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	HFD02-0020	A. BUILDING: _____ B. WING _____	02/20/2020

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TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

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L 000	Initial Comments An Annual Survey was conducted at Transitions Center from 2/9/2020 through 2/20/2020. Survey activities consisted of a review of 75 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. The resident census during the survey was 346. 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 AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HR- Hour	L 000	Transitional Care Center –Capitol City is filing this Plan of Correction in accordance with the State and Federal requirements. Submission of this Plan of Correction is not an admission that any deficiencies identified are correct. This Plan of Correction is to serve as the facility's credible allegation of Compliance with all the requirement of the Medicare/Medicaid Program.	

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L 000	Continued From page 1	L 000		

HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian
RN- Registered Nurse
ROM Range of Motion
Rp, R/P - Responsible party
SCC Special Care Center
Sol- Solution
TAR - Treatment Administration Record

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L 001	Continued From page 2	L 001	1. Resident #187 was refunded the $100.00	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A.Based on observation, record review, and interview for five (5) of 11 sampled residents, whose personal funds are managed by the facility, the facility's staff failed to follow generally accepted accounting principles when depositing a money order made out to one (1) resident and to ensure five (5) residents who have Resident Fund Management System (RFMS) accounts gave the facility staff authorization to manage their funds. Residents' #187, #112, #116, #181 and #238 Findings included ... 1. Review of the medical record for Resident #187 showed that she was admitted to the facility on 9/16/19 with diagnoses that included Hypertension and End-Stage Renal Disease. A review of the Admission Minimum Data Set [MDS] dated 9/23/2019, showed Section C [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "15" which indicated that the resident was cognitively intact. During a face-to-face interview with Resident #187, on February 10, 2020, at 2:58 PM, she stated that the facility cashed a money order that	L 001	2. The facility audited deposited checks and money orders from February 2020 through October 2019 and determined that no other residents were affected by the findings in this deficiency. 3. A new policy and procedure was written to ensure that checks or money orders that are not made payable to the facility are deposited in the facilities operating account. The business office was in-serviced on this policy on 3/18/2020. 4. The Business office manager or designee will audit the deposits daily to ensure that the facility is the payee before deposits are completed. A monthly summary with the findings of those audits will be reported to the facilities QAPI committee for review. 1. Resident #112 account was closed due to inactivity and the account had a zero balance.Resident #116 had a new Authorization and Agreement form generated. Resident #116 signed and dated the form on 3/30/20. Resident #181 has the facility as the representative payee. A new Authorization & Agreement from was generated. A member of the Business Office staff signed the form on behalf of the facility and the form was dated. Resident #238 has the facility as the representative payee. A new Authorization & Agreement form was generated. A member of the Business Office staff signed the form on behalf of the facility.	3/18/20 3/30/20

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L 001	Continued From page 3 was sent to her as a Christmas gift. The resident also said, "the money order was addressed to me, but the facility staff cashed it and applied the money to my balance without my consent. The Resident further stated that she requested a refund from the business office but was unsuccessful. A face-to-face interview was conducted with the Business Office staff (Employees # 1, #25 and #26) on 2/13/2020 at approximately 4:00 PM. The group shared that the Resident#187 money order came in an envelope addressed to the facility via U.S. Mail from the Resident's niece. The envelope was opened and the money order for $100.00 was then scanned and applied to the resident's balance owed to the facility in error. Employee #1 then stated, "It was an honest mistake and the facility will refund the resident her money". The writer was provided a copy of the scanned money order. The money order was addressed to Resident #187 and lack documented evidence that the resident signed it over to the facility. A face-to-face interview was conducted with Employee #27 on 2/14/2020 at approximately 11:45 AM. The employee provided the writer with a copy of a receipt showing that the facility had refunded the resident her money with interest ($100.03). The facility staff failed to follow generally accepted accounting principles by depositings a money order made out to Resident#187. The Business Office failed to ensure four (4) residents who have Resident Fund Management System (RFMS) accounts gave the facility staff	L 001	2. The facility audited the Resident Trust Fund Authorization and Agreement forms to ensure that the forms were signed and dated by the resident or appropriate responsible party. Resident accounts that were affected by this deficiency were resigned and dated by the resident, the facility (if the facility was representative payee)or mailed to the responsible party for a new signature and date. 3. The Business Office Staff was in-serviced on the proper way to fill out a Resident Trust Fund Authorization & Agreement form. 4. An audit will be done monthly on new accounts to ensure, that any accounts opened after the initial audit, have the proper authorization needed to manage the accounts.	3/18/20 3/18/20

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L 001	Continued From page 4 authorization to manage their funds. Residents' #112, #116, #181 and #238 Review of the facilities trial balance as of January 31, 2020, and February 16, 2020, showed the previously mentioned residents had asterisk (*) next to their names indicating that the residents had transferring accounts (automatic transfer of care cost payments due to the facility) that were missing signatures on the application and authorization form (s). Review of the residents business office file showed the following: Resident #112 -"RFMS Authorization and Agreement to Handle Resident Funds form" was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #116 -"RFMS Authorization and Agreement to Handle Resident Funds form" was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #181-"RFMS Authorization and Agreement to Handle Resident Funds form" was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #238- "RFMS Authorization and Agreement to Handle Resident Funds form" was not signed by the resident, there was no date or witness signatures. There was no evidence that facility staff ensured that four (4) of the 11 sampled resident accounts had signed authorization and agreement forms properly completed giving the facility permission	L 001		

