Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0020	A. BUILDING: _____ B. WING _____	11/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments A Licensure Survey was conducted November 16 – 23, 2015. The deficiencies are based on observation, record review, resident and staff interviews for 32 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status g-tube- Gastrostomy tube EKG - 12 lead Electrocardiogram NP - Nurse Practitioner BID - Twice- a-day EMS - emergency medical services (911) HVAC - Heating ventilation/Air conditioning Neuro - Neurological B/P - Blood Pressure CRF - Community Residential Facility CNA- Certified Nurse Aide DMH - Department of Mental Health Peg tube - Percutaneous Endoscopic Gastrostomy NP - Nurse Practitioner L - Liter	L 000	Transitions Healthcare Capitol City is filing this Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not an admission of any of the deficiencies identified. The Plan of Correction is to serve as the facility's credible allegation of compliance with all the requirements of the Medicare and Medicaid programs.	

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L 000	Continued From page 1 Dl - deciliter CMS - Centers for Medicare and Medicaid Services Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - millliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury POS - physician ' s order sheet Prn - As needed Pt- Patient TAR - Treatment Administration Record PASRR - Preadmission screen and Resident Review ARD - assessment reference date IDT - Interdisciplinary team ID - Intellectual disability QIS - Quality Indicator Survey D.C. - District of Columbia D/C- Discontinue Rp, R/P- Responsible Party PO- By Mouth	L 000		
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:	L 001	3200.1 Nursing Facilities A. 1 & 2 1. The care plans of Resident #64 and Resident #103 were revised to reflect the management of functional status changes soon after discovery. 2. A review of all care plans was done to ensure that each reflected the management of functional status changes when appropriate. No other care plans required revision. 3. The licensed nursing staff was inserviced regarding the updating of care plans to reflect the management of functional status changes. The Nursing Quality Improvement Team will audit for the updating of care plans to reflect the management of functional status changes on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/30/15 11/30/15 2/3/16

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L 051	Continued From page 2	L 051		
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 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 two (2) of 30 Stage 2 sampled residents, it was determined that a charge nurse failed to review and revise care plans to manage functional status changes sustained by two (2) residents as coded on their respective Minimum Data Set [MDS] assessments. Resident's #64 and #103. The findings include: 1. A charge nurse failed to review and revise Resident #64 ' s Activities of Daily Living [ADL]	L 051		

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L 051	Continued From page 3 care plan to accommodate declines in functional status. A review of the July 2015, quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of July 7, 2015 as compared to the October 2015 quarterly MDS with an ARD date of October 7, 2015 revealed that Resident #64 ' s functional status declined in the areas of locomotion on and off the unit, and eating as follows: The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for locomotion while on the unit [G0110E]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 3/2 " extensive assistance of one (1) person required for locomotion while on the unit. The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for locomotion while off the unit [G0110F]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 3/2 " extensive assistance of one (1) person required for locomotion while off the unit. The July 7, 2015 quarterly MDS assessment was coded as " 1/2 " supervision of one (1) person physical assist required for eating [G0110H]. In comparison, the October 7, 2015 annual MDS assessment was coded as " 2/2 " limited assistance of one (1) person required for eating. A review of Resident #64 ' s care plan that was updated October 29, 2015 and lacked evidence of a revision related to the resident ' s decline in functional status, locomotion and eating. The current care plan read as follows: " Focus:	L 051		

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L 051	Continued From page 4 Resident is dependent for ADL [activities of daily living] care; Goal: keep clean and odor free; Interventions: resident to receive shower per preference. " A face-to-face interview was conducted with Employee #15 on November 20, 2015 at approximately 10:50 AM. A query was made regarding what type of ADL assistance he/she provides to the resident. He/she stated the resident does not need much assistance from me; I set up [his/her] tray. I may open the utensils; He/she can feed [him/herself]. When transferring from the wheelchair to the commode [he/she] may need assistance to stand and pivot. A face-to-face interview was conducted on November 20, 2015 at approximately 11:00 AM with Employee #8. After review of the care plan he/she acknowledged that the care plan lacked specific care approaches and interventions to address the decline with locomotion on and off the unit and eating. The record was reviewed on November 20, 2015. 2. A charge nurse failed to review and revise Resident #103 ' s Activities of Daily Living [ADL] care plan to accommodate a decline and improvement in functional status. A review of the quarterly MDS dated July 9, 2015 revealed: Under Section G, Functional Status, the resident required: Supervision with setup help only in locomotion " on " the unit and no setup or physical help from staff with locomotion " off " unit. The resident required extensive assistance and one person physical assist with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.	L 051		

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L 051	Continued From page 5 According to the quarterly MDS dated October 8, 2015 Under Section G , Functional Status, the resident required: Limited assistance in locomotion " on " the unit with one person physical assistance, and Supervision with one person physical assistance with locomotion " off " the unit. The resident required extensive assistance and one person physical assist with bed mobility, transfers, dressing, and personal hygiene. The resident required limited assistance with one person physical assistance in eating and toilet use. In comparing the quarterly MDS form July 9, 2015 to October 8, 2015, the resident had a noted decline in locomotion " on " the unit. The resident previously required supervision and set up help only. The resident now requires limited assistance with one person physical assist in locomotion " on " the unit. The resident went from requiring supervision and no set up help, to supervision with one person physical assist in locomotion "off " the unit. A review of the Care Plan, " Resident requires assistance for ADL (activities of daily living) Care, in ...grooming ... last revised on July 23, 2015, revealed, Interventions: "...staff to assist resident with [his/her] ADL care every shift." There was no evidence that a charge nurse revised the ADL care plan with new goals and approaches to address the noted decline with locomotion "on" and " off " the unit. A face-to-face interview was conducted with Employee #9 on November 23, 2015 at approximately 4:00 PM. They acknowledged the findings. The record was reviewed on November	L 051		

