Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	05/22/2015

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THE WASHINGTON HOME	3720 UPTON STREET NW WASHINGTON, DC 20016

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L 000	Initial Comments The annual Licensure survey was conducted on May 11, 2015 through May 22, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 37 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	L 000	The Washington Home makes its best effort. To operate in substantial compliance with both Federal and State law. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its board, officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the Statement of Deficiencies. The following Plan of Correction constitutes the facility's written credible allegation of compliance. It is prepared and/or executed solely because it is required by Federal and State law.	

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L 000	Continued From page 1 MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for	L 051		

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L 051	Continued From page 2 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 observation, record review, and staff and resident interview for one (1) of 37 sampled residents, it was determined that facility staff failed to notify the physician when a second area of skin impairment was first noted on Resident #23's left buttocks. The findings include: Through staff interview it was determined facility staff observed a new wound on Resident # 23 ' s left buttock on the weekend of May 9 to 10, 2015; however, notification to a physician or nurse practitioner was not made. Treatment orders for management of the wound were initiated on May 13, 2015 (approximately 4 days later) after the area was assessed as a stage 3 pressure ulcer during routine wound rounds by the Nurse Practitioner. On May 13, 2015 (Wednesday) incontinence care was observed for Resident #23. It was noted that the resident had two (2) dressings on his/her left buttock and one (1) on the right buttock all	L 051	**L 051** 1. Nurses caring for resident #23 were counseled and re-educated on facility policy for notifying Medical Staff on resident changes in condition. The resident's wound did not worsen in the time period addressed by the deficiency and is resolved. The resident received treatment for the wound although the medical staff were not notified. The staff associated with this incident received counseling and received education regarding the organization's protocol as to what information needs to be communicated to the physician or Advanced Practice Nurse. 2. An audit of all residents with pressure ulcers was completed. Medical Staff notifications and initiation of treatment orders were in compliance with facility policy. Opportunities for improvement were completed at time of audit. An audit of the medical record of all residents with pressure ulcers was conducted to determine if the physician or Advanced Practice Nurse was notified about the wound and if orders were obtained for appropriate treatment of the wound(s). Any remarkable instances were corrected at the time of the audit.	

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L 051	Continued From page 3 initialed by a licensed nurse and dated May 12, 2015. A review of the most recent " Skin Condition Report " dated May 4 and 7, 2015 revealed that Resident #23 had two (2) wounds: left buttock (abscess) and right buttock (abrasion). There was no documentation of a second skin integrity concern on the left buttock as observed on May 13, 2015. Subsequent to the observation of incontinence care on May 13, 2015 the following progress notes were recorded. An Interdisciplinary Progress Note dated May 13, 2015 at 11:15 AM, by the Nurse Practitioner Student revealed the following, " ... Pt. (patient) has not been out of bed ...Skin breakdown - wound care rounds - new orders. L (left) Buttock abscess 2 x 1 x .01cm healing; R (right) buttock 1.5 x 2.5 x .01 cm unstageble, L buttock Stage III 2 x 1 x .01cm ...ordered alternating pressure mattress ... " A review of the Nurse Practitioner ' s note dated May 13, 2015 [no time indicated] revealed, ... Abscess to L butt is healing s/p antbx (antibiotics) - has new pressure ulcers - will order alternating pressure mattress and PT (physical therapy) to evaluate seating for new cushions. " Interviews A face-to-face interview was conducted with Employees #22 (Certified Nurse Aide) on May 15,	L 051	3. Clinical Managers will be educated to audit the electronic healthcare record (EHR) of all residents with pressure ulcers weekly, using criteria added to the weekly Skin Integrity Audit Tool. All licensed nurses will be educated on Medical Staff notification and complete a Skin/Wound Competency. Clinical Managers will conduct a weekly audit of the medical record of all residents with pressure ulcers. The criteria for the audit will be added to the weekly Skin Integrity Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. All licensed nurses will receive education on facility protocol of Notification of Physician (Advanced Practice Nurse) and will be administered a Skin/Wound Care Competency. 4. Clinical Managers will report findings of Skin Integrity Tool to Focus Quality Improvement (QI)-Interdisciplinary Team (IDT) weekly for review and identification of opportunities for performance improvement (OPI). All licensed nurses will complete a mandatory biannual education on physician notification protocol and successfully complete the annual Wound Care Competency.	

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L 051	Continued From page 4 2015 at approximately 3:40 PM. He/she stated, " I observed three (3) areas on the resident this weekend May 9, and 10, 2015." A face-to-face interview was conducted with Employees # 20 and 29 (License Practical Nurses) on May 15, 2015 at approximately 3:43 PM. They stated, " We treated the new area on the left buttocks the same as we did the other areas. It looked the same. We treated it with warm compress and dry dressing. A face-to-face interview was conducted on May 15, 2015 at 3:45 PM with Employee #6. He/she reviewed the physician ' s orders and acknowledged that there was no order to treat three (3) open areas on the resident ' s buttocks. There was no evidence in the clinical record that facility staff notified the physician, when there was a second area of skin impairment identified on Resident #23's left buttock. The record was reviewed on May 22, 2015. B. Based on observation, record review and staff interview for one (1) of 37 sampled residents, it was determined that the charge nurse failed to develop a care plan with goals and approaches for one (1) resident ' s diagnosis of insomnia. Resident # 4 The findings include: The charge nurse failed to develop a care plan with goals and approaches for the care of a resident diagnosed with insomnia. Resident #4	L 051	Data Analysis of the Skin Integrity tool will be discussed weekly at the Focus Quality Improvement meeting and reported quarterly by the QI manager to the Quality Improvement Team. The facility protocol of Notification of Physician (Advanced Practice Nurse) will be conducted as a twice mandatory education session for all Licensed Nurses. All Licensed Nurses will be administered and must successfully pass an annual Wound Care Competency. 5. Compliance Date:	7/22/2015

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L 051	Continued From page 5 A review of the physician ' s order sheet dated 4/23/2015 revealed, " Trazadone hcl (Desyrel), tablet 50 mg: Give 1 Tablet By Mouth 1 time per day at bedtime at 21:00 [9:00 PM], for Insomnia ... " A review of the plan of care for Resident #4 lacked evidence that a care plan with goals and approaches was developed to address resident #4 ' s diagnosis of Insomnia. A face-to-face interview with Employee #6 was conducted on May 19, 2015 at approximately 3:00 PM. He/she reviewed the care plans and acknowledged that a care plan for insomnia was not initiated for Resident #4. The record was reviewed on May 19, 2015. C. Based on record review and staff interview for three (3) of 37 sampled residents, it was determined that the charge nurse failed to review and revise resident care plans to reflect an integrated approach with the participation of hospice, the facility, and the resident or representative to the extent possible for (2) residents; and to address one (1) resident ' s activity needs. Residents ' #109, 120 and 216. The findings include: 1.The charge nurse failed to review and revise Resident # 109 ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible.	L 051	**L 051B** 1. A care plan with goals and approaches for diagnosis of insomnia was completed for Resident #4. Resident #4 did not have a delay in treatment due to not having a care plan for their diagnosis of insomnia. The employee was counseled. 2. A facility-wide audit to verify all diagnoses addressed in care plan was completed and improvements done at time identified. 3. Nurses will be re-educated to address all diagnoses with a plan of care. Clinical Mangers will be educated on use of the Documentation Audit Tool to audit 20% of all current in-house resident records weekly and verify all active diagnoses and problems have a corresponding care plan. Clinical Mangers will submit completed Documentation Audit Tool forms to the Director of Nurses weekly. They will use the Documentation audit tool to complete the audit. 4. Clinical Managers will report variances to Focus QI-IDT meetings monthly. The QI Manager will report audit findings to the QAPI Committee quarterly. Clinical Managers will audit criteria will be added to the Clinical Managers Documentation Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. 5. Compliance Date:	7/22/2015

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L 051	Continued From page 6 A review of the Physician Order Sheet for the month of `April 2015 directed: Admit to Hospice for End Stage COPD [Chronic Obstructive Pulmonary] start date [November 11, 2014]. A review of the residents care plan revealed a care plan for " Resident is Hospice Care " with goals and approaches initiated February 10, 2015. However, the care plan lacked specific identification of the disciplines responsible for the approaches/interventions with hospice, the facility, resident or the responsible party. The charge nurse failed to review and revise the resident ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. The record was reviewed on May 22, 3015. 2. The charge nurse failed to updated the care plan with appropriate goals and approaches to address the resident ' s activity needs for Resident #120. A review of the clinical record revealed that the " Activities care plan " was last updated on May 3, 2015. Revealed " Problems: Patient is in an adjustment period due to recent admission to facility for rehab service. However, Resident #120 was admitted to the facility on May 10, 2013 and has resided in the facility for approximately two years. In addition, the " Evaluation " of goals and approaches related to the activity problem was s last updated on February 15, 2014.	L 051	**L051C** 1. The hospice care plan for Resident #109 was integrated by participation of hospice, the facility, and the residents/family. 2. All hospice patients (3) on long term care (LTC) were reviewed and integrated hospice care plans identified on the Medical Record. 3. Hospice-LTC care plan integration will be verified by hospice and LTC nurses signing at time of care plan. LTC Social Worker will notify Hospice Manager of care plans scheduled for hospice patients on LTC; Hospice Manager will attend the care plan meeting. 4. Hospice Quality Improvement Nurse will audit log tracking integration of care plans reviewed by Hospice interdisciplinary team every fourteen (14) days and Hospice Manager participation in care plan meeting of hospice residents on LTC monthly. Findings will be reported to the QAPI Committee quarterly. 5. Date of compliance:	7/22/2015

