Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING: _____ B. WING _____	11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

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L 000	Initial Comments A Licensure survey was conducted on October 27 through November 5, 2014. The deficiencies are based on observation, record review, resident and staff interviews for 44 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - emergency medical services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - interdisciplinary team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	L 000	Please begin typing your responses here:	

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L 000	Continued From page 1 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance pt - patient ER - Emergency room MD - Medical doctor HIV - Human Immunodeficiency Virus	L 000		
L 002	3201.1 Nursing Facilities An Administrator shall be present forty (40) hours per week during regular business hours, and shall be responsible for the operation of the facility twenty-four (24) hours per day, seven (7) days a week. This Statute is not met as evidenced by:	L 002		

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L 002	Continued From page 2 Based on observation, record review and staff interview, it was determined that facility staff failed to ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The findings include: During the survey, the following areas of concern were identified: CFR 483.15, F253, Housekeeping and Maintenance Services facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: loose call bell housings, dusty exhaust vents, a faulty exhaust system, loose and torn privacy curtains, privacy curtains with no mesh, a toilet seat cover dispenser that needed to be secured in the bathroom wall, missing window blind slats, a cluttered room, soiled floor mats, a broken stand-on weight scale; and in one (1) resident's room the privacy curtain, the floor were soiled and the over-head light did not illuminate. CFR 483.20, F281, Professional Standards: facility staff failed to meet professional standards of care as evidenced by failure to provide nursing interventions, care and services consistent with the needs of one (1) resident and the inaccurate transcription of medications that resulted in the delivery and administration of medications that were not prescribed for one (1) resident.	L 002	1. A recently hired Administrator now ensures necessary resources are consistently provided to deliver the following: -Routine housekeeping and maintenance -Timely standards of care are delivered -Accurate medication transcription & Administration (including changes in medication orders - Timely assessments, treatments, medication therapy, oxygen therapy -Accurate meal consumption & documentation - Timely documentation -Adequate trach care -Timely respiratory care assessments - Ongoing resident supervision -Timely, comprehensive care plans -Sufficient staffing -Personal laundry care -Compliance with applicable law and regulation -Quality Assurance Program -Upheld resident rights	

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L 002	Continued From page 3 CFR 483.25, F309, Provide Care and Services for highest well being: facility staff failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by failure to: ensure that one (1) resident was consistently assessed and monitored for strict fluid restriction and aspiration precautions; administer medications consistent with one (1) resident ' s prescribed medication regimen and diagnoses; assess oxygen saturation levels as prescribed for one (1) resident and administer modified medication dosage in accordance with physician's orders for one (1) resident 483.25 (i)(l), F325 Nutrition: failed to consistently record percentages of meal consumption, verify significant weight changes and ensure the accuracy of weighing mechanisms [bed scale verse chair scale] for one (1) resident who was assessed with potential significant weight loss in a period of 30 days. CFR 483.25 (k), F328, Treatment/Care for Special Needs: failed ensure the management of tracheostomy [trach] and respiratory care as evidenced by failing to ensure that extra and/or replacement trach cannulas of the correct size were at the bedside or readily accessible in the event of an emergency for two (2) residents and failed to consistently assess the respiratory status of one (1) resident when interventions where implemented to manage episodes of	L 002	2. Each Skilled Nursing Facility Program was evaluated to determine whether or not adequate structures and processes were in place to ensure safe resident care. Various processes or programs were established (walking EVS rounds, availability of trach and energy supplies, etc.) to correct identified deficiencies. The new Administrator hired a DON, Director of Quality and various contract staff (Podiatrist, Dental, Linen, etc.) to supplement services provided. 3. QA Program was re-instituted to oversee all activities and to make sure each deficient practice was corrected. Daily, weekly and monthly monitoring will be done to ensure ongoing compliance. At least 30 charts audits will be performed for 3 months. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: Administrator	1/14/15