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L 051	Continued From page 6 23, 2015. B. Based on record review and staff interview for two (2) of 32 Stage 2 sampled resident's, it was determined that a charge nurse failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by a charge nurse ' s failure to administer insulin for one (1) resident as directed by the medical team and assess one (1) resident ' s heart rate in accordance with physician ' s orders prior to the administration of an antihypertensive/anti-anginal medication. Residents' #53 and #54 The findings include: 1. A charge nurse failed to administer Novolog insulin to Resident #53 in accordance with physician ' s orders. A review of the clinical record for Resident #53 revealed physician ' s orders dated October 24, 2015 that directed Lantus insulin [long acting insulin - duration of action 18-26 hours] 10 units at 6AM for diabetes mellitus. An interim telephone order obtained from the nurse practitioner on November 20, 2015 at 7:57 AM read: " Novolog [a rapid acting insulin used to lower elevated blood glucose levels] insulin administer subcutaneously via sliding scale, 4 times daily. Novolog (150-200=2 Units); (201-254=3 units); Novolog (255-300=6 units); Novolog (301-350=8 units); Novolog (351-400=10 units). Call MD for blood sugar greater than 400	L 051	B. 1. Resident #53 has been receiving insulin as prescribed by the attending physician immediately upon discovery. There have been no negative outcomes noted. 2. Physician orders for all residents with insulin orders were double checked to ensure the physician orders were being implemented as prescribed. There were no other issues. 3. The licensed nursing staff was inserviced regarding timely and appropriate administration of insulin per physician orders. The Nursing Quality Improvement Team will audit for the proper insulin administration per physician orders on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/30/15 12/31/15 2/3/16

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L 051	Continued From page 7	L 051		

or less than 60. "

The medication administration record [MAR] revealed that Lantus insulin 10 units was administered to Resident #53 at 6:00 AM on November 20, 2015.

A review of the nursing notes revealed the following:

November 20, 2015 at 06:58 (6:58 AM) revealed, "Fingerstick [glucose] 340 mg/dl [normal glucose range 80 - 130 mg/dl as per American Diabetes Association] 10 units insulin given" .

November 20, 2015 at 07:57 (7:57 AM) revealed, " New order received from NP (nurse practitioner) [Name]: Novolog sliding scale, 4 times daily. Novolog (150-200=2 Units); (201-254=3 units); Novolog (255-300=6 units); Novolog (301-350=8 units); Novolog (351-400=10 units). Call MD [medical doctor] for blood sugar greater than 400 or less than 60. "

A telephone interview was conducted with Employee #13 on November 20, 2015 at 10:55 AM. He/she stated, " ... I called and notified the NP (nurse practitioner) that [Resident #53 ' s] glucose was elevated. I received a new order for sliding scale. The Fingerstick was 340 mg/dl. I gave 10 units of Lantus. I didn ' t ' give the Novolog per the sliding scale. "

Through record review and interviews it was determined that a charge nurse failed to administer Novolog insulin coverage in accordance with the physician's order. There

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L 051	Continued From page 8 was no evidence that the resident sustained any untoward effect. The record was reviewed on November 20, 2015. 2. A charge nurse failed to consistently assess the Resident #54's heart rate prior to the administration of an antihypertensive/anti-anginal medication [Metoprolol] for Resident #54. A medication observation was conducted on November 16, 2015 at approximately 10:38 AM with Employee #16, the following occurred: Employee #16 prepared the resident's medication which included Metoprolol ER 25mg po [by mouth]. Prior to administering the medication Employee #16 assessed the blood pressure, however Employee #16 failed to assess and monitor the resident ' s Heart Rate. A review of the physician's orders directed, Metoprolol ER [Extended Release] tab 25mg Give 0.5 tablet orally one [1] time a day related to unspecified essential hypertension. Hold for systolic blood pressure less than 120 or diastolic blood pressure less than 70 pr HR less than 60 original order date June 14, 2014. A review of the medication administration records for July, August, September, October and November 2015 lacked evidenced of any monitoring of the resident's heart rate prior to administering Metoprolol ER. A face-to-face interview was conducted with Employee #7 on November 18, 2015 at approximately 12:30 PM. After review of the above, he/she acknowledged the findings.	L 051	B. 2. 1. The heart rate of Resident #54 was Assessed and appropriately documented soon after discovery. 2. All residents receiving anti-hypertensive/ antianginal medication with orders to assess their heart rates prior to administration and document the results were reviewed to ensure all documentation was present. There were no other adjustments. 3. The licensed nursing staff was inserviced regarding the need to precisely follow physician orders to include heart rate parameters along with blood pressure parameters with the administration of antihypertensive/antianginal medications. The Nursing Quality Improvement Team will audit for the presence of documentation for the recording of the heart rate and blood pressure for such medications on a monthly basis. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/30/15 12/31/15 2/3/16

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L 052	Continued From page 9	L 052	3211.1 Nursing Facilities	
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: (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	L 052	A. 1. This resident does not routinely eat in this area for dining. Staff called for the tray to be delivered and the resident was subsequently served. 11/18/15 2. A dining audit was conducted and all residents sitting at the same table were served together. 11/24/15 3. The licensed nursing staff was inserviced regarding the need to serve the residents at one table at the same time to enhance dignity. The Nursing Quality Improvement Team will audit for sufficient nursing time afforded to ensure the serving of all residents at one table being served at the same time. 12/31/15 The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2/3/16	