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L 051	Continued From page 7 A face-to-face interview was conducted with Employee# 24 on May 19, 2015 at 11:15 AM. He/she stated, " I give [him/her] the choice in the morning by letting [him/her] know what the activities are for the day ...The last thing [he/she] went to was happy hour ... [He/she] goes outside and collects the tennis balls that the schools hit over. [He/she] likes to read and [he/she] stays to [him/herself] a lot of the time. " There was no evidence that the care plan was updated to include current goals and approaches to address the resident ' s activities needs. During the aforementioned face-to-face interview with Employee # 24, he/she acknowledged the findings. The record was reviewed on May 19, 2015. 3.The charge nurse failed to review and revise Resident #216 ' s care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. A review of the Physician Order Sheet for the month of May 2015 directed: Admit to Hospice for End Stage Parkinson ' s Disease. A review of the residents care plan revealed a care plan for " death with dignity, comfort and support care plan " with goals and approaches initiated March 6, 2015. However, the care plan lacked specific identification of the disciplines responsible for the approaches/interventions with hospice, the facility, resident or the responsible party. A face-to-face interview was conducted on May	L 051	**L051 #2.** 1. Care plan d/c and updated for Resident # 120. 2. No other resident was affected by this practice. 3. All residents care plans will be reviewed and updated to ensure needs are met. 3. a) provide in-service to activity staff regarding update of the activity plan of care b) monitor activity care plans on a quarterly basis. 4. The Director of Activities will monitor compliance on a daily basis and will report any variance to the Monthly QI Committee. 5. Compliance Date:	7/22/2015

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L 051	Continued From page 8 22, 2015 with Employee #6 at approximately 11:30 AM. After review of the care plans he/she acknowledged the findings. The charge nurse failed to review and revise Resident # 216's care plan for hospice to reflect an integrated approach with the participation of hospice, the facility and the resident or representative to the extent possible. The record was reviewed on May 21, 2015. 4. Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that the charge nurse failed to clarify the indication of use for the medication MAPAP [Acetaminophen] with the physician. Resident #133 The findings include: The charge nurse to clarify the indication of use for the medication MAPAP with physician. Resident #133 During an Unnecessary Medication Review, it was noted on the Interim Order Form signed and dated April 7, 2015 that Resident #133 was placed on MPAP "(Acetaminophen Extra Strength) Tablet 500mg, Give 2 tablets by mouth every eight hours at 06:00, 14:00, 22:00, for Osteoarthritis " A review of Admission and Annual Physical Examination Form signed and dated August 15, 2014 revealed the following diagnosis under Summary Plan: HIV [human immunodeficiency	L 051	**L051 #3** 1. The hospice care plan for Resident #216 includes specific identification of the disciplines responsible for the approaches and interventions with hospice, the facility, and resident or responsible party. (Copy of hospice care plan attached) 2. Care plans for all hospice patients (3) on LTC were reviewed. The signatures of disciplines responsible for approaches and interventions were present. Discipline signatures are viewed in computer; full screen too large to fit on chart. 3. Hospice Manager or designee will audit care plans for hospice residents on LTC for inclusion of disciplines responsible for approaches and interventions at hospice interdisciplinary team meeting every two (2) weeks. 4. Hospice Manager or designee will report audit findings to QAPI Committee quarterly. 5. Date of Compliance:	7/22/2015

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L 051	Continued From page 9 virus], HIV Dementia, Thrombocytopenia, CKD [chronic kidney disease] stage 2, HTN [hypertension], Frequent falls, (R) tib/fib [tibia/fibula] fracture s/p [status post] ORIF [open reduction internal fracture]. A review of the Interdisciplinary progress note revealed Resident #133 ' s 60 day review dated April 6, 2015 at 1:40PM reads as follow: " HIV, HIV Dementia, Thrombocytopenia, CKD stage 2, HTN, Frequent falls, (R) tib/fib fracture s/p [status post] ORIF. " A/P [active /Plan] #6 reads " Back pain + [positive], pt [patient] c/o [complain of] mild intermittent achy pain, start scheduled Tylenol Q (every) 8 hours. " A review of the Minimum Data Set (MDS) dated February 17, 2015 revealed in Section 1 Active Diagnosis the following diagnoses: Anemia Hypertension, Other Fracture, Non Alzheimer ' s Dementia, Psychotic Disorder, Human Immunodeficiency Virus, Unspecified Thrombocytopenia, insomnia unspecified, Dementia Unspecified with behavior, Chronic Kidney Disease stage 2, Other Specified Paranoid States, Unspecified Vitamin B Deficiency, Unspecified Vitamin D Deficiency and Edema. Review of the EMAR [Electronic Medication Administration Record] for the month of April, 2014 revealed electronic order for " MAPAP Acetaminophen 500mg: Give 2 tablets by mouth every eight hours (from Pharmacy) at 06:00, 14:00, 22:00, for Osteoarthritis; from Nurse practitioner, order enter by registered nurse. "	L 051	**L051 #4** 1. Osteoarthritis was added to list of diagnoses for Resident #133. In the Electronic Medical Record (EMR) and Minimum Data Set (MDS) Section I. 2. A facility-wide search of EMR identified all other residents on MAPAP Acetaminophen had a diagnosis specified with physician's order, on diagnoses list in medical record, and in MDS. 3. Medical Staff was educated to add new diagnoses to diagnoses list for inclusion in MDS Section I. Clinical Managers and MDS nurses will check for new diagnoses at time of each assessment. 4. Medical Director will monitor compliance during ongoing monthly reviews and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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L 051	Continued From page 10 The medical record lacked evidence of facility staff clarifying the indication for use of the MPAP with the physician's for a diagnosis of osteoarthritis. A face-to-face interview was conducted with Employee #4 on May 20, 2015 at approximately 2:30 PM. After review of the above, Employee #4 acknowledged the findings. The record was reviewed on May 20, 2015.	L 051	**L052** 1. Hand sanitizer and hand wipes were removed from table of Resident #200. Nursing staff present were educated to keep hand cleaning products separate from resident dining tables. Resident #200's food was not contaminated by the cleaning supplies. The cleaning supplies were removed from the dining area during the Survey observation. Nursing staff present during the meal received education regarding the subject of not having cleaning supplies present on a table where resident meals are being served. Resident # 157 was annoyed with nursing assistant was counseled and received education to respect resident # 157's and all resident's dignity by knocking before entering their room and waiting for a reply prior to entering a resident room. During the Survey observation Resident #162 acknowledged that the sign in her room was placed there at a time when the resident was not to get up on their own. During the Survey observation the sign was removed from the wall of the resident's room by employee #6. 2. An inspection of all facility dining areas identified hand cleaning products located separately from resident dining tables.	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident 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:	L 052		

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L 052	Continued From page 11 (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 j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations and staff interview for three (3) of 37 sampled residents, it was determined that sufficient nursing time was not given to ensure a resident's dignity was promoted as evidenced by, failing to enhance dignity during dining for one (1) resident and failing to knock before entering one (1) resident ' s room and maintain an environment free of signage with personal information for (1) one, ensure that one (1) resident was free of facial hair. Resident ' s #200 # 157 and #162. The findings include: 1. Sufficient nursing time was not given to ensure that facility staff provided an environment of	L 052	All nursing staff was re-educated on appropriate locations for hand cleaning supplies. All nursing staff have received education to not having any cleaning supplies present on dining tables during service of resident meals. All nursing staff have received education regarding knocking and waiting for an answer prior to entering a resident's room. All nursing staff have received education regarding the proper placement of signage in a resident room in a manner that respects the resident's dignity and privacy. 3. All nursing staff will be re-educated two (2) times annually on correct location of hand cleaning supplies during resident dining. Mandatory education sessions with the topics maintaining resident dignity and respect (to include knocking and waiting for a response prior to entering a resident room, not having cleaning supplies stored along with food items in the same area, proper placement of signage in resident room) will be conducted two times per year for all nursing staff. 4. Clinical Managers, or designee, and Infection Control Preventionist will monitor location of hand cleaning products during dining service during nursing unit rounds and report variances to Focus QI-IDT meetings monthly.	