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L 002	Continued From page 4 shortness-of-breath. CFR 483.25 (h), F323, Free of Accident Hazards/Supervision/Devices: failure to ensure that residents in the dayroom were supervised and free of accidents as evidenced by two (2) residents were observed in a physical altercation while not being monitored. CFR 483.25(l) F329, Unnecessary Drugs: failed to ensure that one (1) resident was free from unnecessary medications as evidenced by the inaccurate transcription of three (3) medications that resulted in the delivery and administration of unprescribed medicines. CFR 483.30, F353, Sufficient Staff: facility staff failed to ensure that sufficient nursing staff was available provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. CFR 483.65, F441, Infection Control: facility failed to ensure that the residents ' personal laundry was handled with appropriate measures to prevent cross-transmission/spread of infection. CFR 483.75, F492, Comply with Federal State and Local and local laws and regulations: facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a	L 002		

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L 002	Continued From page 5 facility. CFR 483.75, F520, Quality Assurance: facility staff failed to maintain a quality assessment and assurance committee that meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. CFR 483.10, F156 Resident rights: facility staff failed to inform three (3) residents at the time of admission of their rights, all rules and regulations governing resident conduct and responsibilities; their rights and benefits for Medicare and Medicaid services in writing (such as, equal access to waiving rights, written assurance of residents eligibility, costs for services and changes in cost for services), as evidenced by failure to have residents sign the applicable admission forms. There was no evidence that the facility ensure that it was is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	L 002		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical	L 051		

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L 051	Continued From page 6 and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A.Based on observation, record review, resident and staff interview, for one (1) of 44 sampled residents, it was determined that the charge nurse failed to ensure that Resident #85 received reasonable accommodations of food preferences as evidenced by being served foods he/she preferred not to have due to a diagnosis of Gouty Arthritis. The findings include: 1.The charge nurse failed to ensure that Resident #85 received reasonable accommodations of food preferences as	L 051	A. 1. Resident #85 was given another tray without wheat pancakes and his care plan was updated to reflect his preferences and restrictions. The resident was not harmed by the deficient practice. 2. All residents' food preferences were reviewed to ensure compliance with dietary preferences and restrictions. Any issues of noncompliance was corrected. 3. All resident admissions and re-admissions will be reviewed for accurate care planning of dietary preferences and restrictions within 72 hours of admission. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 051	Continued From page 7 evidenced by being served foods he/she preferred not to have due to a diagnosis of Gouty Arthritis. A resident interview was conducted on October 29, 2014 at approximately 9:00 AM with Resident #34. During this time Resident #85 (roommate to Resident #34) interjected and stated, "I have wheat pancakes on my breakfast tray, wheat bothers my Gout. " An observation was made of Resident # 85's breakfast tray which included two (2) brown colored [wheat] pancakes. The menu slip, located on the resident tray dated October 29, 2014 revealed, " NO WHEAT BRD [BREAD] LIKES PANCAKES ... " A review of the resident's History and Physical dated March 7, 2014 revealed the resident was admitted with the following diagnoses which included: [Insulin Dependent Diabetes Mellitus] IDDM, Debility, Gout, [Hypertension] HTN, Atherosclerotic Cardiovascular Disease, Osteoarthritis, and Gouty Arthritis. " A face-to-face interview was conducted on October 29, 2014 at approximately 11:00 AM with Employees #9 and #12. After an observation was made of the resident's menu, and breakfast tray both acknowledged that the resident received wheat pancakes although the menu slip directed " NO WHEAT BRD. "	L 051		

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L 051	Continued From page 8 The charge nurse failed to ensure that Resident #85 received reasonable accommodations of food preferences as evidenced by being served foods he/she preferred not to have due to a diagnosis of Gout. B.Based on record review and staff interview for one (1) of 44 sampled residents, it was determined that the charge nurse failed to develop a care plan with goals and approaches to address the residents diagnosis of Gouty Arthritis and the residents preference not to receive wheat products secondary to a diagnosis of Gouty Arthritis. The findings include: 1. The charge nurse failed to develop a care plan with goals and approaches to address the residents diagnosis of Gouty Arthritis and the residents preference not to receive wheat products secondary to a diagnosis of Gouty Arthritis. A resident interview was conducted on October 29, 2014 at approximately 9:00 AM with Resident #34. During this time Resident #85 (roommate to Resident #34) interjected and stated, "I have wheat pancakes on my breakfast tray, wheat bothers my Gout. " An observation was made of Resident # 85's breakfast tray which included two (2) brown	L 051	B. 1. Care plans for Resident #22 is now complete. Missing components (e.g. goals & approaches related to dietary preferences & gouty arthritis) were added to the care plan. 2. All residents' charts were reviewed for Complete care plans including goals, & approaches to care dietary preferences. Any identified deficiencies were corrected. 3. (a) All residents' admissions and re-admissions will be reviewed for complete care plans within 72 hours of admission. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: Individual.	1/14/15