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L 052	Continued From page 10 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 an observation and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to enhance one (1) resident's dignity during dining, as he/she sat idle while other residents dined. Resident #160 The findings include: Facility staff failed to provide sufficient nursing time to enhance Resident #160's dignity during dining, as he/she sat idle, waiting to be served a meal while other residents dined. On November 16, 2015 at approximately 12:38 PM, a dining observation was conducted on unit, 2 north. Four (4) of five (5) residents were observed seated and eating their meals. Resident #160 [one (1) of the five (5) residents] was seated in his/her wheel chair at the table waiting for his/her meal to be served. Resident #160 called out, "Where is my tray. I don ' t thinks they are going to bring me nothing." Employee #22 who was present and feeding another resident stated, " Your food is on the way. They are going to bring you something. " At approximately 12:50 PM, Resident #160 ' s received his/her tray. At the time of the observation, a face-to-face	L 052		

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L 052	Continued From page 11 interview was conducted with Employee #7, who acknowledged the aforementioned findings. Facility staff failed to provide sufficient nursing time to enhance Resident #160's dignity during dining. B. Based on observations made on November 17, 2015 at approximately 3:30 PM, it was determined that facility staff failed to provide sufficient nursing time to accommodate the needs for two (2) of 32 Stage 2 sampled residents as evidenced by call bells that were not within reach while the residents were in bed, as the call bells were observed on the floor and/or out of reach. Additionally, facility staff failed to ensure that pull cords to call bells located in resident bathrooms were fully accessible in three (3) of 59 resident bathrooms. Residents' #10, #214, #242, #270, and #289 The findings include: 1. Facility staff failed to provide sufficient nursing time to ensure the Resident #10's call bell was accessible while he/she lied in bed. The call bell in room #306 was observed on the floor, away from one resident who was in bed (B) and was not within his/her reach. This observation was made during a one-to-one visit with the resident. 2. Facility staff failed to provide sufficient nursing	L 052	B, 1,2 & 3 1. Upon discovery, the call bells were placed within the reach of the resident either by repositioning it on the bed or changing to a longer cord for the call bells in the bathroom. 2. All call bells throughout the facility were Inspected to ensure their proper position on the Bed and their proper length in the bathrooms. 3. Nursing staff was inserviced regarding having sufficient nursing time to accommodate the needs of the resident specific to call bell placement on the bed and call bell length in the bathroom. The Nursing Quality Improvement Team will audit for the sufficient nursing time allowed for the accommodation of the resident needs specific to call bells at the bed and in the bathroom. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/20/15 12/31/15 2/3/16

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L 052	Continued From page 12 time to ensure the Resident #214 ' s call bell was accessible while he/she lay in bed. On November 11, 2015 at 9:23 AM, Resident #214 was observed lying in bed. The resident stated, " I would like to use my call light. " Upon looking for the call the cord was observed extending from the wall and between the mattress and the bed frame, and out of the resident ' s reach. This observation was made in the presence on Employee # 7, who acknowledged the finding. 3.Call bells located in the bathrooms of three (3) of 59 resident rooms that were observed were determined to have pull cords that were too short to be accessible by a resident while in the bathroom in the event of an emergency. The resident rooms were assigned to Residents #242, Resident 289 and Resident 270.	L 052		
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 per resident day hours], it was determined that the Nursing Facility failed to meet the four and one tenth (4.1) hours	L 056	3211.5 Nursing Facilities 1. The nursing schedule was reviewed with education for on-going compliance given to the staffing coordinator. 2. Review of future staffing schedules was done to ensure that each day's schedule was staffed to the required 4.1/.6 PPD. 3. The facility increased its efforts to recruit RNs and CNAs through the use of Career Builders, Indeed, The Washington Post, Ward 8 Job posting Board, University of the District of Columbia, Community College Division of Workforce Development and Lifelong Learning program, VMT School, and Transitions Healthcare website Job Posting Link. The Human Resources Quality Improvement Team will collect data on new hires, terminations, resignations, use of overtime all in an effort to ensure proper staffing. The results of their study will be discussed with the Director of Human Resources. 4. The Director of Human Resources will present the findings of this data collection along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/23/15 2/3/16 2/2/16 2/3/16

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L 056	Continued From page 13 of direct nursing care per resident per day on two (2) of seven (7) days reviewed and the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on two (2) of the seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on November 23, 2015 at approximately 3:00 PM. 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 tenth (0.6) hour 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. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/Advanced Practice Registered Nurse for two (2) of seven (7) days reviewed as outlined below. November 15, 2015 it was determined that the facility provided RN coverage at a rate of 0.5 hours. November 21, 2015 it was determined that the facility provided RN coverage at a rate of 0.4 hours.	L 056		

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L 056	Continued From page 14 The facility failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day, for two (2) of seven (7) days reviewed as outlined below: November 15, 2015 it was determined that the facility provided direct nursing coverage at a rate of 3.1 hours. November 21, 2015 it was determined that the facility provided direct nursing coverage at a rate of 3.5 hours. A face-to-face interview/review was conducted with Employee # 23 on November 23, 2015 at approximately 3:00 PM. He/she acknowledged the findings.	L 056		
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and	L 088		

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L 088	Continued From page 15 (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews for three (3) of 32 Stage 2 sampled residents, it was determined that facility staff failed to follow accepted standards of infection control practices as to prevent cross contamination and reduce the transmission of infection and disease as evidenced by: failure to ensure that one (1) resident's pressure ulcers were consistently covered with dressings in accordance with physician's orders; failure to maintain appropriate hand hygiene and infection control practices during a tracheal suctioning treatment for one (1) resident; and failure to maintain proper hand hygiene practices during the administration of medication for one (1) resident. Residents' #10, #53, and, #147 The findings include: According to the Centers for Disease Control and Prevention [CDC] Guidelines for Hand Hygiene in Health-Care Settings; Hand-hygiene technique includes: " How should you wash your hands? Wet your hands with clean, running (warm or cold), turn off the tap, and apply soap, lather your hands by rubbing them together with the soap. Be sure to lather the back of your hands, between your fingers, and under your nails, scrub your hands for at least 20 seconds. Need a timer? Hum the " Happy Birthday " song from beginning to end twice; rinse your hands well under clean running water, dry your hands using a clean towel or air	L 088		