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L 001	Continued From page 5 to manage their funds. During a face-to-face interview with Employee # 27 on 2/16/2020 at approximately 10:30 AM, he acknowledged the findings. B. Based on record review, resident and staff interview for one (1) of 75 sampled residents, facility staff failed to consistently monitor Resident #274 with sexually aggressive behavior from inappropriately touching female residents. Findings included ... Resident #274 was admitted to the facility on 8/27/2010 with diagnoses that included, unspecified Dementia without behavioral disturbance, Alcohol Abuse, Mood Affective Disorder, Major Neurocognitive Disorder Unspecified, without behavioral disturbance. The Annual Minimum Data Set dated July 18, 2019, showed Resident #274 had a Brief Interview for Mental Status (BIMS) score of "13" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident had no impairment of his upper extremities and used a wheelchair for mobility. Review of Resident #274's record showed a Social Worker note dated, 9/25/2019 at 15:00, "Social worker was made aware by nursing that a CNA observed [Resident #274] in a female resident's room with his hand on the female resident private area. At 9:26 AM SW [social	L 001	1. Resident #233 was interviewed post incident and expressed that she felt safe within the facility. No other incident has occurred from this wandering resident (#274). Resident #274 remains on one-on-one monitoring. His one-to-one monitoring was discontinued without the input of the Behavioral Psychologist who chairs the facility's Behavior Management Committee. All one-on-one assignments, due to behavioral issues, will be reviewed by the Behavior Management Committee before discontinuing any one-on-one assignments to ensure that an appropriate monitoring plan is in place. 2. The facility acknowledges that all residents have the potential to be affected by this finding. 3. Staff was educated on a new protocol for "one-on-one" assignments to reflect the purpose of the monitoring and to ensure that staff understood "their" role. The Interdisciplinary Team will be in-serviced to ensure that this process is followed. 4. A listing of all one-on-one assignments will be submitted and reviewed by the QAPI Committee monthly for further analysis and recommendation(s).	3/5/20

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L 001	Continued From page 6 worker and Assist Director of Nursing] met with resident to interview him regarding the report from the CNA. During the interview, resident stated, 'I went to the room, nothing happened, I saw she had no draws, I looked but I did't touch her. I know it was wrong going in there and I came out of the room by myself.' Nursing called the police..." A review of a care plan initiated 9/26/19 showed Resident #274 was placed on 1:1 monitoring s/p [status post] inappropriately touching a female resident. The 1:1 monitoring was discontinued on 10/1/19. A review of PsychoGeriatric Services, LLC Late entry note for 10/1/19 generated on 10/2/19 showed "Chief complaint: Patient seen to evaluate mental status and adjust medications for behavioral disturbance. Chief Complaint: C/O [Complaint of) of sexual abuse ... he was evaluated d/t (due to) report of inappropriate sexual conduct with another female resident. Patient initially denied entering into the patient's room or touched her vaginal, Though after cues was able to answer the question admitting the claim and did not volunteer any further information. It appears that this patient has engaged in this type of behavior in the past. Noted that he was doing well while on Paxil and Risperdal but both were discontinued apprentice and not sure why... Chart reviewed, no report of agitation or aggression. Patient was counseled and he verbalized understanding. Currently on 1:1... for safety per facility protocol. Diagnosis: F10.10 [Alcohol Abuse], F39 [Mood Affective Disorder], F06.Major Neurocognitive DisorderUnspecified, without behavioral disturbance - F03.90. Treatment plan/recommendations Plan: Supportive therapy	L 001		

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L 001	Continued From page 7 provided. Reviewed SE [side effects] and Risk/ Benefits analysis, Psychiatric team will monitor mood and behavior, Patient encouraged to participate in activities on the unit. Will d/c [discontinue] 1:1... Start Paxil 10mg qd [every day] for mood disorder. Nursing staff to maintain close monitoring of patient every shift, and redirect promptly if necessary." SW [Social Worker] note dated 12/19/2019 at 10:02 AM showed, "SW met with met with resident at 8:39 AM today s/p alleged inappropriate touching of female resident on 12/18/2019. Upon interview resident stated, "I stuck my hand in her pants. I made a mistake, the police told me I will go to jail for doing that." SW counseled resident re the behavior and he expressed understanding. Resident is currently on 1:1 montioring... A review of another care plan initiated 12/18/19 showed Resident #274 was placed on 1:1 monitoring s/p [status post] inappropriately touching a female resident. A face-to-face interview was conducted with Resident #274 on 2/12/20 at approximately 3:00 PM concerning him inappropriately touching female residents' vaginal area. The Resident responded, "Yes" I want to touch the P____y ..." The resident was asked where were staff when this happened? The resident responded, "I don't know." Transition Healthcare Hourly Resident Monitoring Log showed the following: 9/26/19 to 9/30/19 - showed continuous monitoring of Resident's behavior was checked at	L 001		