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L 052	Continued From page 12 dining with dignity for Resident #200. During the lunch observation conducted on May 11, 2015 at approximately 1:30 PM, facility staff was observed using table where Resident# 200 was seated as a central location area for sanitizing their hands and dispensing hand wipes to sanitize other residents hands prior to serving their meals. These activities continued as Resident #200 sat eating his/her meal. During a second breakfast observation on May12, 2015 at approximately 8:50 AM Resident #200 was sitting alone eating his/her meal, as the facility staff use the area as central location for sanitizing their hands and dispensing hand wipes to sanitize other residents hands prior to serving their meals. A face-to-face interview was conducted with Employee #8 on March 12, 2015 at approximately 09:00 AM regarding the aforementioned observation. Immediately, Employee #8 instructed staff to remove items from the residents table acknowledging the findings. The observation was made on May 12, 2015 at approximately 09:00 AM. 2. Sufficient nursing time was not given to ensure that facility staff knocked and awaited for permission prior to entering Resident #157 ' s room during an isolated observation. On May 13, 2015 at approximately 10:30 AM Employee #35 entered Resident #157 ' s room without knocking. A face-to-face resident interview was in progress and Resident # 157 immediately stated " this happens all the time " . A face-to-face interview was conducted on May 13, 2014 with Employee # 8 at approximately 12:30 PM. A query was made regarding the facility's practice when needing to enter a resident	L 052	The Quality Improvement (QI) Manager will report findings to QAPI Committee quarterly. The Clinical Educator will audit the education sessions for attendance each time they are presented and submit the audit to the Quality Improvement Manager. The Quality Improvement Manager will report the audit to the Quality Improvement Committee. 5. Compliance Date:	7/22/2015
			#2 1. Employee #35 was counseled and re-educated to knock and await resident's response prior to entering the room. 2. All other staff was observed knocking and awaiting resident's reply prior to entering a resident room. 3. The Clinical Educator or designee will re-educate all nursing staff on requirement to respect resident privacy by knocking and awaiting resident's response prior to entering a resident room. This in-service will be mandated for all nursing staff two (2) times a year. 4. Clinical Managers or designee will monitor compliance with knocking prior to entering resident rooms during nursing unit rounds and report variances to Focus QI-IDT monthly. The QI Manager will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 13 ' s room. Employee # 8 stated "They should have knocked and waited for permission prior to enter." The observation was made on May 13, 2015. 3a. Sufficient nursing time was not given to ensure that facility staff maintained Resident #162 ' s environment in which there were no signs posted in the resident ' s area in view of other residents and visitors which included personal information. A resident room observation was conducted on May 13, 2015 at approximately 9:40 AM. Two (2) signs were observed on the wall inside the resident room. The sign indicated " Do not get up on your own " . One of the sign was posted on the wall adjacent to the resident ' s bed and on the wall to the right of the bathroom door. Several observations were made during the survey period. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 1:00 PM. After the observation Employee #6 acknowledged the observation and removed the signs. The observation was made on May 13, 2015. 3b. Facility staff failed to ensure that Resident #162 received necessary services to maintain the resident free of facial hair. An observation of the resident ' s room was conducted on May 13, 2015 at approximately 9:40 AM. The resident was observed with facial hair on [his/her] chin. A face-to-face interview was conducted with the	L 052	**#3a** 1. The sign was removed from room wall of Resident #162. 2. A facility-wide check identified resident rooms with posted clinical signage that was then removed or documented in the medical record as posted at request of resident or family, and that staff informed resident or family that posting of clinical signs violates resident's privacy. 3. Clinical Mangers or designee will identify resident rooms with posted clinical signage during nursing unit rounds and request resident/family permission to remove signage. Denied permission will be documented in medical record as resident/family choice after privacy issue information was provided. 4. Clinical Mangers will report posted clinical signage variances to Focus QI-IDT monthly. QI Manager will report findings to QAPI Committee quarterly. Nursing staff will be re-educated two (2) times annually on protecting resident privacy related to signage. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 14 Resident #106 and Employee #6 on May 22, 2015 at approximately 1:00 PM. At that time a second observation was made of the resident. A query was made regarding unwanted and unshaven facial hair. The resident indicated that he/she would like to cut [his/her] chin hair, if [he/she] had [his/her] own shaver. After the observation, Employee #6 acknowledged the findings. Facility staff failed to ensure that the resident received necessary services to maintain the resident free of facial hair. The observation was made on May 13, 2015. 4. Sufficient nursing time was not given to ensure that Resident #55, who is unable to carry out activities of daily living the necessary services received grooming to his/her face and nails. According to the annual Minimum Data Set dated March 10, 2015 Resident #55 was coded as totally dependent with one (1) person physical assistance in personal hygiene under Section G110 Activities of Daily Living (ADL) Assistance. The resident ' s diagnoses under Section I (Active Diagnoses) included: the resident was coded as having a Neurogenic Bladder, Hypertension, Diabetes Mellitus, Non-Alzheimer's, and Dementia. On May 13, 2015 at approximately 3:11 PM Resident #55 was observed in the dayroom/television room seated in a recliner chair. His/her chin had gray hair on both sides and his/her finger nails on the left hand were	L 052	**L052 #3b & #4** 1. Resident #162 did not receive services to ensure they were free of facial hair. Resident #55 had a dark substance underneath the nail beds of fingernails on left hand. Employees received counseling. 2. No other resident was affected by this practice. 3. All nursing staff will receive education as to how encouragement can be given to the resident (especially those that are behavior challenged) to have their ADL care completed and what interventions to take if the resident remains resistant to receiving ADL care. Mandatory education sessions on the topic of resident dignity and respect (including why dignity is harmed when a resident is not groomed and how to encourage the resident to receive grooming) will be conducted two times per year for all nursing staff. 4. The Clinical Educator will audit the education sessions for attendance each time they are presented and submit the audit to the Quality Improvement Manager. The Quality Improvement Manager will report the audit to the Quality Improvement Committee. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 15 observed with a dark substance underneath the nail beds. Employee #6 was present at the time of the observation and acknowledged the findings. There was no evidence that facility staff carried out activities of daily living necessary to maintain good grooming for Resident #55. B. Based on record review and staff interview for four (4) of 37 sampled residents, it was determined that sufficient nursing time was not given to ensure that an initial nursing assessment for hospice was a part of the residents clinical active file for two (2) residents; assess for pain, monitor effectiveness of pain medication, and modify the approaches to pain as necessary for one (1) resident; ensure that the physician ' s orders were transferred to the ETAR [electronic treatment administration record] for the use of a foot brace and that the physician orders for use of ted stockings was followed for one (1) resident. Residents #109, #120 #125 and #216. The findings include: 1.Sufficient nursing time was not given to ensure that the initial nursing assessment for hospice was a part of Resident #109 active clinical file. A review of the Physician Order Sheet for the month of April 2015 directed: Admit to Hospice for End Stage COPD [Chronic Obstructive Pulmonary Disease] start date 11/11/14 [November 11, 2014]. Further review of the clinical record lacked evidence of the Admission-Initial and Comprehensive Assessment.	L 052	**L052 B. #109** 1. The initial nursing assessment for Resident #109 is on the medical record. 2. All hospice patients on LTC were reviewed and initial nursing assessments were identified on the medical record. Hospice EHR admission assessments are printed as part of the interdisciplinary team assessment. 3. Hospice Clinical Manager or designee will audit the assessments to verify initial hospice nursing assessments are in chart timely. 4. All variances will be reported at the Weekly hospice IDT meetings. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 16 A face-to-face was conducted on May 21, 2015 at approximately 11:00 AM with Employees #6, 17, 18, and 19. After review of the A review of the clinical all acknowledged the finding. 2. Sufficient nursing time was not given to assess for pain, monitor effectiveness of pain medication, and modify the approaches to pain as necessary for Resident #120. Resident #120 was readmitted to the facility on March 13, 2015 with diagnoses that included neuropathic pain, depression, Diabetes Mellitus, and right foot Cellulitis. A face-to-face interview was conducted with Resident #120 on May 18, 2015 at 11:50 AM. The resident stated, " Right now my pain is a 6/10 [range 0 is the lowest and 10 is the highest]. I always have pain. The medication helps but it doesn't relieve the pain. The nurses don ' t ask me if I am in pain." This interview was held in the presence of Employee #6. A review of the quarterly MDS dated May 3, 2015 section J0300 [Pain Presence] " Have you had pain or hurting at any time" in the last 5 days?" The section was coded as " No " . Section I8000 [Additional active diagnoses] is coded for other Chronic pain. A review of the clinical record revealed a care plan updated on May 3, 2015 for Pain Management. The Problem is alteration in comfort related chronic pain (lower extremities). Resident has a history of Cellulites, right foot plantar ulcer, and DVT. A review of the electronic physician ' s order	L 052	**L052 Resident #120** 1. Resident #120 did receive pain medication as per physician order and pain assessments were carried out, however documentation of pain assessment was inconsistent. This event(s) can not be corrected. Employee received education to improve pain assessment documentation. The Minimum Data Set Section J0300 (Pain Presence) and Section I (Additional Active Diagnoses) were updated to reflect current clinical status. 2. An audit was done of all residents receiving pain medication to ascertain to verify accuracy accurateness of pain assessments by licensed nurses. Nurses were re-educated and/or counseled, as indicated by audit findings. 3. Education and/or counseling given to licensed nurses if inconsistencies of documentation were observed. MDS assessments for all residents receiving pain medication was audited and updated, as indicated by resident's current clinical status.	