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L 088	Continued From page 16 dry them. <http://www.cdc.gov/handwashing/when-how-handwashing.html>. 1.Facility staff failed to follow accepted standards of infection control practices as evidenced by the observation of Resident #10 lying in bed without dressing covering multiple pressure ulcers observed along the resident ' s back, hips, buttock, lower leg and heel/foot. Additionally, facility staff failed to practice proper hand hygiene and placed a gloved hand directly over and exposed Stage 3 pressure ulcer while positioning Resident #10 in preparation for a wound treatment. A wound treatment observation was conducted on November 19, 2015 at 8:00 AM Following Resident 10 ' s consent to observe the procedure. Employees' # 4, 10, and 19 were present. Upon entering the room, Resident # 10 was observed lying in bed on his/her back. Employee #19 entered room closed door and donned a pair of plastic gloves without first washing his/her hands. Employee #19 then assisted in repositioning Resident #10 from his/her back onto the left side his/her left side. Once the resident was positioned on his/her side, open ulcers were observed at multiple sites along the dorsal surface of his/her back, hips, buttocks, lower leg and heel/foot. The open ulcers were observed uncovered and in contact with bed linens when the resident was lying supine. At this time the Employee #19 with the same gloved hands, placed and positioned a clear trash bag in the trash receptacle located in the resident ' s room and with his/her feet, slid the trash receptacle near the nurse who would perform the dressing change. With the same gloved hands, Employee	L 088	3217.3 Nursing Facilities 1. 1. The dressing change protocols including proper infection control techniques, resident handling, hand washing following the physician orders was afforded Resident #10. 2. Wound rounds were done to observe dressing changes to ensure the facility's dressing change and infection control protocols and practices were afforded all other residents and to ensure the receipt of necessary treatment services. 3. The Nursing Staff was inserviced Regarding the facility's wound care protocol, infection control techniques, hand washing and following physician orders being afforded to ensure the receipt of necessary treatment services to promote healing and prevent infection. The Nursing Quality Improvement Team will audit for the wound Rounds observations on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/16/15 11/30/15 11/30/15 2/3/16

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L 088	Continued From page 17	L 088		

#19 returned to the resident and positioned his/her [gloved] hands along the residents ' shoulders/back as if to hold the resident in place for wound treatment. Upon doing so Employee #19 placed his/her hands directly over the resident's Stage 3 pressure ulcer of the right upper back.
At this time the State Agency Representative intervened with the dressing change as the aforementioned observations did not reflect infection control standards of practice.

The " Weekly Wound Report " dated November 13, 2015 revealed the following alterations in skin integrity:

Unstageable pressure ulcer of the Left dorsal foot measuring 3cm x 2cm x 0cm
Unstageable pressure ulcer of the Left hip measuring 1.5 cm x 1.5 cm x 0 cm
Stage III pressure ulcer of the Right upper back measuring 11cm x 6cmx 0.4cm
Stage III pressure ulcer of the Sacrum measuring 11cm x16cm x 1.5cm
Stage III pressure ulcer of the Right Ischium measuring 7cm x 3cm x0.9cm
Stage II pressure ulcer of the Left lateral heel measuring 2cm x 4cm x0cm
Stage III pressure ulcer of the Right hip measuring 8cm x 8cm x 0.5 cm
Stage II pressure ulcer of the Right lateral lower leg measuring 1cm x1cm x1 cm
Stage II pressure ulcer of the Left lower back measuring 6cm x7cm x0.5cm
Stage II pressure ulcer of the Right elbow measuring 3cm x3cm x 0cm

A review of the clinical record revealed:
The quarterly Minimum Data Set (MDS) dated

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L 088	Continued From page 18 August 24, 2015 revealed the following: Section M0300 (Current Number of unhealed pressure ulcers at each stage) the was coded as having a two (2) Stage 2, three (3) Stage 3, and five (5) Unstageable pressure ulcers indicating the resident had 10 pressure ulcers in total. Under Section C (Cognitive Patterns) the resident had a BIMS (Brief Interview for Mental Status) score of 11 [a score of 8-12 reflects-moderate impairment] indicating that the resident ' s cognition is moderately impaired. Under Section G (Functional Status) the resident required total dependence on staff with bed mobility, and was totally dependent on staff for dressing, toilet use and personal hygiene. Under Section H Bladder and Bowel the resident was coded as always incontinent Interviews: A face-to-face interview was conducted with Employees ' #10 (Unit Manager) on December 19, 2015 at approximately 11:30 AM. Employee #10 was asked why was Resident#10 was lying in a supine position with his pressure ulcers in direct contact with bed linens He/she stated, " The unlicensed staff removed them because they were soiled." A face-to-face interview was conducted with Employee #19 (unlicensed staff) on December 19 2015 at approximately 11:45 AM when queried he/she stated, " I removed Resident#10 ' dressings and bunny boots because they were soiled and I knew they were going to do his/her wound care around 8:00 AM. The Licensed nurse knew I had removed the dressing and that the wounds were not covered. " A face-to-face interview was conducted with Employees ' #20 on December 19 2015 at 3:00 PM when queried regarding the unlicensed staff members training and role during wound care he/	L 088		