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L 001	Continued From page 8 the allotted space. 10/1/19 - showed 1:1 started at midnight and discontinued at 8:00 AM. 12/18/19 to 2/14/20 - showed 1:1 started at 12/18/19 4:00 PM and was continuous through this time period. A face-to-face interview was conducted on 2/13/20 at approximately 4:14 PM with Employee #8 concerning the Psych Recommendation on 10/2/20 for "Nursing staff to maintain close monitoring of patient every shift, and redirect promptly if necessary." Employee #8 stated, "The resident was on 1:1 for a month and that was discontinued on 10/2/19. Prior to the incident on 12/18/19, the resident was being watched by staff and redirected when necessary. There was no monitoring log presented for the Resident's close monitoring from 10/2/19 to 12/17/19. There was no documented evidence to show that facility staff proteceted Resident #233 from being touched in a sexual manner by Resident #274. Resident #274 was not monitored every shift from 10/2/19 to 12/18/19 to prevent him from further inappropriately touching of female resident's vaginal area. On February 13, 2020, approximately at 4:14 PM, Employee #8 acknowledged the findings.	L 001		
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	L 051		

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L 051	Continued From page 9 required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for three (3) of 75 sampled residents, the charge nurse failed to develop patient-centered Care Plans for one (1) the use of oxygen for one (1) resident; (2) the resistant /refusal of ADL [activity of daily living] care for one (1) resident; and (3) the diagnosis of Adjustment Disorder with Anxiety and Depressed Mood for one (1) resident (Residents' #106, #220 and #235). Findings include... 1. The charge nurse failed to develop a patient-centered Care Plan for Resident #106's use of Oxygen. Review of a physician's order for the resident dated September 18, 2019, showed that the	L 051	1. Resident #106's care plan was updated to reflect the appropriate setting(s) for her continuous oxygen. Resident #220 care plan was updated to reflect her incontinence care and periodic refusals. Resident #235 was referred to behavioral health services for appropriate care-planning of his Adjustment Disorder with Anxiety and Depressed Mood. 2. The facility recognizes that all residents can be affected by this deficiency, but no negative outcomes have resulted. 3. The Interdisciplinary Team Members were in-serviced by Regional Nurse Consultant on the appropriate updating of resident care plans. Resident care plans will be updated, at a minimum, quarterly, annually, and with change of condition to reflect change and focus of their plans of care. 4. Unit Managers will audit five (5) random residents from each Unit monthly and verify that care plans have been updated and report their findings to the QAPI Committee for further review and recommendation.	4/8/20

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L 051	Continued From page 10 resident has an order for "O2 (Oxygen) at 2 liters continuously for SOB (Shortness of Breath)." According to the Annual Minimum Data Set dated November 19, 2019, the resident was coded for receiving Oxygen Therapy. However, review of the comprehensive care plans failed to show a comprehensive person-centered care plan for the resident's continuous use of Oxygen. A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on February 20, 2020. The employee reviewed the care plans and acknowledged that the facility staff failed to develop a patient-centered Care Plan for Resident # 106's continuous use of Oxygen. 2. The charge nurse failed to develop a patient-centered Care Plan for Resident #220's use of Oxygen. Resident #220 was admitted to the facility on May 22, 2019, with diagnoses that included Quadriplegia, Hypertension, Peripheral Vascular Disease, and Anxiety disorder. A review of Section C400 of the quarterly Minimum Data Set (MDS) dated December 19, 2019, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident is totally dependent on physical assistance from two or more persons for all aspects of care: bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.	L 051		

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L 051	Continued From page 11 The resident was observed lying in bed on February 10, 2020, at 2:37 PM when she stated to the surveyor, "I need to talk with you, my absorbent brief is only changed once every 8 hours. Interview conducted on February 12, 2020, at 1:30 PM with Employee #19 concerning Resident #220's absorbent brief changed only once a shift. The employees stated, "The resident's absorbent brief is changed when the resident request to be changed. She refuses when CNA [Certified Nursing Assistant] goes to change her." Interview conducted on February 12, 2020, at 1:40 PM with Employee #20 concerning Resident #220 absorbent brief being changed only once a shift. The employee stated, "The resident [will] refuse or ask that staff to come at a given time for her brief to be changed. I am her CNA I go back to her several times for the day for her to verbalize [when] she is ready to be changed." A review of Resident # 220's Care Plans showed there was no documented evidence of goals and interventions to address the resident's resistance/refusal of activity of daily living care. A face-to-face interview was conducted with Employee #19 at approximately 2:00 PM on February 12, 2020. When asked about the care plan that shows resident resistant /refusal of ADL care plan, Employee #19 reviewed the record and acknowledged the findings. 3. The charge nurse failed to develop a patient-centered Care Plan to address Resident # 235's diagnosis of Adjustment Disorder with	L 051		

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L 051	Continued From page 12 Anxiety and Depressed Mood. Review of Resident # 235's current medical record on 02/19/20 at 1:00 PM showed that the resident was admitted on 12/24/20 with several diagnoses including Adjustment Disorder with Anxiety and Depressed Mood. Continued review of the medical record showed a Care Plan dated 12/24/19 that failed to outline how the staff provided care to address Resident # 235's diagnosis of Adjustment Disorder with Anxiety and Depressed Mood. During a face-to-face interview on 02/19/20 at 3:00 PM, Employee #7, Unit Manager, acknowledged the finding.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (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;	L 052		