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L 052	Continued From page 17 sheet dated April 1, 2015 directed, " Order and Start date March 14, 2015, Acetaminophen 500 mg give 2 tablets by mouth 3 times per day; Order and Start date March 16, 2015, Methadone 10 mg give 1 tablet by mouth 3 times per day at 06:00, 14:00, 22:00 for pain; Order and Start date March 16, 2015, Methadone 5 mg give 1 tablet by mouth 1 time per day at 06:00 for diabetic neuropathy; Order and Start date March 16, 2015, Methadone 5 mg give 1 tablet by mouth 1 time per day at 22:00 for pain " A review of the March, April and May 2015 Medication Administration Records revealed that the resident received Acetaminophen 500 mg, Methadone 10mg and 5 mg as per the physician ' s order. Review of the nursing notes from March 16, 2015 to May 21, 2015 revealed pain assessments that contained inconsistent /inaccurate information for example: Pain assessment for March 18, 2015 · Cancer pain: Controlled by current interventions. The resident did not have a medical diagnosis of cancer Pain assessment for March 19, 2015 · Cancer pain: Levels unchanged in the last 6 months controlled by current interventions. The resident did not have a medical diagnosis · Observation: Chronic pain level=0/10 · Pain perceived as an ache, but pain level is recorded as 0/10 · Pain related to chronic process osteomyelitis Pain assessment for April 7, 2015 · History noted as cardiovascular pain, pain from emotional psychological distress · Pain is recorded as intermittent pain in the leg · Observation reveals that resident verbalizes pain, chronic pain level 0/10 relieved by	L 052	All licensed nurses were re-educated on Pain Assessment and Documentation. This in-service and completion of Pain Assessment Competency with post-competency test, are mandated two (2) times annually. The Clinical Educator will report test scores to the Director of Nurses on staff who have received education on policy and procedure of Pain Assessment and documentation of Pain Assessment. The MDS nurse will audit residents on pain medication monthly to verify current pain status addressed in MDS Sections J and I. 4. The Clinical Educator will submit a summary of Pain Assessment Competency post-test pass/fail rate to QI Manager quarterly for quarterly reporting to the QAPI Committee. The MDS nurse will report Section J and I variances to QAPI Committee quarterly. All licensed nurses will receive a twice yearly Pain Assessment and documentation of Pain Assessment Competency education and examination. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 18 medication Pain assessment for May 3, 2015 Cancer pain: Levels unchanged in the last 6 months controlled by current interventions. The resident did not have a medical diagnosis · Observation: Chronic pain level=0/10 · Pain perceived as an ache, but pain level is recorded as 0/10 · Pain related to chronic process osteomyelitis There is no evidence that sufficient nursing time was given to consistently and accurately assessed Resident #120 ' s level of pain. A face-to-face interview was conducted with Employee #6 on May 18, 2015 at approximately 12:30 PM. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 3a.Sufficient nursing time was not given to ensure that the physician ' s orders transferred to the physician order sheet was continued and carried over to the ETAR [electronic treatment administration record] for one resident. Resident #125 A review of the Physician Order Sheet signed and dated January 7, 2015 revealed the following hand written transferred orders that directs, " Treatment staff for functional/maintenance program and foot brace to be worn on left foot for 1 hour as tolerated each day. " A review of ETAR [electronic treatment record] Report for the month of January, 2015 lacked evidence that the order " Treatment staff for functional/maintenance program and foot brace to be worn on left foot for 1 hour as tolerated	L 052	**L052 #3a & 3b** 1. The foot brace and knee high TED stockings were placed on Resident #125. Nursing staff assigned to Resident #125 was re-educated and counseled. Resident #125 order to for a foot brace to be worn on their left foot 1hour as tolerated was not carried over to the ETAR (electronic treatment record) and during several observation periods they were not wearing TED stockings as ordered. Resident did not sustain any decline in medical status. Licensed nurse(s) and nursing assistant(s) received counseling. 2. A facility-wide audit of all residents with orders for braces and TED stockings was completed. All residents were identified as receiving braces and TED stockings, as ordered. An audit was conducted on treatment orders of all residents with needs for braces, TED stockings or other appliances to ensure physician orders were carried over on the ETAR. Clinical Managers conducted daily nursing unit rounds to observe adherence to physician orders of residents needing TED stockings. 3. Nurses were re-educated on electronic healthcare record processing of physician orders to ETAR and all nursing staff re-educated on documenting care ordered is provided.	

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L 052	Continued From page 19 each day " was carried over and was documented as discontinued. A face-to-face interview was conducted on May 20, 2015 at approximately 10:30AM with employee #4. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 3b. Sufficient nursing time was not given to ensure physician orders for one resident to use ted stockings was followed. Resident #125	L 052	All nursing staff will be re-educated to review closet care plans daily and ensure races and TED stockings are provided as ordered. Clinical Managers or designee will complete a minimum of two (2) rounds each shift to verify residents have braces and TED stockings in place as ordered. Findings will be documented on the Nursing Unit Rounds Audit Tool and submitted weekly to the Director of Nurses.	
	A review of the physician order sheet signed and dated by the physician directed, " Knee High Ted Stockings on in AM 1 time per day, special instructions: Om [On] at 8AM and Off at 8Pm from [physician name] Medical Doctor, order entered by [nurse name] Licensed Practical Nurse. " Several observations on the following days May 18, 19 and 20, 2015 of resident #125 sitting in her wheel chair with foot on leg rest revealed that he/she was not wearing socks and not Ted stockings in accordance with the physician order. A review of ETAR [electronic treatment record] Report for the month of May, 2015 lacked evidence that the order " Knee High Ted Stockings on in AM 1 time per day, was documented as discontinued. A face-to-face interview was conducted on May 20, 2015 at approximately 10:30AM with employee #4. He/she acknowledged the findings. The record was reviewed on May 20, 2015. 4. Sufficient nursing time was not given to ensure that the initial nursing assessment for hospice was a part of Resident #216 active clinical file.		House Supervisors will conduct unit rounds a minimum of two (2) times each shift on a minimum of one (1) clinical unit and submit completed Nursing Unit Rounds Audit Tool to the Director of Nurses. Unit Clerks will audit physician orders daily, matching new and/or existing orders to ETARS and/or EMARs. Audit findings will be reported to the Clinical Manager who will follow-up, as indicated. All nursing staff will receive education to daily review all residents Closet Care plans to ensure needs such braces, TED stockings, other appliances are a part of care given to residents as per physician orders. 4. Clinical Managers will report audit findings to Focus QI-IDT meeting monthly. The QI Manager will report a summary of audit findings to QAPI Committee quarterly.	

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L 052	Continued From page 20 A review of the Physician Order Sheet for the month of March 2015 directed: Admit to Hospice start date 3/6/15[March 6, 2015]. Further review of the clinical record lacked evidence of the Admission-Initial and Comprehensive Assessment. A face-to-face was conducted on May 21, 2015 at approximately 11:00 AM with Employees #6, 17, 18, and 19. After review of the A review of the clinical all acknowledged the finding. C. Based on observation, record review, and staff interview it was determined facility staff failed to notify a resident ' s physician/nurse practitioner when a new wound was identified at Stage III and failed to obtain orders for the immediate care and treatment of the wound for one (1) of 37 residents reviewed. Resident #23. The findings include: Through staff interview it was determined facility staff observed a new wound on Resident # 23 ' s left buttock on the weekend of May 9 to 10, 2015; however, notification to a physician or nurse practitioner was not made. Treatment orders for management of the wound were initiated on May 13, 2015 (approximately 4 days later) after the area was assessed as a stage 3 pressure ulcer during routine wound rounds by the Nurse Practitioner. On May 13, 2015 (Wednesday) incontinence care	L 052	Observations of residents needing braces, TED stockings, etc to ensure adherence to physician orders will be added as an observation to the Clinical Managers/House Supervisor Nursing Unit Rounds Audit Tool. Clinical Managers will round on their assigned nursing unit at least twice per shift to ensure appliances are being applied. The Nursing Unit Rounds Audit tool will be submitted weekly to the Director of Nursing or their designee. 5. Compliance Date: 7/22/2015 **L052 #4** 1. The initial nursing assessment for Resident #216 is on the medical record. 2. All hospice patients on LTC were reviewed and initial nursing assessments were identified on the medical record. Hospice EHR admission assessments are printed as part of the interdisciplinary team assessment. 3. Hospice Clinical Manager or designee will audit the assessments to verify initial hospice nursing assessments are in chart timely. 4. All variances will be reported at the Weekly hospice IDT meetings. 5. Compliance Date: 7/22/2015	

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L 052	Continued From page 21 was observed for Resident #23. It was noted that the resident had two (2) dressings on his/her left buttock and one (1) on the right buttock all initialed by a licensed nurse and dated May 12, 2015. A review of the most recent " Skin Condition Report " dated May 4 and 7, 2015 revealed that Resident #23 had two (2) wounds: left buttock (abscess) and right buttock (abrasion). There was no documentation of a second skin integrity concern on the left buttock as observed on May 13, 2015. Subsequent to the observation of incontinence care on May 13, 2015 the following progress notes were recorded. An Interdisciplinary Progress Note dated May 13, 2015 at 11:15 AM, by the Nurse Practitioner Student revealed the following, " ... Pt. (patient) has not been out of bed ...Skin breakdown - wound care rounds - new orders. L (left) Buttock abscess 2 x 1 x .01cm healing; R (right) buttock 1.5 x 2.5 x .01 cm unstageble, L buttock Stage III 2 x 1 x .01cm ...ordered alternating pressure mattress ... " A review of the Nurse Practitioner ' s note dated May 13, 2015 [no time indicated] revealed, ... Abscess to L butt is healing s/p antbx (antibiotics) - has new pressure ulcers - will order alternating pressure mattress and PT (physical therapy) to evaluate seating for new cushions. " Skin Condition Reports A review of facility documents revealed licensed nurses conducted and recorded wound/skin	L 052	**L052 C.** 1. Nurses caring for resident #23 were counseled and re-educated on facility policy for notifying Medical Staff on resident changes in condition. The resident's wound did not worsen in the time period addressed by the deficiency and is resolved. The staff associated with this incident received counseling and received education regarding the organization's protocol as to what information needs to be communicated to the physician or Advanced Practice Nurse. 2. An audit of all residents with pressure ulcers was completed. Medical Staff notifications and initiation of treatment orders were in compliance with facility policy. Opportunities for improvement were completed at time of audit. An audit of the medical record of all residents with pressure ulcers was conducted to determine if the physician or Advanced Practice Nurse was notified about the wound and if orders were obtained for appropriate treatment of the wound(s). Any remarkable instances were corrected at the time of the audit.	