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L 088	Continued From page 19 she stated " unlicensed staff are trained to observe resident ' s skin for changes and to report them to the licensed nurse immediately, and at no time are unlicensed staff required or allowed to remove or replace dressings on wounds. " After review of the aforementioned all employees acknowledged the findings. There was no evidence that facility staff followed accepted standards of practice for infection control when managing wounds for Resident #10, as the resident ' s pressure ulcers were exposed because the dressings were removed and the open areas were observed directly in contact with bed linens. Additionally, staff failed to practice proper hand hygiene, as Employee #19 failed to sanitize his/her hands prior to donning gloves and applied his/her hand directly over the resident ' s exposed stage 3 pressure ulcer during positioning. The clinical record was reviewed on November 19, 2015. 2. Facility staff failed to follow accepted standards of infection control practices related to hand hygiene to prevent potential cross contamination and spread of infection while conducting tracheal suctioning for Resident #53. Facility Policy: "Respiratory Care/Nursing Suctioning A Tracheostomy Tube " policy last updated 10/09/09 stipulated, " Procedure- Equipment Needed: 1. Normal saline or sterile H20 ...2. Suction kit (catheter, N/S [normal saline], 2 sterile gloves), sterile field...5. Portable suction device with container and connecting tubing... " "General Information, Procedure Steps and	L 088	2. 1. The dressing change protocols including proper infection control techniques while suctioning a resident , hand washing and following the physician orders was afforded Resident #53. 2. Trach care rounds were done to observe trach care changes to ensure the facility's infection control protocols and practices were afforded all other residents and to ensure the receipt of necessary treatment services. 3. The Nursing Staff was inserviced regarding the facility's trach care protocol, infection control techniques, hand washing and following physician orders being afforded to ensure the receipt of necessary treatment services to promote healing and prevent infection. The Nursing Quality Improvement Team will audit for the trach care rounds observations on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/16/15 11/30/15 11/30/15 2/3/16

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L 088	Continued From page 20 Rationale ...3. Prepare needed equipment: a. open suction kit. Maintain sterile technique ...8. Place the sterile glove on the hand that will advance the catheter down the tracheostomy tube. Maintain sterile technique ...19. Discard disposable equipment ..." On November 19, 2015 at 11:00 AM an observation was conducted of Employee #18 performing tracheal suctioning on Resident #53. Employee #18 first washed his/her hands for approximately 15 seconds. He/she turned off the faucet with bare hands and then dried his/her hands with a paper towel and applied gloves...Employee #18 opened three (3) bottles of sterile saline, turned on the suction machine, manipulated the suction tubing and water bottle connection. With the same gloved hands, Employee #18 then opened and placed a sterile package of gloves on the resident ' s bed. With gloved hands he/she picked up one of the sterile gloves. At this time, Employee #6 (the Unit Manager) who was present stated words to the employee that the writer was unable to hear. Employee #18 then returned the sterile glove to the package and removed the gloves from his/her hands. Employee #18 went to the bathroom located in the resident ' s room to wash his/her hands, leaving the sterile gloves exposed. Employee # 18 wash his/her hands for approximately five (5) seconds and turned the faucet off with his/her bare hand, and dried his/her hands with a paper towel. Employee #18 returned to the resident ' s bed and applied the previously exposed gloves...After suctioning the resident, Employee #18 washed his/her hands in the bathroom located in the resident ' s room hands for approximately 20 seconds. He/she returned to the resident ' s room, disposed of supplies used during suctioning. Without gloved	L 088		

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L 088	Continued From page 21 hands, Employee #18 removed the suction canister and tubing from the suction machine, took the items to the resident ' s bathroom, and set them on the ledge to the mirror. The employee then proceeded to empty the contents of the canister with the tubing still attached into the commode. Employee #18 then returned the used suction canister with tubing to the suction machine and set it up for reuse. Facility staff failed to use accepted standards of infection control practice for hand washing and use of sterile gloves during a tracheal suctioning procedure. A face-to-face interview was conducted with Employees #6 and #18 immediately following the observation. The both acknowledged to the findings. 3.Facility staff failed to maintain proper hand hygiene practices during the administration of medication for Resident #147. A medication observation was conducted on November 16, 2015 at approximately 10:38 AM with Employee #16, and Employee #7 the following occurred: Employee #16, after preparing the residents medication entered the residents room, wet hands with running water, applied soap washed the front and back of his/her hands, between his/her fingers, and under his/her nails. However, Employee #16, scrubbed his/her hands for and sanitized hands less than 20 seconds. Employee #7 entered the room to assist Employee #16, rinsed hands, applied soap and washed hands for less than 20 seconds. A face-to-face interview was conducted on November 18, 2015 at approximately 12:30 PM	L 088	3. 1. The medication administration protocols including proper infection control techniques and hand washing was afforded Resident #147. 2. Medication administration rounds were done to ensure the facility's infection control protocols and practices were afforded all other residents and to ensure the receipt of proper hand washing. 3. The Nursing Staff was inserviced regarding the facility's med administration protocol, infection control techniques, and hand washing being afforded to ensure the receipt of necessary treatment services to promote healing and prevent infection. The Nursing Quality Improvement Team will audit for med administration and handwashing rounds observations on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/16/15 11/30/15 11/30/15 2/3/16