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L 052	Continued From page 13 (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, and interviews for two (2) of 75 sampled residents, the charge nurse failed to ensure that the residents were treated with respect and dignity, as evidenced by: allowing one (1) resident to lay on soiled linen until the change of shift, and by not providing incontinent care and not removing facial hair for one (1) resident. Residents # 169 and #197 Findings include...	L 052	1. Resident #169's soiled linen was changed immediately and is inspected daily by the Unit Manager/Supervisors to ensure that they were being changed consistently for thirty (30) days. Resident #197's facial hair was removed and her care card updated to perform this task on shower days. 2. All female residents presenting with facial hair were reviewed and care plans established for routine removal of their facial hair as appropriate. 3. Direct-care staff was in-serviced on the routine care and services that are to be provided to all residents with thoroughness, dignity, and respect. Unit Managers shall perform random audits during walking rounds to inspect the care of residents to include incontinence care as well as hygiene and linen change. This audit shall include 5 residents per week for 4 weeks, then monthly. 4. The results of these audits will be reported to the QAPI Committee monthly for further review and recommendations.	2/18/20 2/18/20 3/14/20

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L 052	Continued From page 14 1. The charge nurse failed to ensure that Resident #169 was treated with dignity and respect by allowing her to lay in bed on soiled bed linen (a fitted sheet) until the change of shift. Resident #169 was admitted to the facility on September 17, 2019 with diagnoses with included Hypertension, Diabetes Mellitus, Depression, and Anxiety Disorder. According to the Quarterly Minimum Data Set completed on 12/18/2019, Resident #169 had a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident required extensive assistance with 2 person physical assistance with transfer and toilet use, and one person physical assistance with personal hygiene and bed mobility. Under Section H Bowel and Bladder the resident was coded as having occasional urinary incontinent and frequently incontinent of bowel. During a face-to-face interview with Resident #169 on 2/19/2020 at approximately 10:30 AM. The resident stated that she called for assistance to use the bedpan. The CNA instructed her to use her incontinent brief. Continued interview revealed that the CNA eventually helped her use the bedpan, after arguing with her. Further interview revealed that after the CNA Employee #32 helped her use the bedpan, the CNA Employee #32 made her aware that there was a brown stain on her fitted sheet. When queried about the brown stain, the resident said	L 052		

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L 052	Continued From page 15 "It was stool because I had an upset stomach all that day". The resident then stated, "I asked the CNA to change the fitted sheet, but the CNA said, No, I'll change it before I leave in the morning." According to Employee #2, DON, on 02/19/19 at 4:00 PM, the CNA Employee #32 was suspended because she allowed Resident #169 to lay on soiled linen until the change of shift. The charge nurse failed to ensure that Resident #169 was provided with dignity when she was left to lay on soiled bed linen. 2A. The charge nurse failed to ensure that Resident #197 was treated with dignity and respect by not providing the resident with incontinent care. Observation on 02/09/20 at 7:10 AM showed Resident #197 sitting on a bare mattress naked and holding pajama in front of her body. Also noted was a fluid soaked fitted sheet lying on the bed. This writer informed Employee #11 at 7:15 AM that the resident was naked, her bed was soiled and she needed to be changed. The employee stated, she was going to send someone to the room to take care of the resident. According to Section H0300 (Urinary Continence) of the quarterly Minimum Data Set (MDS) dated December 31, 2019 the resident is coded for occasional incontinence.	L 052		

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L 052	Continued From page 16 During a face-to-face interview on February 09, 2020 at approximately 10:30AM. Employee #10 acknowledged the finding. 2B. The charge nurse failed to provide Resident #197 with dignity and respect by not removing the resident's unwanted facial hair. On February 20, 2020 at approximately 11:00 AM Resident #197 was observed sitting on the seat of her rollator (walker) across from the Nurses' Station. While speaking to the resident this writer observed thick facial hair around the resident's mouth and chin. The resident was asked whether she wanted the hair around her mouth and on her chin and she responded, "No. I need somebody to take it off." Employee #10 was asked to observe the resident's face immediately after the aforementioned observation. The employee observed the resident's face and asked the resident, "Do you want it (hair) off?" While pointing to the hair on the Resident#197's face. The resident said, "Yes." The employee then stated, "I will get someone to take it (hair) off right away." During a face-to-face interview with Employee #10 on February 20, 2020 at approximately 11:30 AM, the employee acknowledged that the charge nurse failed to respect Resident #197's dignity by not removing the resident's facial hair.	L 052		

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L 056	Continued From page 17	L 056	1. The facility's Attendance Policy was reviewed by the Director of Nursing and Staffing Coordinator and Human Resources. 2. Staffing Coordinator will coordinate with Human Resources to recruit staffing for daily requirements for resident care. 3. Monetary incentives programs were revamped to attract Certified Nursing Assistants and Registered Nurses for the nursing department. 4. Due to COVID-19 pandemic, all job fairs were placed on hold, telephone interviews are being held and the facility is still accepting applications via email.	4/14/20
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that the facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for 18 of 18 days and sixth tenths (0.6) Advance practiced registered nurse per Resident per day for two (2) of 18 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included . . . According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall	L 056		