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L 052	Continued From page 22 assessments weekly on a form entitled " Skin Condition Report Without Images. " The " Skin Condition Report Without Images " for Resident #23 was reviewed for the period of May 1 - 13, 2015. The (wound/skin) forms lacked evidence of a wound assessment related to the ' new ' alteration in skin integrity that was initially observed on May 9, 2015. The alteration in skin integrity identified as one (1) of two wounds on the left buttocks was assessed by the Nurse Practitioner during routine scheduled wound rounds on Wednesday, May 13, 2015 wherein the wound was initially assessed at an advanced stage 3 (full thickness tissue los...slough may be present but does not obscure the depth of tissue loss ...). Physician Orders On May 13, 2015 (time not recorded) " Ulcers to bilateral buttocks ... New treatment 1 time per day at 09:00, ... clean ulcers with NS (normal saline) pat dry, cover with Sratasorb daily. " The prior physician orders for wound care were as follows: May 11, 2015 - Right Buttock clean with NS, pat dry apply Optifoam dressing every Monday and Thursday and PRN. On April 30, 2015 for the left buttock [note only one (1) wound identified on the Skin Condition Report at the time of this order] three times a day during day, evening, night - warm compress from the store room, apply 15 minutes. Staff Interviews A face-to-face interview was conducted with Employee #22 (Certified Nurse Aide) on May 15, 2015 at approximately 3:40 PM. He/she stated, "I observed three (3) areas on the resident this weekend (May 9, and 10, 2015)."	L 052	3. Clinical Managers will be educated to audit the electronic healthcare record (EHR) of all residents with pressure ulcers weekly, using criteria added to the weekly Skin Integrity Audit Tool. All licensed nurses will be educated on Medical Staff notification and complete a Skin/Wound Competency. Clinical Managers will conduct a weekly audit of the medical record of all residents with pressure ulcers. The criteria for the audit will be added to the weekly Skin Integrity Audit Tool. All Clinical Managers will receive education as to how the audit tool is to be used. All licensed nurses will receive education on facility protocol of Notification of Physician (Advanced Practice Nurse) and will be administered a Skin/Wound Care Competency. 4. Clinical Managers will report findings of Skin Integrity Tool to Focus Quality Improvement (QI)-Interdisciplinary Team (IDT) weekly for review and identification of opportunities for performance improvement (OPI). All licensed nurses will complete a mandatory biannual education on physician notification protocol and successfully complete the annual Wound Care Competency.	

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L 052	Continued From page 23 A face-to-face interview was conducted with Employees # 20 and 29 (License Practical Nurses) on May 15, 2015 at approximately 3:43 PM. Both employees stated, "Noticed the area a few days ago. Treated the new area on the left buttocks the same as the other areas. It looked the same. Treated it with warm compress and dry dressing." A face-to-face interview was conducted on May 15, 2015 at 3:45 PM with Employee #6. He/she reviewed the physician ' s orders and acknowledged that there was no order to treat three (3) open areas on the resident ' s buttocks. The resident ' s care needs are documented as dependent care and has incontinence on the most recent Minimum Data Set (MDS). A review of the quarterly MDS dated April 1, 2015 revealed the following: Under Section G [Functional Status] the resident required extensive assistance for Bed mobility, Transfers, Toilet Use, and Personal hygiene, two plus persons physical assist. Under section H [Bladder and Bowel] the resident was coded as being frequently incontinent of bladder and bowel; Under section M [Skin Conditions], in response to the question " is this resident at risk for developing pressure ulcers " the resident was coded as "no". Under Skin and Ulcer Treatments the resident is coded for pressure reducing device for bed, turning/repositioning program, applications of ointments/medications other than to feet. Through staff interview it was determined that a second wound on the left buttock (the area superior to the abscess/furuncle on the left buttock) was first observed on May 9, 2015 by facility staff. Four (4) days lapsed without	L 052	Data Analysis of the Skin Integrity tool will be discussed weekly at the Focus Quality Improvement meeting and reported quarterly by the QI manager to the Quality Improvement Team. The facility protocol of Notification of Physician (Advanced Practice Nurse) will be conducted as a twice mandatory education session for all Licensed Nurses. All Licensed Nurses will be administered and must successfully pass an annual Wound Care Competency. 5. Compliance Date:	7/22/2015

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L 052	Continued From page 24 physician and/or nurse practitioner assessment and treatment orders. The record was reviewed on May 22, 2015.	L 052	**L091** 1. Resident #162 had multiple bedpans in a shared bathroom: bedpans were not labeled for any specific resident. Employee received infection prevention education regarding proper storage and labeling of resident supplies when supplies are in a shared area. 2. An audit was conducted of all care supplies used by residents that share a bathroom to ensure proper labeling and storage. All nursing employees will receive infection prevention education regarding proper storage and labeling of resident supplies when supplies are in a shared area. 3. The Clinical Manager will make daily nursing unit rounds to observe infection prevention relating to resident care items stored in shared resident bathrooms: items labeled and stored according to infection prevention standards. This observation will be added to the Nursing Unit Rounds Audit Tool. 4. The Nursing Unit Rounds Audit Tool will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation and staff interview, it was determined that the Infection Control Committee failed to ensure that infection control policies and procedures were implemented as evidenced by failing to ensure the decrease and the spread of infection by storing multiple unlabeled bed pans in one (1) resident ' s bathroom; failed to sanitize hands in between feeding and assisting two (2) residents; and failed to ensure the toilet seat riser was stored properly when not in use. The findings include: 1.The Infection Control Committee failed to ensure the decrease and spread of infection by not clearly labeling three (3) bed pans in Resident #162 ' s bathroom that was shared with another resident. An observation of resident #162's bathroom was conducted on May 13, 2015 at approximately 9:45 AM. It was observed that two (2) pink bedpans were observed stored in the resident ' s room. One (1) behind the commode on the floor; one (1) on the grab bar behind the toilet and one (1) white fracture bedpan observed stored on the	L 091		

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L 091	Continued From page 25 grab bar to the left of the toilet. A face-to-face interview was conducted on May 22, 2015 at approximately 1:00 PM with Employee #6. At that time a second observation was made of the resident ' s bathroom. After making the observation Employee #6 acknowledged the finding. 2.The Infection Control Committee failed to ensure the decrease the spread of infection as evidenced by not sanitizing hands in between assisting two (2) residents. Employee #31 was observed on May 21, 2015 at approximately 12:45 PM feeding a male resident. Employee # 31 observed that another resident at the table needed assistance, stopped and assisted that resident (touching the hands of the resident) and returned back to feeding the first male resident without sanitizing his/her hands. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately 11:40 AM. After review of the above scenario, he/she acknowledged the findings. 3. The Infection Control Committee failed to ensure that a toilet seat riser was stored properly when not in use. On May 19, 2015 at 12:05 PM a tour of Resident #23 ' s bathroom was conducted. At this time a white toilet seat riser was observed on the floor in the bathroom. Employee #6 was present at the time of the observation and acknowledged the finding.	L 091	**L091 #2.** 1. Hand sanitizer and hand wipes were removed from table of Resident #200. Nursing staff present were educated to keep hand cleaning products separate from resident dining tables. Resident #200's food was not contaminated by the cleaning supplies. The cleaning supplies were removed from the dining area during the Survey observation. Nursing staff present during the meal received education regarding the subject of not having cleaning supplies present on a table where resident meals are being served. Resident # 157 was annoyed with nursing assistant. Nursing assistant was counseled and received education to respect resident # 157's and all resident's dignity by knocking before entering their room and waiting for a reply prior to entering a resident room. During the Survey observation Resident #162 acknowledged that the sign in her room was placed there at a time when the resident was not to get up on their own. During the Survey observation the sign was removed from the wall of the resident's room by employee #6. 2. An inspection of all facility dining areas identified hand cleaning products located separately from resident dining tables.	

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L 099	Continued From page 26	L 099		
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 made on May 11, 2015 at approximately 9:15 AM, it was determined that the facility failed to prepare and store food under sanitary conditions as evidenced by foods such as one (1) of four (4) bags of cheddar cheese, one (1) of one (1) pan of tomato, ham and turkey breast chunks, one (1) of one (1) pan of roast beef slices, one (1) of one (1) pan of chopped meat, one (1) of one (1) pan of noodles and carrots slices, one (1) of one (1) pan of shredded lettuce and one (1) of one (1) pan of onions and celery slices that were stored in the walk-in refrigerator undated, a soiled floor in the main kitchen, dry food storage and dishwashing area, two (2) of two (2) convection ovens that were soiled on the inside and outside and one (1) of one (1) plate warmer with clean plates that was left uncovered. The findings include: 1. One (1) of four bags of cheddar cheese, one of (1) pan of tomato, ham and turkey breast chunks, one (1) of one (1) pan of roast beef slices, one (1) of one (1) pan of chopped meat, one (1)of one (1) pan of noodles and carrots slices, one (1) of one (1) pan of shredded lettuce and one (1) of one (1) pan of onions and celery slices were stored in the walk-in refrigerator undated.	L 099	All nursing staff was re-educated on appropriate locations for hand cleaning supplies. All nursing staff have received education to not having any cleaning supplies present on dining tables during service of resident meals. All nursing staff have received education regarding knocking and waiting for an answer prior to entering a resident's room. All nursing staff have received education regarding the proper placement of signage in a resident room in a manner that respects the resident's dignity and privacy. 3. All nursing staff will be re-educated two (2) times annually on correct location of hand cleaning supplies during resident dining. Mandatory education sessions with the topics maintaining resident dignity and respect (to include knocking and waiting for a response prior to entering a resident room, not having cleaning supplies stored along with food items in the same area, proper placement of signage in resident room) will be conducted two times per year for all nursing staff. 4. Clinical Managers, or designee, and Infection Control Preventionist will monitor location of hand cleaning products during dining service during nursing unit rounds and report variances to Focus QI-IDT meetings monthly.	