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L 088	Continued From page 22 and 2:00 PM with Employees #16 and #7. After review of the above both Employees acknowledged the findings. The observation was made on November 16, 2015.	L 088		
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 November 16, 2015 at approximately 9:30 AM, and on November 19, 2015 at approximately 9:45 AM, it was determined that the facility failed to prepare and serve foods under sanitary conditions as evidenced by one (1) of two (2) soiled grease fryers, a staff member ' s failure to test the three-compartment sink sanitizing solution as recommended by the manufacturer, a three-compartment sink sanitizing solution that twice tested at less than the recommended 150 parts per million (PPM), a staff member ' s failure to sanitize the thermometer in between food temperature verifications and 18 of 36 Glucerna therapeutic nutrition eight-ounce cans that were expired. The findings include: 1. One (1) of two (2) grease fryers was soiled with leftover fried food particles. 2. Staff on two (2) occasions failed to test the	L 099	3219.1 1. 1. The fryer was cleaned immediately upon discovery. 2. Both fryers were inspected for cleanliness and both were determined to be clean. 3. Cook/Supervisors were inserviced on the proper cleaning of grease fryers. The Dietary Quality Improvement Team will inspect the fryers monthly to ensure their cleanliness. The team will report their findings to the Direc tor of Dietary. 4. The Director of Dietary will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2. & 3. 1. The 3 compartment sink was drained and refilled with sanitizing solution to ensure the proper procedure was used to test the sanitizing solution per manufacturer's specifications and to ensure the proper PPM solution strength. 2. This is the only 3 compartment sink used for pot washing. 3. Cook/Supervisors/Pot Washers were inserviced on the proper measurement and strength of the sanitizing solution. Dietary Quality Improvement Team will test the sink solution monthly to ensure their proper PPM. The team will report their findings to the Direc tor of Dietary. 4. The Director of Dietary will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/16/15 11/16/15 12/30/15 2/3/16 11/16/15 11/16/15 12/30/15 2/3/16

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L 099	Continued From page 23 three-compartment sink sanitizing solution as recommended by the manufacturer. Staff, on the first occasion, left the test strip in the sanitizing solution for about 15 seconds, five (5) seconds more that the recommended ten seconds exposure time. On the second occasion, staff counted to ten in about six (6) seconds before removing the test strip from the sanitizing solution. 3. The three-compartment sink sanitizing solution twice tested at less than the manufacturer's recommended minimum of 150 parts per million (PPM) on November 16, 2015 at approximately 9:30 AM. A new pot sink dispenser for the three-compartment sink was installed on November 16, 2015 at approximately 3:30 PM and afterwards, the sanitizing solution tested at 200 PPM. 4. Staff failed to wash, rinse, sanitize and air dry the thermometer used to measure food temperatures on the third floor dining room on November 16, 2015 at approximately 12:30 PM. 5. 18 of 36 Glucerna eight-ounce vanilla flavored therapeutic nutrition located in the Storage room on 2 North were expired as follows: Six (6) were expired as of August 1, 2015 One (1) was expired as of October 1, 2015 11 were expired as of November 1, 2015.	L 099	4. 1. The employee involved was immediately Instructed on the proper method of thermometer handling and sanitizing. 2. All dining room servers and cooks/supervisors were observed during the temperature taking process to ensure proper methods were being used for handling and sanitizing. 3. Cook/Supervisors/Servers were inserviced on the proper handling and sanitizing thermometers. Dietary Quality Improvement Team will test the sink solution monthly to ensure their proper PPM. The team will report their findings to the Direc tor of Dietary. 4. The Director of Dietary will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 5. 1. All expired cans of Glucerna were removed Immediately upon discovery. 2. All cans of Glucerna found on the unit's satellite supply areas were inspected and revealed no other further issues. 3. Licensed staff were inserviced regarding checking for expiration dates on enteral formula. The Nursing Quality Improvement Team will audit for compliance on a monthly basis and forward their audit results to the Director of Nursing. 4. The Director of Nursing will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/18/15 12/30/15 2/3/16 11/18/15 11/18/15 11/30/15 2/3/16

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L 099	Continued From page 24 Observations one (1) thru five (5) were made in the presence of Employee #11 and the last observation was made in the presence of Employee #12. They both acknowledged the findings	L 099		
L 150	3227.1 Nursing Facilities Medication shall be stored in accordance with this section. This Statute is not met as evidenced by: Based on observation and staff interview during a medication storage in (1) of 1 one (1) treatment cart observation on November 16, 2015, it was determined that facility staff failed to ensure that four (4) tubes of ointments and creams were properly stored and one (1) of one (1) insulin injection pen was stored beyond the recommended time frame. The findings include: " Victoza pen Manufacture Recommended Storage: Prior to first use, Victoza® should be stored in a refrigerator between 36°F to 46°F (2°C to 8°C) (Table 14). Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze Victoza® and do not use Victoza® if it has been frozen. After initial use of the Victoza® pen, the pen can be stored for 30 days at controlled room temperature (59°F to 86°F; 15°C to 30°C) or in a refrigerator (36°F to 46°F; 2°C to 8°C). Keep the pen cap on when not in use. " During an inspection of the 1 South treatment cart	L 150	3227.1 Nursing Facilities 1. Improperly stored ointments and the Insulin pen which was found out of date were Immediately removed upon discovery. 11/18/15 2. All treatment carts and medication refrigerators were inspected to ensure the proper storage of ointments and no Insulin pens was out of date. No further issues were found. 11/18/15 3. Licensed staff was inserviced regarding checking for expiration dates on Insulin pens and that ointments are properly stored. The Nursing Quality Improvement Team will audit for compliance on a monthly basis and forward their audit results to the Director of Nursing. 12/31/15 4. The Director of Nursing will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2/3/16	