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L 056	Continued From page 18 be in addition to any coverage required by subsection 3211.5. A review of the Nurse Staffing was conducted on February 20, 2020, at approximately 1:00 PM. Of the eighteen (18) days reviewed, Eighteen of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day and two (2) of the days failed to provide a minimum daily average of six tenths (0.6) hours of advanced practiced registered nurse as follows: Hours of Direct Care per resident per day Saturday, August 31, 2019, showed that the facility provided direct nursing care per resident at a rate 2.97 hours. Sunday, September 1, 2019, showed that the facility provided direct nursing care per resident at a rate of 2.71 hours. Monday, September 2, 2019, showed that the facility provided direct nursing care per resident at a rate of 2.97 hours. Wednesday, November 27, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.56 hours. Thursday, November 28, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.10 hours. Tuesday, December 24, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.29 hours. Wednesday, December 25, 2019, showed that	L 056		

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L 056	Continued From page 19 the facility provided direct nursing care per resident at a rate of 2.90 hours. Sunday, February 9, 2020, showed that the facility provided direct nursing care per resident at a rate of 2.90 hours. Monday, February 10, 2020, showed that the facility provided direct nursing care per resident at a rate of 2.66 hours. Tuesday, February 11, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.61 hours. Wednesday, February 12, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.70 hours. Thursday, February 13, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.5 hours. Friday, February 14, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.35 hours. Saturday, February 15, 2020, showed that the facility provided direct nursing care per resident at a rate of 2.79 hours. Sunday, February 16, 2020, showed that the facility provided direct nursing care per resident at a rate of 2.72 hours. Monday, February 17, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.36 hours. Tuesday, February 18, 2020, showed that the	L 056		

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L 056	Continued From page 20 facility provided direct nursing care per resident at a rate of 3.39 hours. Wednesday, February 19, 2020, showed that the facility provided direct nursing care per resident at a rate of 3.64 hours. Hours of Advanced practice Registered Nurse per resident per day Saturday, August 31, 2019, showed that the facility provided advanced practiced registered nurse per resident at a rate 0.55 hours. Wednesday, December 25, 2019, showed that the facility provided advanced practiced registered nurse per resident at a rate of 0.55 hours. A face-to-face interview was conducted with the Staffing Coordinator at the time of the staffing review and she acknowledged the findings.	L 056		
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 interview, facility staff failed to provide a safe, sanitary environment to help prevent the expansion and transmission of communicable diseases and infections as evidenced by one (1) of one (1) heater blower in use, that was soiled with dust in the laundry room	L 091	1. All dust was immediately cleaned from the heater blower in the laundry room during the annual survey and completed on February 19, 2020. 2. Environmental services staff will use a Dryer/Vent/ & Heater audit tool and monitored daily. 3. Environmental Services Director will check Dryer/Vent/& Heater audit tool weekly. 4. Director of Environmental will inform the results of these audits to the QAPI Committee monthly.	2/19/20

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L 091	Continued From page 21 and the lack of a water management program with a risk assessment to identify where Legionella and other waterborne pathogens could grow in the facility's water system. Findings included ... 1. During a walkthrough of the facility's laundry area on February 19, 2020, at approximately 11:07 AM, one (1) of one (1) heater blower, hanging down from the ceiling in the washing machine room, was soiled with dust. This deficient practice consistently exposes resident clean, personal clothing and linen to dust contamination. 2. A comprehensive water management plan to include a complete description of all potable and non-potable water systems in the building and a facility risk assessment to identify where Legionella and other water borne pathogens could grow and spread in the facility's water system was not available for review on February 14, 2020, at approximately 9:15 A.M. These findings were acknowledged by Employee #15 on February 18, 2020, at approximately 1:00 PM.	L 091	1. The Legionella risk assessment was completed but located in a different section of the manual. 2. 2. A flow diagram of all potable and non-potable water was created by an outside contractor and completed on March 26, 2020. 3. Risk assessment will be reviewed annually to stay in compliance. 4. Director of Maintenance will inform QAPI of any changes made to the water system.	3/26/20
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.	L 099	1. The freezer was charged with Freon and temperatures were corrected immediately and outside refrigerator temperature gauge was replaced. New air curtains (slats) were ordered on 2/24/2020 and replaced on March 3/4/2020. The temperature gauge for refrigerator #5 was replaced immediately during survey.	2/19/20 - 3/4/20