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L 099	Continued From page 27 2. The entire kitchen floor, including the floor in the dry food storage area and in the dishwashing area was marred, scarred and discolored. 3. The inside and the outside of two (2) of two (2) convection ovens were soiled. 4. One (1) of one (1) plate warmer with clean plates was observed uncovered in the main kitchen. These observations were made in the presence of Employee #9 and/or Employee #10 who acknowledged the findings.	L 099	The Quality Improvement (QI) Manager will report findings to QAPI Committee quarterly. The Clinical Educator will audit the education sessions for attendance each time they are presented and submit the audit to the Quality Improvement Manager. The Quality Improvement Manager will report the audit to the Quality Improvement Committee. 5. Compliance Date:	7/22/2015
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate	L 128	**L099** 1. Staff that prepared the food that morning was permitted by surveyor to label food with date. 2. No other unlabeled food identified. 3. All Staff re-educated on mandatory label system. Management will inspect food for current label on a daily basis. 4. Dining Services Director will report findings to QAPI Committee quarterly. 5. Compliance Date: 1. Kitchen floor is scheduled for repair. 2. No other area identified during inspection. 3. Dining Services Director will inspect floors weekly and report variances to Plant Operations. Staff educated to observed floor conditions and report to maintenance/housekeeping staff for immediate cleaning/repair. 4. Dining Services Director will report inspection findings to QAPI Committee quarterly. 5. Compliance Date	7/22/2015 7/22/2015

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L 128	Continued From page 28 reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: A. Based on record review and staff interview for one (1) of 37 sampled residents, it was determined that the pharmacist failed to ensure review of the resident's drug regimen was reviewed at least monthly. Resident #4	L 128	1. Soiled ovens identified during survey were cleaned during survey. 2. These were no other ovens identified as soiled during survey. 3. Shift supervisors re-educated on Daily Checklist inspection requirement to inspect cleanliness of ovens daily. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly.	
	The findings include: A review of the clinical record revealed a Medication Regimen Review (MRR) sheet from November 6, 2014 through May 6, 2015. The clinical record lacked a MRR sheet for the months of May 2014 through October 2014. A face to face interview with Employee #6 was conducted on May 20, 2015 at approximately 3:00 PM. When queried regarding the missing MRR sheet he/she responded That he/she did not know where the previous MRR was and said " pharmacy takes care of that " . The record was reviewed on May 20, 2015.		5. Compliance Date: 1. Uncovered clean plates in plate warmer were covered immediately. 2. No other plates were identified during survey. 3. Staff was re-educated on requirement to keep plates in plate warmer covered. Supervisors will monitor compliance at all meals. 4. Supervisors will report variances to Dining Services Director who will report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015
	B. Based on observation, record review and staff interview, it was determined that the pharmacist failed to ensure Controlled Drug Count Verification (shift count sheet for Narcotics) was reconciled by two (2) nurses ' signatures. The findings include:		**L128 A.** 1. Resident #4 did not have a pharmacy drug review for May 2014 through October 2014. Documentation of the MRR for the dates in question does exist, was located and sent to State Agency.	

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L 128	Continued From page 29 The pharmacist staff failed to ensure that the Controlled Drug Count Verification (shift count sheet for Narcotics) was reconciled by two nurses ' signatures. (Unit 2B) A review of the Controlled Drug Count Verification records conducted on May 21, 2015 at approximately 11:55AM revealed the following Narcotics reconciliation concerns: On November 21, 2014 11:00 PM to7:00AM shift the Narcotic reconciliation had one (1) nurse signature in the space allotted for going off duty. The space allotted for signature of nurse coming on duty was left blank indicating the narcotics reconciliation was conducted by one nurse. On November 21, 2014 3:00 PM to 11:00 PM shift the Narcotic reconciliation Narcotics had one (1) nurse signature in the space allotted for coming on duty. The space allotted for signature of nurse going off duty was left blank indicating the narcotics reconciliation was conducted by one nurse. A face -to -face interview was conducted on May 21, 2015 at approximately 11:56AM with Employee #6. He/she stated that according to facility ' s Controlled Substances Policy " Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together and they must document and report any discrepancies. " There was no evidence that the pharmacist	L 128	2. An audit was done to ensure all residents have a current MRR by a licensed pharmacist. 3. According to the policy and procedure of Remedi pharmacy an MRR will be conducted on all residents 4. Unit Clerks re-educated to conduct a quarterly audit of all residents' medical record to ensure a MRR has been done by Remedi pharmacy and is available in the medical record of all residents. The audit will be submitted to the Director of Medical Records for review and follow- up. 5. Compliance Date: **L 128 B.** 1. Controlled Substance reconciliation form not signed by two nurses: on coming nurse did not sign. Reconciliation count was accurate. Employee counseled. 2. An audit was done of all Controlled Substance reconciliation forms. 3. The Clinical Manager or their designee will conduct a daily audit of the Controlled Substance reconciliation sheet. All nurses were re-educated on the controlled substance reconciliation process and the need for two signatures.	7/22/2015

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L 128	Continued From page 30 ensured the Controlled Drug Count Verification records had two (2) nurse ' s signature for Narcotic reconciliation of controlled medications. Controlled substance reconciliation records were blank or signed by one (1) nurse as either ' off-going and on-coming ' [tour of duty] on the shifts delineated above. A face-to-face interview was conducted on May 21, 2015 at approximately 11:58AM with Employees #8. After reviewing the signature sheet forms, he/she acknowledged the aforementioned findings. The observation was conducted May 21, 2015.	L 128	4. Consistency of two signatures on the Controlled Substance Reconciliation form will be added as an item to the Nursing Unit Rounds Audit Tool. The Nursing Unit Rounds Audit Tool will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015
L 152	3227.3 Nursing Facilities Proper storage temperature shall be maintained for each medication according to the manufacturer's direction. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to maintain medication storage in accordance with accepted professional principles as evidenced by: two (2) unit refrigerator temperature log sheets were not consistently checked and recorded once a day. The findings include: Two (2) unit refrigerator temperature log sheet was not consistently check and record once a day. (Unit 3A and 3B) On May 21, 2015 at approximately 11:45AM a	L 152	**L152** 1. Recordings of refrigerator temperature logs were not consistent on units 3a and 3B. Employee(s) on unit 3a counseled. Unit 3b is closed for renovations. 2. An audit was conducted of all unit refrigerator temperature logs to ensure consistency of documentation. 3. Documentation of refrigerator temperature logs will be added to the Nursing Unit Rounds Audit Tool. The Clinical Managers will check consistency of documentation of refrigerator temperatures daily using the Nursing Unit Rounds Audit Tool. Clinical Managers will receive education as to how to use Nursing Unit Rounds Audit Tool.	

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L 152	Continued From page 31 review of the " Refrigerator Monitoring Log " on unit 3A and 3B revealed that the temperature recordings were left blank indicating not completed on the following month and days: Unit 3B: February 15, 16 17, 26, 2015 Unit 3A: April 12, 26, 27, 2015 Unit 3A: May 2, 13, 2015 Unit 3B: May 1, 3, 4, 8, 9, 20, 2015 There was no documented evidence that facility staff consistently monitored the temperature of the Medication refrigerator located in the nurse ' s station medication rooms on units 3A and 3B.	L 152	4. The Nursing Unit Rounds Audit Tool with the documentation refrigerator temperatures are consistently observed will be submitted weekly to the Director of Nursing for review and follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report to the weekly Focus Quality Improvement team. 5. Compliance Date:	7/22/2015
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to maintain medication storage in accordance with accepted professional principles as evidenced by: one (1) blister packet medication was stored beyond the expiration date for one (1) resident. The findings include: Facility failed to maintain medication storage in accordance with accepted professional principles as evidenced by: One (1) blister packet medication was stored beyond the expiration date for one resident.	L 161	**L161** 1. Expired blister pack of oxycodone observed for resident #95. Resident did not suffer ill effects. Employee(s) responsible received counseling. The medication was removed from the medication cart. 2. An audit was done of all medication carts and medication storage refrigerators and other medication storage containers to ensure all medications have current usage dates. 3. Clinical Managers will conduct a weekly audit of medication carts, medication storage refrigerators, and other medication storage containers to ensure all medications have a current usage date. This observation will be a part of the Nursing Unit Rounds Audit Tool. Clinical Managers will receive education on how to conduct the audit and use the audit tool.	

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L 161	Continued From page 32 (Resident #95) On May 21, 2015 at approximately 11:40AM one (1) blister packet medication was found stored beyond the expiration date. The medication storage observations revealed the following: On Unit 3A Resident# 95 had 28 tablets of Oxycodone 5mg stored for use. The expiration date on the package was March 2015. The observation was made in the presence of Employee #8. He/she acknowledged the findings.	L 161	4. The Nursing Unit Rounds Audit Tool with the weekly criteria to inspect medication usage dates will be submitted to the Director of Nursing weekly for follow up. The Director of Nursing will submit the Nursing Unit Rounds Audit Tool to the Quality Improvement Manager. The Quality Improvement Manager will report results of audit during the weekly Focus Quality Improvement meeting. 5. Compliance Date:	7/22/2015
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff interview for 16 of 46 " Resident/Family Communication " forms reviewed, it was determined that facility staff failed to implement policies and procedures to ensure that allegations of mistreatment and/or abuse were reported to the State Agency. The findings include: The Code of Federal Regulations 483.13 (b) defines abuse as: · "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or	L 206		