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L 150	Continued From page 25 on November 16, 2015 at approximately 9:00 AM, multiple tubes of ointments and creams were noted without caps replaced after use. The caps were not located in the designated drawers. Treatment Cart Inspection: Four (4) tubes of ointment without caps stored in treatment cart [no cap] Two (2) tubes of Santyl Ointment [no cap] One (1) tube of Fluocinonide cream 0.0 05% ----60 grams [no cap] One (1) tube of Triple Antibiotic ointment [no cap] Triamcinolone Acetonide Ointment 0.025% [no name on label] There was no evidence that the medications ointments and creams were adequately stored to preserve their integrity. Medication Refrigerator Inspection: Victoza pen opened and dated as opened August 17, 2015 no expiration date present. There was no evidence that facility staff ensured that one (1) of one (1) that the Victoza pen, stored for use was properly labeled with the date that the vial pen usage expired. The observation was made in the presence of Employee #6. He/she stated that the manufacturer expiration date was what the staff was using not the 30 day rule as used for other injectable medications. Upon further discussion Employee #6 acknowledged the Victoza pen was expired after 30 days.	L 150		
L 191	3231.2 Nursing Facilities A designated employee of the facility shall be assigned the responsibility for implementing and maintaining the medical records service.	L 191		

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L 191	Continued From page 26 This Statute is not met as evidenced by: Based on staff interviews and record review for two (2) of 32 Stage 2 sampled residents, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized as evidenced by: the physician failed to document an assessment of one (1) resident's blood pressure and failed to transcribe the order for the resident's trach size into the electronic medical record system; and failure to accurately code the electronic medication administration record for one (1) resident who had an elevated blood glucose level. Residents' # 53 and #366 The findings include: 1. The physician failed to document an assessment of Resident #53 ' s blood pressure in the active clinical record. A review of the report of consultation dated October 30, 2015 revealed, " ...Order: Discontinue Diovan and Metoprolol. Diagnosis: Diarrhea side effects of hypertension medications. " A face-to-face interview was conducted with the attending physician for Resident #53 on November 23, 2015 at approximately 4:30 PM. He/she stated I address the issue with the	L 191	3231.2 Nursing Facilities 1. 1. The physician's assessment of the resident's blood pressure has been added to the medical record. 2. Review of the medical records of other residents consultation reports found that all were acknowledged by the physician 3. The physician was given a one-on-one inservice by the Administrator on the need to acknowledge the results from any consultation. Implementation of the recommendations is totally up to the attending physician. The physician acknowledged his understanding. The Nursing Quality Improvement Team will audit for the physician's co-signature on a consultation on a monthly basis and forward the results of their audits to the Director of Nursing. 4. The Director of Nursing will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/27/15 11/27/15 12/31/15 2/3/16

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L 191	Continued From page 27 resident ' s blood pressure. I assessed (him/her). I did not agree with the consultation to take the resident off [his/her] the blood pressure medication. I did not document the assessment in the clinical record. " There was no documented evidence of the physician ' s assessment of the resident's blood pressure in the active clinical record. The record was reviewed on November 23, 2015. 2. Facility staff failed to transcribe the order for the resident's trach size into the electronic medical record system for Resident #53. The May 2015 Physician ' s Order Sheet signed and dated by the physician on May 20, 2015 directed, " Trach tube size Shiley #6 " . A review of electronic medical record system was conducted on November 23, 2015. There was no evidence that the order for the tracheostomy tube size was transcribed into the electronic system. A face-to-face interview was conducted with Employee # 6 on November 20, 2015 at approximately 10:00 AM. He/she acknowledged the findings. The record was reviewed on November 20, 2015. 3. Facility staff failed to accurately code the electronic medication administration record for Resident # 366 who had elevated blood glucose.	L 191	2. 1. The nursing staff immediately transcribed the correct trach size in the resident's electronic medical record. 2. A review of the medical records for all residents with trachs revealed the correct trach size was noted for each. 3. The Nursing Staff was inserviced regarding the proper documentation of trach size The Nursing Quality Improvement Team will audit for the trach sizes on a monthly basis and forward the results of their audits to the Director of Nursing. 4. The Director of Nursing will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 3. 1. The nursing staff immediately entered the correct code into the electronic medical record. 2. A review of other medical records for proper coding. No other issues were found. 3. The Nursing Staff was inserviced regarding the proper coding in the EHR. The Nursing Quality Improvement Team will audit for the coding on a monthly basis and forward the results of their audits to the Director of Nursing. 4. The Director of Nursing will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/18/15 11/18/15 12/31/15 2/3/16 11/18/15 11/18/15 12/31/15 2/3/16

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L 191	Continued From page 28 The November 2015 Medication Administration Record revealed that on November 3 and 20, 2015 at 0600 " 8 " was coded in the allotted spaces for signature and codes. According to the MAR "Chart codes/Follow Up Codes " revealed that " 8=nauseated/vomiting " . A review of the nursing notes revealed: November 3, 2015 revealed, " Fingerstick 309 mg/dl " . November 20, 2015 at 06:58 (6:58 AM) revealed, " Fingerstick 340 mg/dl 10 units insulin given " .	L 191	3242.4 Nursing Facilities 1. The kitchen floor was washed, polished and stains removed wherever possible at the time of the survey. 2. The Director of Facility Services has met with Feature Flooring and a different type of chemical is being recommended to remove the surface dirt and stains from the kitchen floor. 3. The Supervisors will be inserviced on the new chemical and upgraded techniques for the proper care of the kitchen floor. The Dietary Quality Improvement Team Will monitor the floor for cleanliness The results of these audits will be forwarded to the Director of Nutritional Services for review and evaluation. 4. The Director of Nutritional Services will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. on a monthly basis.	11/16/15 2/3/16 2/3/16 2/3/16
L 284	3242.4 Nursing Facilities Floors shall be easily cleaned, and either carpeted or of non-slip surface. This Statute is not met as evidenced by: Based on observations made on November 16, 2015 at approximately 9:30 AM, and on November 19, 2015 at approximately 9:45 AM, it was determined that the facility failed to ensure that the kitchen environment was sanitary as evidenced by a kitchen floor that was stained, discolored and marred. The findings include: During an observation of the kitchen on November 16, 2015 at 9:30 AM, in the presence of Employee #11 the kitchen floor was observed to be stained, discolored and marred throughout.	L 284		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided:	L 306	3245.10 Nursing Facilities 1. Call bells cited at the time of the survey Were immediately repaired upon discovery. 2. All call bells were tested to ensure Proper working order. 3. The Maintenance Staff was inserviced regarding proper techniques of call bell maintenance. The Maintenance Quality Improvement Team will audit for the proper call bell functioning on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Facilities for his review and evaluation. 4. The Director of Facilities will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/19/15 11/19/15 11/30/15 2/3/16

