basis, Plant Operations will conduct monthly audits to ensure rooms are in good working condition. Any identified instances of non-compliance will be immediately addressed and compliance will be reported for 90 days to QAPI committee.	
L 486	3267.7 Nursing Facilities Each nursing facility shall have a worker education requirement regarding modes of	L 486	5. Corrective action will be completed by 6/22/21	

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L 486	Continued From page 15 transmission, use of personal protective equipment, disinfection policies and procedures, and other preventive measures in accordance with current CDC guidelines on the use of " Standard Precautions " and " Transmission-Based Precautions " . This Statute is not met as evidenced by: Based on two (2) of two (2) observations, record review and staff interview, facility staff failed to maintain infection control prevention practices in accordance with standards of practice to minimize the potential spread of infections. The findings included ... 1. Facility staff failed to don required personal proctective equipment while in a resident care area. During a tour of unit 3 south on 04/19/2021, at approximately 11:00 AM, it was noted that there was a sign on all the resident's doors that revealed, "Please wear the following when entering in resident's room: Gown, gloves, surgical mask, face shield..." During an observation on 04/19/2021, at 1:18 PM, Employee #10 was observed inside resident room #329, not wearing a gown while setting up the resident's meal tray. It should be noted that the employee was wearing a mask, face shield and gloves. During a face-to face interview conducted at the time of the observation, Employee #10 acknowledged the finding and stated, "I just came back from lunch and was setting her tray set up. And I gown up in the room."	L 486	L486 1. Corrective Action for Identified residents: a)There is no further corrective action for resident in room #329 found to have been affected by the deficient practice as the resident has been discharge. b)Identified employee #3, #14 responsible for the deficiency was reeducated on the appropriate use of PPE by his/her nursing supervisor/charge nurse April 19, 2021. c)Employee # 10 who failed to proper donning of personal protective equipment while assisting resident during meal was re educated by the nurse on proper donning and doffing of PPE after deficient practice was noted. 2.Identification of Other residents having the Potential of to be Affected: a) All residents having the potential to be affected by the same deficient practice, following the survey infection control practices of staff in resident care areas have been evaluated and addressed to ensure that no additional deficient practice remains. 3. Systemic Changes to Prevent Recurrence: a) Counsel Wound Ostomy Nurse on relevant policies (INPR-POL001, HEIC004, REN038, REN033, REN044). b) Education to Renaissance staff on proper Donning and Doffing of Personal Protective Equipment (PPE), performing the proper Hand Hygiene, and review of relevant policies (INPR-POL001, HEIC004, REN038, REN033, REN044) c) An RCA was conducted on 5/18/21 for the deficient statement and the finding are addressed in the corrective action plans and there is no additional action to be taken	

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L 486	Continued From page 16 During a face-to face interview conducted on 04/22/2021, at 2:44 PM, Employee #3 stated, "The standard is to have on face shield and mask everywhere, at all times in the [Skilled Nursing Facility]. In resident rooms, the standard is to have on a gown in the room regardless if doing patient care or not. Gowns are to be put on before entering the resident's room." 2. Facility staff failed to maintain Infection Prevention and Control Practices while performing wound care. On 04/20/2021, at 11:15 AM, observation of wound care being provided for Resident #28's surgical wound (lower back staples) revealed the following: Employee #14, Wound/Ostomy Nurse, placed wound care supplies on top of the resident's bedspread while the resident was lying under it at the start time of the dressing change. After removing the old dressing and placing it on the bed, the employee failed to perform hand hygiene and put on new gloves before cleaning the resident's lower back surgical site. The employee failed to maintain infection prevention and control practices to help prevent the development and transmission of infections by failing to place wound supplies on a clean surface. During a face-to-face interview conducted on 04/20/2021, at approximately 11:25 AM, Employee #14, acknowledged that she failed to place the wound care supplies on a clean surface and sanitize her hands between removing the old dressing and cleaning the resident's surgical site.	L 486	4.Monitoring and Incorporation into Quality Assurance and Performance Improvement Process: a)The quality nurse will complete direct observations of all staff providing care to residents to ensure ongoing compliance of donning and doffing of PPE and the 5 moments for hand hygiene. Just in time coaching will be provided to employees when applicable. Compliance will be reported monthly to leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5. Corrective action will be completed by 6/22/21.	

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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, record review and staff interview, for one (1) of 17 sampled residents, facility staff failed to treat a resident with an indwelling catheter with respect and dignity as evidenced by his urinary collection bag being exposed while walking in the hallway. Resident #284. The findings included ... Resident #284 was admitted to the facility on 04/14/2021, with diagnoses that included: Left hip postop wound infection, Deep Vein Thrombosis (DVT), Post-Operative Pain, Difficulty Urinating due to Benign Prostatic Hypertension and Insomnia. Review of the admission Minimum Data Set (MDS) dated 04/14/2021, revealed in Section H (Bowel and Bladder) "16 Fr [French] Catheter Balloon size 10mL (milliliters) Placement 4/8/2021 by urology." Review of the care plan dated 04/14/2021, revealed for the problem, "Indwelling Catheter Maintenance", intervention #12, "Nursing staff will ensure resident's Foley bag is covered when out of resident's room to ensure resident dignity" During a tour of unit 3 south on 04/20/2021, at 11:56 AM, Resident #284 was observed walking in the hallway with Employee #7 with his urinary catheter drainage bag not covered, exposing the	L 521	L521 1.Corrective action for Resident #284 was corrective immediately after the deficiency was discovered by covering the indwelling collection bag with privacy cover and remained in placed until the resident discharge the deficiency was noted and addressed in staff meetings by the Director of Nursing on May 17, 2021. 2. Identification of Other residents having the Potential of be Affected: All residents with indwelling catheters having the potential to be affected by the same deficient practice will be identified on admission. All residents on the REN during the time of survey were observed to ensure the indwelling foley catheter had privacy covers. There were no findings. 3. Systemic Changes to Prevent Recurrence: The following systemic changes will be put in place to ensure deficient practice will not recur. a.Nursing staff was educated immediately in safety huddles following the survey on the deficiency and requirements of treating residents with dignity respect during staff meetings by the Director of Nursing on May 17th, 19thand 21st 2021. b.Education provided to both Rehab and Nursing around resident dignity and respect to include use of privacy cover for Foley catheter. c.Supply of privacy cover for indwelling catheter and drains are now available for Nursing and Rehab and location of supply has been communicated during the safety huddles. d.Management of Residents with Indwelling Urinary catheter Policy (REN063) was reviewed and updated to maintain the respect and dignity of resident.	

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L 521	Continued From page 18 contents of the drainage bag. During a face-to-face interview conducted with Employee #7 on 04/20/2021, at approximately 11:56 AM, she acknowledged the finding and stated, "I am not sure about any privacy covering for the regular drainage bag."	L 521	L521 con't 4.Monitoring and Incorporation into Quality Assurance and Performance Improvement Process: a)Nursing Leadership will conduct randomized observations monthly to ensure compliance of privacy cover for resident identified with indwelling catheter and or drain. Any identified instances of non-compliance will be immediately addressed. Compliance will be reported monthly to leadership and at each QAPI committee until compliance is sustained for a continuous 3 months. 5. Corrective date will be completed by 6/22/21	