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L 099	Continued From page 22 This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to store and prepare foods under sanitary conditions as evidenced by inadequate internal temperatures in one (1) of one (1) walk-in freezer, four (4) of four (4) soiled convection ovens, one (1) of five (5) missing slat in one (1) of one (1) walk-in refrigerator and a broken outer gauge in one (1) of three (3) reach-in refrigerator. Findings included ... During a walkthrough of dietary services on February 9, 2020, at approximately 7:20 AM, the following were observed: 1. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38 degrees F between 7:22 AM and 9:30 AM. Food items such as mixed vegetables and French fries were still frozen but approximately 15 of 15 one-serving containers of ice cream were melted and discarded. No other foods were affected as the walk-in freezer was repaired soon thereafter. 2. Four (4) of four (4) convection ovens were soiled throughout with burnt food deposits. 3. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator. 4. The outer temperature gauge to reach-in refrigerator #5 was broken. These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM.	L 099	2. Temperatures will be checked 3x daily and logged on temperature checklist by shift supervisors. 3. Director of Food Services will check temperature log sheets weekly to ensure that there are no fluctuating temperatures. 4. Director of Food Services will inform the results of these audits to the QAPI Committee monthly. 1. All convection ovens were cleaned and put on cleaning schedules (3xweek). 2. All convection ovens will be checked and cleaned daily by dietary supervisors and logged on cleaning checklist. 3. Food Services Director will audit cleaning checklist weekly. 4. Director of Food Services will inform the results of these audits to the QAPI Committee monthly.	2/18/20

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L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and interview, for two (2) of 75 sampled residents, the facility's pharmacist failed to identify a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review for one (1 resident; and to ensure the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (August 2019 and Jaqnuary 2020) for one (1) resident. (Residents #23 and #220).	L 128	1. Resident # 220 medications were reviewed by the Pharmacist on 2/29/20. Resident #23's medications were reviewed and audited to ensure that all of his medications were current and available. His care plan was updated to reflect his hypertensive and diuretic medications as well. 2. The pharmacist performed a review of all resident medications on 2/29/20 to identify medication issues as well as any recommendation for GDRs. All findings were followed-up with the residents' respective physicians and care plan updated accordingly. 3. The Director of Nursing will in-service Nursing Management and ensure that the pharmacist performs the required drug review of all residents monthly. The Unit Managers will ensure that recommendations are reviewed and addressed by the physician(s) timely. 4. A random audit of 5 residents from each unit will be performed by the Unit managers monthly and reported to the QAPI Committee for further review and recommendation.	3/3/20-3/15/20

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L 128	Continued From page 25 Continued review of Resident #23's medical record showed a document entitled, "Pharmacist's Chronological Record of Medication Regimen Review" dated 01/27/20. The review lacked documented evidence that the pharmacist captured the medication error that the facility's staff did not administer Resident #23's physician ordered Norvasc or Lasix for 19 days from 01/02/20 to 01/20/20. However, the pharmacist documented "NI" (indicating no irregularities). During a face-to-face interview with Employee #4 at approximately 9:00 AM on February 20, 2020, the employee acknowledged that the pharmacist failed to identfy a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review. 2.The facility failed to ensure that the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (8/2019 and 1/2020) for Resident #220. Resident #220 was admitted to the facility on May 22, 2019, with diagnoses which include Quadriplegia, Hypertension, Peripheral Vascular Disease, and Anxiety disorder. A review of Section C400 of the Quarterly Minimum Data Set (MDS) dated December 19, 2019, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions.	L 128		

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L 128	Continued From page 24 Findings include... 1. During an interview on 02/10/20 at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his hypertension medications for January 2020. Review of Resident #23's current medical record on 02/13/20 starting at 2:00 PM showed that the resident had an initial admission date of 07/30/19 with multiple diagnoses including Essential Hypertension, Cerebral Infarction, and Acute Kidney Failure. Further review of the resident's record revealed a January 2020 Medication Administration Record (MAR) that showed the following: Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) give 1 tablet by mouth one time a day for HTN (Hypertension) with a start date of 08/20/19 and a discontinued date of 01/01/20. Lasix (Furosemide) Tablet 40 mg (milligram) give 1 tablet by mouth one time a day for edema with a start date of 08/20/19 and a discontinue date of 01/01/20. Continued review of the January 2020 MAR showed that the facility's staff failed to administer Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) 1 tablet by mouth one time a day for HTN (Hypertension) and Lasix (Furosemide) Tablet 40 mg (milligram) 1 tablet by mouth one time a day for edema from 01/02/20 to 01/20/20 (for a total of 19 days). Further review of Resident #23's medical record showed no evidence of a physician's order to discontinue the Norvasc or Lasix on 01/20/20.	L 128		

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L 128	Continued From page 26 A review of the medical record showed The Pharmacist's Chronological Record of Medication Regimen Review was available on the record. The Medication Regimen Review was documented on the record from February 2019 through February of 2020. However, there was no documentation to show that the review was completed for August of 2019 and January 2020. A face-to-face interview was conducted with Employee #4 on 2/18/20 at approximately 1:00 PM concerning omission of the the two-months Medication Regimen Review by the Pharmacist without a reason as to why the review was not available in the resident's record. Employee #4 stated, "I will check to see if the resident was hospitalized." The employee later reported, "The resident was in the facility. I do not know what happened. will check and let you know" Employee #4 acknowledged the finding, during the aforementioned interview.	L 128		
L 203	3232.1 Nursing Facilities Each facility shall maintain and keep for three (3) years, from the date of the incident, summaries and analyses of unusual incidents within the facility or on the premises with regard to a resident, visitor or employee, including but not limited to accidents, injuries, drug errors, abuse, neglect and misappropriation of resident funds. This Statute is not met as evidenced by: Based on review of the facility's incident report and staff interviews for one (1) of 75 sampled resident, the facility's administration failed to thoroughly investigate an allegation of sexual abuse to one (1) female resident. Resident # 99.	L 203	1. Resident #99 was seen by local police as well as assessed by the forensic nurse of the District of Columbia to rule out sexual abuse with DNA analysis. No evidence was found and the case was closed out. Resident #99 was queried if she felt safe within the facility and she replied that she does. The resident's roommate during this incident has since been discharged from the facility. 2. The facility recognizes that all residents have the potential to be affected by this finding.	