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L 306	Continued From page 29 (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 made on November 16, 2015 at approximately 10:45 AM, it was determined that the facility failed to ensure that call bells in resident's room function as intended as evidenced by non-functioning call bells in four (4) of 59 residents ' rooms surveyed. The findings include: Call bells in resident rooms #202, #231, #306 and #317 failed to initiate an alarm when tested. These observations were made in the presence of Employee #12 who acknowledged the findings.	L 306	3246.5 Nursing Facilities 1. The procedure to protect resident's privacy while giving injectable medications was immediately reinforced with the staff upon discovery. 11/18/15 2. Medication Pass observations were conducted regarding privacy while giving Injectable medications. Privacy was provided In every instance. 11/25/15 3. The Nursing Staff was inserviced regarding privacy while giving injectable medication. The Nursing Quality Improvement Team will audit for privacy while giving medications on a monthly basis to ensure on-going compliance in this area. The results of these audits will be forwarded to the Director of Nursing for review and evaluation. 11/30/15 4. The Director of Nursing will present the findings of these audits along with any action plans for improvement to the Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2/3/16	
L 314	3246.5 Nursing Facilities If the room is not for single occupancy, each bed shall have flameproof ceiling suspended curtains	L 314		

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L 314	Continued From page 30 which extend around each bed in order to provide the resident total visual privacy, in combination with adjacent walls and curtains. This Statute is not met as evidenced by: Based on an observation and staff interview for one (1) of 32 Stage 2 sampled residents, it was determined that facility staff failed to provide one (1) resident ' s total visual privacy by failure to keep the resident's body sufficiently covered while administering medication. Resident #103 The findings include: Facility staff failed to provide Resident #103's total visual privacy by failure to keep the resident's body sufficiently covered while administering medication. On November 17, 2015 at approximately 11:35 AM Employee #17 was observed from the hallway in room 329 with the door open removing Resident # 103 ' s shirt and administering an injection to his/her right arm. During the procedure the resident was visible to other residents, staff who were all present in the hallway at the time of the occurrence. A face-to-face interview was attempted with the employee immediately after the occurrence. He/she acknowledged the finding.	L 314	3246.1 Nursing Facilities 1. The air vents, privacy curtains, marred walls, and damaged geri-chair arm rests cited were addressed and corrected upon discovery. 2. All air vents, privacy curtains, resident room walls and geri-chair arms were evaluated to ensure a sanitary, orderly and comfortable interior. 3. Housekeeping and Maintenance staffs were inserviced on proper cleaning and repair techniques. The Facility Services Quality Improvement team will audit the vents, privacy curtains, walls, and geri-chair arm rests on a monthly basis and reports their findings to the Director of Facilities. 4. The Director of Facilities will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/19/15 11/30/15 12/31/15 2/3/16
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made from November 16, 2015 thru November 20, 2015, it was determined	L 410		

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L 410	Continued From page 31 that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior as evidenced by: dusty air vents in three (3) of 59 residents bathrooms, privacy curtains were inadequately secured in two (2) of 59 residents' rooms, two (2) of 59 resident rooms had marred walls, and one (1) geriatric chair was observed with torn and tattered armrests in one (1) of 59 resident's rooms. The findings include: 1. Air vents in three (3) of 59 resident bathrooms observed were soiled with dust on the inside and outside, bathrooms #317, # 310 and #145. 2. Privacy curtains were hanging loose and unhooked in two (2) of 59 residents rooms #317 and #323. 3. The walls in resident rooms #217 and #306 were marred in several areas. Observations one (1) through three (3) were made in the presence of Employee #12 who acknowledged the findings. On November 17, 2015 at approximately 3:30 PM an observation of a geriatric chair stored in room #306 and used by Resident #10 had armrests torn and tattered. Employee #10 acknowledged the finding.	L 410		
L 426	3257.3 Nursing Facilities	L 426		

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L 426	Continued From page 32 Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made on November 16 through November 19, 2015, it was determined that the facility failed to maintain the environment free of pest and insects as evidenced by a crawling pest observed in one (1) resident ' s room and flying pest seen on the 3 South nursing unit in on e (1) of six (6) nursing units observed during the survey period. The findings include: 1. A crawling pest was observed on the wall adjacent to the closet in resident room #128 on November 17, 2015 at approximately 1:12 PM. 2. Flying pests were observed on the 3 South nursing units on multiple occasions throughout the survey period (November 16 through November 19, 2015).	L 426	3257.3 Nursing Facilities 1. The facility's pest control company was Called and the areas were serviced again. 2. All areas of the facility have been Exterminated on a rotating and continuous schedule. No pests have been seen. 3. the pest control company is in the facility 3-4 times per month, thoroughly inspects and exterminates every area of the facility and reports their findings to the Director of Facilities and the Director of Nutritional Services. 4. The Director of Facilities will evaluate the results of these inspections and report his findings to the Quality Improvement Committee which meets monthly and is chaired by the Administrator.	11/30/15 11/30/15 12/31/15 2/3/16