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L 206	Continued From page 33 punishment with resulting physical harm, pain or mental anguish. (42 CFR 488.301) This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. · "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that she will never be able to see her family again. · "Mental abuse" includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. A review of the facility ' s Resident/Family Communication forms revealed 46 forms that were recorded as "concerns". 16 of the 46 forms identified as " concern " revealed allegations of mistreatment and/or abuse by staff that ranged from failure to provide timely incontinent care, rough handling, speaking in a harsh tone to missing property. Examples of allegations are as follows: 1.Relative reported to facility on December 8, 2014 that their [mother/father] was crying and holding the call bell because no one came to	L 206	**L206** 1. All identified allegations of mistreatment, neglect and/or abuse have been investigated thoroughly and each resident was protected from further abuse. All allegations of mistreatment, neglect, and/or abuse have been reported to the State Agency. 2. Any new allegations of mistreatment, neglect and/or abuse will follow specific abuse policies and procedures to ensure residents are protected in the event of an allegation of abuse. The Abuse Investigation Policy was updated to protect all residents. 3. Specific procedures for staff to follow in the event of allegations involving mistreatment, neglect and/or abuse will be outlined in the TWH Abuse Investigation policy and procedure. The policy and procedure will be distributed in the facility and staff will receive re-education on the policy. 4. Nursing Administration or designee will report any adverse outcomes from an abuse investigation to QAPI monthly. 5. Compliance Date:	7/22/2015

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L 206	Continued From page 34 assist their [mom/dad.] It was reported by staff that they were under staffed. Resident #186 2.Resident reported on May 21, 2014 an allegation of verbal abuse with a [male/female] Registered Nurse. Resident #6 3..Relative reported to the facility on January 2, 2015 that a Certified Nursing Assistant came into his/her mom/dad ' s room woke him/her up to put him/her on a bed pan. The resident screamed " No, No, No " that he/she did not need to go to the bathroom. The resident was left flat on his/her back and had a difficult time breathing and his/her back was in pain. Resident #186 4.Resident reported to the facility on January 19, 2015 that his/her significant other was wearing the same clothes for two (2) days and was soaking wet after having lunch. Resident #139 5.Relative reported to the facility on January 21, 2015 that night aide was verbally abusive and called his/her mom " crazy " and that [his/her] [mom/dad] was a trouble maker. Resident #14 6.Resident reported on July 19, 2014 that he/she felt intimidated by the staff assigned to [him/her] on the 3-11 shift. TSD#2 The records lacked evidence that the allegations were fully investigated and reported to the State Agency. A face-to-face interview was conducted with Employee #37 on May 21, 2015 at approximately 2:00 PM. Employee #37 was designated to manage allegations of abuse in the facility and	L 206		

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L 206	Continued From page 35 stated that he/she was not aware of the 16 allegations of mistreatment illustrated on the " Resident/Family Communication " forms. Employee #37 stated that the Department of Nursing was responsible for reviewing the forms and would forward to his/her department as necessary. He/she denied having knowledge of the concerns recorded in the 16 forms reviewed, that alleged mistreatment/abuse. A face-to-face interview was conducted with Employee #2 on May 21, 2015 at approximately 3:30 PM. He/she stated that he/she would research whether or not the allegations of mistreatment and/or abuse recorded on the " Family/Relative Communication " forms were reported to the Department of Health. There was no evidence provided by Employee #2 to reflect that the allegations of abuse were reported. The records were reviewed May 21, 2015.	L 206	**L214 #1** 1. Space heater was removed immediately. 2. Maintenance inspection of all resident rooms identified no other space heaters. 3. Maintenance staff re-educated to inspect resident rooms weekly and will immediately report unauthorized electrical equipment in resident rooms. 4. Plant Operations Director or designee will report any repeat occurrences to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	
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 made on during the survey, it was determined that facility staff failed to ensure resident ' s environment was free of accident hazards as evidenced by a electric space heater observed in one (1) residents room; an extension cord observed in use to supply power to the fish tank on unit 2B, a wood plank lifted from the floor in the hallway of the nursing	L 214	**L214#2** 1. Extension cord was removed immediately. 2. No other extension cord was identified during inspection. 3. All fish tanks were inspected; no extension cords found. Maintenance staff re-educated to check fish tanks for unauthorized extension cords during Weekly Maintenance Rounds 4. Plant Operations Director or designee will report any repeat occurrence to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	

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L 214	Continued From page 36 unit and a splintered headboard that was attached to the wall in one resident's room. The findings include: 1. On May 18, 2015 at 10:50 AM, a space heater was observed on the floor of the resident ' s room between the bed and the window. The heater was plugged into the wall and actively circulating warm air about the room in one (1) of one (1) space heater observed. Employee #6 was present at the time of the observation and acknowledged the finding. 2. On May 13, 2015 at approximately 2:30 PM a extension cord was observed plugged in to the wall and to the fish tank located on unit 2B. This observation was made in the presence of Employee # 12, who acknowledged the finding. 3. On May 13, 2015 at 11:00 AM a wood plank was observed lifted from the floor in the hallway nearby the storage closet on unit 2B. Employee #6 was present at the time of the observation and acknowledged the findings. 4. On May 13, 2015 a headboard attached to the wall in one (1) residents room was observed to be splintered. A tour of Resident #162's room was conducted on May 13, 2015 at approximately 10:30 AM. It was observed that the wall in the resident ' s room adjacent to the residents bed (towards the foot of the bed) was splintered wood. A face-to-face interview was conducted with Employee #6 on May 22, 2015 at approximately	L 214	**L214 #3** 1. Wood plank in flooring near 2B storage closet was repaired. 2. No other loose plank was found during inspection. 3. Maintenance inspection on all Units identified no other loose floor planks. Maintenance staff re-educated to inspect hallway floors during Weekly Maintenance Rounds, and correct any damage identified. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: **L214 #4** 1. The wall protector behind head of bed in room 162 was repaired. 2. Maintenance inspected protective wall boards behind head of bed in all resident rooms; none were splintered. 3. Maintenance staff will inspect protective wall board at head of bed during Weekly Maintenance Rounds. Maintenance staff re-educated on conducting inspection of walls in residents' rooms. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015 7/22/2015

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L 214	Continued From page 37 11:30 AM. After making an observation of the room, he/she acknowledged the findings. B. Based on observation, record review, and staff and resident interview it was determined that facility staff failed to keep resident free from falls as evidenced by failure to transfer resident in accordance with the plan of care using two (2) persons and a mechanical lift. The findings include: Resident #23 was admitted on January 7, 2015 with diagnoses that included, Altered mental status, CVA, and right Hemiparesis. A review of an Incident Report dated February 10, 2015 revealed the following, " Resident called, upon entering the room immediately after answering call, found resident sitting on the floor and leaning on wheel chair. Assessment conducted [he/she] verbalized sliding off the wheel chair. Denies pain, denies hitting head. ROM within normal limit, no apparent injury noted. Remain alert and oriented at this time. Review of the care plan initiated on February 12, 2015 revealed the following, " Problem Statement - Resident was observed sitting on the floor on 2/10/2015. No injuries noted; Interventions and approaches - Resident will be transferred with a mechanical lift at all times by nursing staff, and will be assisted on a bed pan as needed. A review of the quarterly MDS dated April 1, 2015 revealed the following: Under Section G [Functional Status] the resident required extensive assistance for Bed mobility, Transfers, Toilet Use, and Personal hygiene, meaning the resident was involved in activity, staff provides weight bearing support, two (2) plus persons physical assist. Under section H [Bladder and	L 214	**L214B** 1. Resident #23 facility staff failed to keep resident free from falls as evidenced by failure to transfer resident in accordance with the plan of care using two persons and a mechanical lift. Employee was counseled to the highest extent. 2. All nursing staff will receive education on the facility Transfer of Residents policy and procedure. 3. The Transfer of Residents policy and procedure will be reviewed during annual education sessions with all nursing staff. 4. A nursing assistant Transfer of Residents Competency will be developed. All nursing assistants will be administered the Transfer of Residents Competency annually. The Clinical Educator will report the scores to the Quality Improvement Manager and the Quality Improvement Manager will report the scores to the Quality Improvement Team. 5. Compliance Date:	7/22/2015

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L 214	Continued From page 38 Bowel] the resident was coded as being frequently incontinent of bladder and bowel meaning 7 or more episodes of urinary incontinence, but at least on episode of continent voiding. Under section J [Health Conditions] the resident was coded for having no falls since admission/entry or reentry or prior assessment. Review of the nursing note dated April 15, 2015 revealed the following, " ...Resident was transferred from unit #[unit letter] to [unit number] today during morning shift. Alert and verbally responsive. Denied pain and breathing normal. Resident is dependent with ADLs two (2) person assist and transfer by Hoyer lift ... " A review of the nursing note dated April 16, 2015 revealed, " General Pain Comments -Writer was called into room [room number] at 10 AM. Staff explained that resident told [him/her] [that] [he/she] can walk to the toilet, staff assisted resident to the toilet ...Upon assisting resident to the chair [he/she] slid to the floor in front of the toilet. No injury sustained. Resident was assisted to [his/her chair]. Denies pain/discomfort. " There is no evidence that facility staff followed the plan of care which stated that the resident was a two person assist with a Hoyer lift, for safe transfer and toileting. A face-to-face interview was conducted on May 15, 2015 at 3:43 PM with Employee #6. He/she also stated, " The [certified nurse aide] should have asked for help when transferring the resident from the commode. " The record was reviewed on May 15, 2015. Based on an observation made on May 11, 2015 at approximately 3:00 PM and on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to ensure that it was free of accident hazards as evidenced by one (1) of one (1) oxygen tank stored unsecured in one (1) of 45	L 214		