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L 203	Continued From page 27 Findings include... An incident report dated May 14, 2019 at 19:15. "Titled, Alleged Abuse ...report to the charge nurse... incident description "[Resident #99] sister reported to charge nurse that she thinks her sister had been sexually abuse. She said that Resident who is nonverbal had been demonstrating with her hands and head that she has been abused sexually by putting her fingers in her mouth pointing towards her vagina and the door... Immediate Action: police department is notified ... [Officer] arrived ... [Physician] notified ... statements are being collected from staff that worked on that floor from Sunday night 5/12//19 to this evening (5/14/2019), investigation is ongoing." Review of the facility's investigation failed to show that the resident roommate was included in the investigative process to get her account or information related to the allegation. Facility staff closed the investigation as unsubstantiated. There was not enough evidence (such as, a documented interview with the resident's roommate) to show that the incident was thoroughly investigated. On 2/20/2020, approximately at 11:15 AM, Employee #2 acknowledged the findings.	L 203	3. The Director of Nursing, Administrator, Department Heads, and Nursing Management were in-serviced by the Regional Clinical Nurse Consultant on the Abuse Policy, performing thorough investigations, analyzing the facts of investigations to follow them to their ultimate conclusion, and making sound determinations on whether abuse occurred and what type (verbal, sexual, etc.). 4. All incident investigations will be reviewed for thoroughness and sound conclusions, at a minimum, by the Administrator, Director of Nursing, Regional Clinical Nurse Consultant, and Medical Director. A summary of completed incidents will be submitted to the QAPI Committee for review to identify any opportunity to improve the investigative process and its conclusions as well as to ensure compliance.	3/11/20

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L 206	Continued From page 28	L 206	1. The language in the facility policy (OPS-346 "Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property" Revised 12/10/18) was immediately corrected by the company's Operations Officer of Clinical Services. This was submitted to the surveyors during the survey and now serves as the revised version dated 2/10/20.	2/10/20
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 review of the facility's Abuse policy and staff interviews, the facility failed to instruct staff to report allegations of abuse immediately but not later than two hours in their abuse policy. The census on the first day of survey was 346. Findings include ... Policy Title: OPS-346 "Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property" Revised 12/10/18 stipulates: "VII. Reporting/Response A. All alleged incidents involving abuse, neglect, exploitation or mistreatment, including injures of unknown origin and misappropriation of resident's property will be reported immediately to the facility administrator ...Appropriate state survey agencies and other officials in accordance with state law will be notified within 5 working days of the incident by the facility administrator or his/her designee ..." Facility staff failed to develop and implement an abuse policy that includes reporting immediately,	L 206	2. No residents was affected by this citation, however, the facility recognizes that all residents have the potential to be affected. 3. Department Heads and the Nurse Management Team were immediately in-serviced on this update on the same day (2/10/20). 4. To ensure appropriate and updated content in the future, the QAPI Committee will review this policy quarterly for needed revisions and ensure that facility staff and residents are educated whenever a change is made.	2/10/20

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L 206	Continued From page 29 but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. During a face-to-face interview on 2/10/2020 at 12:29 PM, Employees #2 and #28 acknowledged the findings.	L 206		
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. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 60 resident's rooms that failed to alarm when tested, torn protective cover in five (5) of 60 observations and a broken reset button from one (1) of 60 resident call bell housing.	L 306	1. All call bell issues identified in room #124A, #205A, #214A, #235 and #332 were repaired immediately during annual survey. 2. Call bell system was checked throughout the facility and repaired as needed. 3. Maintenance staff was in-serviced on the importance of working call bells. The maintenance staff will continue to monitor rooms during daily rounds. 4. Director of maintenance will report results of findings to QAPI committee will determine compliance.	3/17/20

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L 306	Continued From page 30 Findings included... During an environmental walkthrough of the facility on February 10, 2020, between 10:35 AM and 3:30 PM: 1. Call bells in resident's rooms #332 and #355 did not alarm when tested, two (2) of 60 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. 2. The top, protective plastic cover to call bell cords in resident's room's #124A, #205A, #214A, #235 and #332 was torn, five (5) of 60 resident's rooms. 3. The reset push-button to the call bell housing, attached to the wall in resident room #336 was broken, one (1) of 60 resident's rooms. 4. One (1) bed bumper board was observed loose, detached from the wall, on the floor behind the head bed in room #201. Facility staff acknowledged the finding at the time of the observation on 2/19/2020 at approximately 2:00 PM These findings were acknowledged by Employee #14 on February 10, 2020, at approximately 3:30 PM.	L 306		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and	L 410		

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L 410	Continued From page 31 maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by stained ceiling tiles in nine (9) of 60 resident's rooms, soiled exhaust vents in six (6) of 60 resident's rooms, and broken door closures in three (3) of 360 resident's rooms. Findings included ... During an environmental walkthrough of the facility on February 10, 2020, between 10:35 AM and 3:30 PM the following were observed: 1. Ceiling tiles were stained in nine (9) of 60 resident's rooms including rooms #104, #120, #136, #202, #205, #208, #210, #235, #243. 2. Exhaust vents were soiled with dust in resident room ##209, #251, #305, #349, #355, #359, six (6) of 60 resident's rooms. 3. Door closures to the entrance door in resident rooms #104, #204 and #249 failed to function as intended and a trash bag was used to keep the door in place. These findings were acknowledged by Employee #14 on February 10, 2020, at approximately 3:30 PM.	L 410	1. Exhaust vents in room #209, #251, #305, #349, #355, and #329 were checked and cleaned immediately during annual survey. 2. Environmental Staff will monitor and clean vents during daily room cleaning. 3. Environmental Services Director will conduct weekly audits during room inspections. 4. Director of Environmental will report results of findings to QAPI committee and will determine compliance 1. Stained ceiling tiles in room #104, #120, #136, #202, #205, #208, #210, #235, and #234 were removed and replaced immediately during annual survey. 2. Maintenance staff was in-serviced on the importance of assessing and changing ceiling tiles. The maintenance staff will continue to monitor ceiling tiles during daily rounds. 3. Director of Maintenance will complete weekly audits on facility audit checklist tool and make corrections to any identified stained ceiling tiles. 4. Director of maintenance will report results of findings to QAPI committee will determine compliance.	2/24/20

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L 442	Continued From page 32	L 442	1. The concentrator for Resident #215 was adjusted after confirming the order. Care plan reflects the specific amount of oxygen that the concentrator should be set at.	
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 , record review and staff interview, the facility's staff failed to: (I) maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off; and (II) ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 67 sampled residents (Resident #215). Findings included ... (I). The facility's staff failed to maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off. 1. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38 degrees F between 7:22 AM and 9:30 AM and food items were not frozen solid as required. 2. The outer temperature gauge to reach-in refrigerator #5 was broken, one (1) of five (5) reach-in refrigerators. 3. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator.	L 442	2. An audit of all concentrators as well as oxygen via nasal cannula was performed facility-wide. No other resident was affected by this finding. 3. Licensed nursing staff was in-serviced on the proper settings of oxygen concentrators and returned demonstrations to verify competency. 4. Unit Managers will randomly audit 5 residents weekly to inspect and ensure that oxygen concentrator settings are correct based on physician orders. Any findings will be corrected immediately, staff directed to the educator for re-training, and a summary submitted to the QAPI committee monthly for review and further recommendation(s).	3/20/20 3/3/20 – 3/20/20

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L 442	Continued From page 33 4. Remote bed controller cords were torn throughout in resident's rooms #104, #141 and #325, three (3) of 60 resident's rooms. These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM. (II). The facility's staff failed to ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 67 sampled residents (Resident #215). Findings included: According to the New Life Intensity Oxygen Concentrator Service Manual under Section 4.1.1 Air Intake Gross Particle Filter/GPF - The external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly. Observation on 02/09/20 at 8:00 AM of Resident #215's room showed that the resident was sitting in bed, receiving oxygen at a flow rate of 7 liters per nasal cannula being delivered by an oxygen concentrator. Continued observation of the back of the oxygen concentrator revealed that the concentrator had a serial number of CBB0117250050 and an inspection sticker dated 06/17/17. Further observation showed that the concentrator did not have an Air Intake Gross Particle Filter, and dust particles were collected in the filter area. It should be noted that Resident #215 did not appear to	L 442		

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L 442	Continued From page 34 have any respiratory distress, and her oxygen saturation was 95% on oxygen at 7 liters per nasal cannula. Review of the facility's Preventive Maintenance Log revealed preventive maintenance service for equipment was conducted on 08/07/19. Continued review of the log lacked documented evidence that Resident #215 oxygen concentrator #CBB0117250050 was inspected on 08/07/19. During a face to face interview on 02/10/20 at 10:00 AM, Employee #16, Director of Environmental Services and Supplies, acknowledged the finding. Employee #16 stated that he was not aware that Resident #215's oxygen concentrator #CBB0117250050 had not been inspected during the preventive maintenance services on 08/07/19. He also said that he was not aware that oxygen concentrator #CBB0117250050 did not have a filter. Continued interview with Employee #16 revealed that oxygen concentrators are inspected by "a company" every six (6) months. However, he did not have documented evidence on when oxygen concentrators were inspected before 08/07/19. When asked if he knew what residents were assigned to each oxygen concentrator, Employee #16 stated, "No, I'm new to the job. I would have to go to the floors and look at the serial numbers on each resident's concentrator." The facility failed to ensure Resident #215's oxygen concentrator was maintained in a safe operating condition.	L 442		