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L 214	Continued From page 39 resident ' s rooms (#324B) and a loose, in use extension cord located on the floor of room #211, one (1) of 45 resident rooms surveyed. The findings include: 1. An oxygen tank was observed in room #324B, on the floor and unsecured, one (1) of 45 resident ' s rooms surveyed. 2. An extension cord was observed in use, on the floor of room #211, one (1) of 45 resident ' s rooms surveyed. These observations were made in the presence of Employee #11 and Employee #12 who acknowledged the findings.	L 214	**L306** 1. Call bell cords in bathrooms 135,146, and 227 were replaced with correct length cords immediately. 2. Maintenance inspected all bathroom call bell cords; all were correct length. 3. Maintenance staff re-educated to inspect length of bathroom call bell cords during Weekly Maintenance Rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly, and report variances to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
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 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.	L 306	1. Call bell in room 150 was replaced immediately. 2. Maintenance inspected all call bells; all functioned correctly. 3. Maintenance staff re-educated to inspect call bells during Weekly Maintenance Rounds. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 1. Call bell in #214A was located where resident had placed it (bed side stand drawer) and returned to wall. 2. Maintenance inspected all rooms for missing call bells; all call bells in place. 3. Maintenance staff re-educated to inspect call bells during Weekly Maintenance Rounds.	7/22/2015 7/22/2015

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L 306	Continued From page 40 This Statute is not met as evidenced by: Based on an observations made on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to maintain the call bell communication system in good working condition as evidenced by call bell pull cords that were too short in three (3) of 45 resident's bathrooms, a non-functioning call bell in one (1) of 45 resident's rooms and a missing call bell in one (1) of 45 resident's rooms. The findings include: 1. Call bell pull cords located in the bathroom of resident room #135, #146, and #227 were too short and could not function as intended, three (3) of 45 resident's rooms surveyed. 2. The call bell in resident room #150 did not emit an alarm when tested, one (1) of 45 resident's rooms surveyed. 3. The call bell in resident room #214A was missing, one (1) of 45 resident's rooms surveyed. These observations were made in the presence of Employee #11 and/or Employee #12 who acknowledged the findings.	L 306	4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 **L410 #1.** 1. Window blind replacements ordered for rooms 105, 144, and 249. 2. No other window blinds were found to be broken in residents' rooms. 3. Maintenance staff re-educated to inspect window blinds during Weekly Maintenance Rounds; broken blinds will be repaired or replaced 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly 5. Compliance Date: 7/22/2015 **L410 #2** 1. Walls in rooms 123, 144, 237, 249, and 256 were repaired or repainted. Doors in rooms 104, 105, 106, 115, 116, 202-B, and 207B were repaired. 2. No other doors or walls were found to be marred. 3. Maintenance staff re-educated to inspect resident room walls and doors during Weekly Maintenance Rounds and repairs completed.	
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	L 410	4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	

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L 410	Continued From page 41 manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on May 15, 2015 at approximately 11:30 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by broken slats from window blinds in three (3) of 45 resident's rooms, marred walls in five (5) of 45 resident's rooms, marred entrance doors in seven (7) of 45 resident's rooms, loose wallpaper in the hallways of unit 2B, paint peeling from the ceiling above the resident ' s bed, clear pieces of tape stuck in several areas in the ceiling of room #251 and a missing floor tile in the bathroom of room #251, one (1) of 45 resident's rooms surveyed. The findings include: 1. There was one (1) broken slat from one (1) of one (1) window blind in room #105, two (2) broken slats from one (1) of two (2) window blinds in room #144 and one (1) broken slat from one (1) of two (2) window blinds in room #249, three (3) of 45 resident's rooms surveyed. 2. Walls in five (5) of 45 resident's rooms were marred including rooms #123, #144, #237, #249 and #256 and entrance doors in seven (7) of 45 resident's rooms were marred including rooms #104, #105, #106, #115, #116, #202B and #207B.	L 410	**L410 #3** 1. Loose wall paper in 2-B hallways was removed. 2. During inspection, no other loose wallpaper was identified. 3. Maintenance re-educated to inspect loose wallpaper during Weekly Maintenance Round replace if needed. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: **L410 #4** 1. Room 251B ceiling was repaired; tape removed and ceiling repainted. 2. No other ceiling was found to be peeling during inspection. 3. Maintenance re-educated to inspect ceilings in all residents' rooms during Weekly Maintenance Rounds; damaged ceilings will be repaired. 4. Plant Operations Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: **L410 #5** 1. Bathroom floor tile in room 251 was replaced. 2. No other missing tile was identified during inspection. 3. Maintenance staff re-educated to inspect floor tiles in all resident bathrooms during Weekly Maintenance Rounds, and replace damaged tiles if needed.	7/22/2015 7/22/2015

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L 410	Continued From page 42 3. The wallpaper hanging in the hallways of unit 2B was loose in several areas. 4. The paint was peeling off an area from the ceiling above the resident's bed in room #251B and there were multiple pieces of clear tape stuck to other areas in the ceiling, one (1) of 45 resident's rooms surveyed. 5. There was a floor tile missing in the bathroom of resident room #251 on May 19, 2015 at approximately 12:05 PM, one (1) of 45 resident's rooms surveyed. These observations were made in the presence of Employee #11 and Employee #12 who acknowledged the findings. B. Based on observation and staff interview for one (1) of 37 residents it was determined that facility staff failed to decrease the spread of disease causing organisms as evidence by oxygen tubing lying uncovered on the floor, oxygen bag with tubing inside lying on the floor. Resident #106 The findings include: A resident room observation was conducted on May 15, 2015 at approximately 10:00 AM. The following was observed: In a chair adjacent to the resident ' s bed, was a BiPAP [bi-level positive airway pressure] machine with a face mask and long hose attached. Portions of the hosing was observed uncovered on the floor in front of the chair; oxygen tubing connected to the portable oxygen tank with portions coming in contact with the floor; extra oxygen tubing covered in a plastic bag observed on the floor.	L 410	4. Plant Ops Director or designee will review Weekly Maintenance Rounds Checklists weekly and report variances to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 **L410 B.** 1. Oxygen tubing and facemask were replaced and stored in compliance with facility policy. Resident #106 did not sustain harm. The incident was corrected during the Survey observations. 2. A facility-wide inspection of all residents with oxygen was completed; oxygen supplies stored in compliance with facility policy. 3. All nursing staff will be re-educated on infection prevention related to oxygen supplies. Prevention of contamination of all respiratory equipment including oxygen tubing will be added to nursing unit rounds. Clinical Managers will round on their assigned nursing unit at least twice per shift and House Supervisors will observe for hazardous infection prevention incidents during rounds. 4. The Director of Nurses or designee will review the audits during weekly Nursing Management Team Meetings. Variances will be reported to Focus QI-IDT meeting weekly and to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0005	A. BUILDING: _____ B. WING _____	05/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 43 A face-to-face interview was conducted on May 22, 2015 with Employee #6 at approximately 11:30 AM. A second observation was made in the room. The tubing from the BiPAP was observed on the floor; the oxygen tubing connected to the portable oxygen tank was observed on the floor, and the oxygen tubing within a bag was observed on the floor. Employee #6 acknowledged the findings at the time of the observation.	L 410	**L442 #1** 1. Toaster oven knob replaced during survey. 2. No other broken toaster was identified during survey. 3. Staff re-educated to report broken equipment to supervisor promptly. Supervisor re-educated to add toaster oven to Daily Checklist inspection. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date:	7/22/2015
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and interview on May 11, 2015 at approximately 9:10 AM, it was determined that the facility failed to maintain essential equipment in safe, operating condition as evidenced by one (1) of one (1) toaster oven that lacked a temperature adjustment knob, one (1) of two (2) hand washing sinks housing with a loose cover, one (1) of one (1) ice machine with a cracked plastic lid, one (1) of two (2) non-functioning garbage disposals and one (1) of one (1) reach-in box that has been out of order for more than a year. The findings include: 1. One (1) of one (1) toaster oven in the main kitchen was without a temperature adjustment knob.	L 442	**L442 #2** 1. Hand washing sink cover housing repaired during survey. 2. No other hand washing sink housing was identified as loose during survey. 3. Staff re-educated to report broken equipment to supervisor promptly. Supervisor re-educated to add hand washing sink to Daily Checklist. 4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 **L442#3** 1. Plastic cover on inside lid of ice machine is in process of being replaced. 2. No other cracked ice machine lid was identified during survey. 3. Supervisor was re-educated to inspect ice machine as part of Daily Checklist and report variances promptly	7/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 442	Continued From page 44 2. The cover to the housing of one (1) of two (2) hand washing sinks hung loosely from the sink and needed to be repaired. 3. The plastic cover on the inside of the lid of one (1) of one (1) ice machine was cracked. 4. One (1) of two (2) garbage disposals was not functioning. 5. One (1) of one (1) reach-in box has been broken for over a year. During an environmental tour of the main kitchen on May 11, 2015 at approximately 9:30 AM, Employee #9 was asked about the reach-in box that was no longer operational and he/she responded that it had been out of service for over a year. These observations were made in the presence of Employee #9 who acknowledged the findings.	L 442	4. Dining Services Director will review Daily Checklist inspections a minimum of weekly and report findings to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 **L442 #4** 1. The non-functioning garage disposal was removed. 2. No other non-functioning garbage disposal was identified during survey. 3. Supervisor was re-educated to inspect garbage disposals as part of Daily Checklist and report malfunctions to Dining Services Director promptly. 4. Dining Services Director will report on any malfunctioning garbage disposals to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015 **L442 #5** 1. Broken reach-in box was removed. 2. No other broken reach-in box was identified during inspection. 3. Dining Services Director will report malfunctioning/broken equipment to Plant Operations promptly. Staff will also be educated to make reports if equipment is malfunctioning or has broken parts. 4. Dining Services Director will report on broken equipment to QAPI Committee quarterly. 5. Compliance Date: 7/22/2015	