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L 051	Continued From page 9 colored [wheat] pancakes. The menu slip, located on the resident tray dated October 29, 2014 revealed, " NO WHEAT BRD [BREAD] LIKES PANCAKES ... " A review of the resident's History and Physical dated March 7, 2014 revealed the resident was admitted with the following diagnoses which included: [Insulin Dependent Diabetes Mellitus] IDDM, Debility, Gout, [Hypertension] HTN, Atherosclerotic Cardiovascular Disease, Osteoarthritis, and Gouty Arthritis. " A review of the residents care plans dated September 15, 2014 lacked evidence of a problem with goals and approaches to address the resident ' s diagnosis of Gouty Arthritis and not to be served wheat products. A face-to-face interview was conducted on October 29, 2014 at approximately 11:00 AM with Employees #12. He/she stated there was a time when the resident would eat wheat pancakes, but would change his/her mind periodically. A face-to-face interview was conducted with Employee #9 on October 29, 2014 at approximately 11:00 AM. After reviewing the care plans, he/she acknowledged that the care plans lacked evidence of a problem with goals and approaches to address the residents '	L 051		

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L 051	Continued From page 10 diagnosis of Gouty Arthritis and not be served wheat products. There was no evidence that facility staff developed a care plan with goals and approaches to address the residents diagnosis of Gouty Arthritis and the residents preference not to receive wheat products secondary to a diagnosis of Gouty Arthritis. C.Based on observation, record review and interviews for two (2) of four (4) residents with tracheostomies and one (1) of 44 sampled residents, it was determined that the charge nurse failed ensure the management of tracheostomy [trach] and respiratory care as evidenced by failing to ensure that extra and/or replacement trach cannulas of the correct size were at the bedside or readily accessible in the event of an emergency for two (2) residents and failed to consistently assess the respiratory status of one (1) resident when interventions where implemented to manage episodes of shortness-of-breath. Resident's #76, 98 and 347. The findings include: 1. The charge nurse failed to ensure that an extra cannula of the correct size was stored at the bedside and/or readily accessible for Resident #76 in the event of an emergency. Physician ' s orders for October 2014 directed, " O2 humidifier at 28% trach mask to maintain 02 sat (saturation) >90%. Oxygen continuous	L 051	C. 1. Extra cannulas of the appropriate sizes are now located at each resident's bedside. The respiratory status of each resident was also assessed to determine whether or not interventions were implemented to manage any shortage of breath (SOB) episodes. 2. All residents with tracheostomy tubes were reviewed to ensure an extra cannula was maintained at the bedside and interventions were implemented to manage any shortage of breath (SOB) episodes. Any Identified Deficiency was corrected.	

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L 051	Continued From page 11 5L/min via tracheostomy mask; trach size/type 4 Shiley. " A review of the " Tracheostomy "care plan initiated August 29, 2014 and last updated November 5, 2014 revealed, " Tube out procedures: Keep extra trach tube and obturator at bedside/HOB (head of bed) " On October 30, 2014 at 10:52 AM a tour of Resident #76 ' s room revealed that there was no extra cannula [that can be inserted into the tracheostomy to deliver oxygen] at the bedside. Employee #9 was present at the time of the observation and acknowledged the findings. A tour of the 6th floor nursing unit ' s clean supply room was conducted. There were no extra cannulas available in the event of an emergency. Employee #9 was present at the time of the observation and acknowledged the findings. In addition, there was no evidence that facility staff assessed and monitored the resident ' s room to ensure that emergency supplies were readily available. A face-to-face interview was conducted on October 30, 2014 at approximately 9:30 AM with Employee #9. He/she acknowledged the findings. The record was reviewed on October 30, 2014. 2. The charge nurse failed to ensure that an extra cannula of the correct size was stored at the bedside and/or readily accessible for Resident #98 in the event of an emergency.	L 051	3. All new admissions and readmissions will be reviewed to ensure an extra cannula of the correct sizes is maintained at each resident's bedside. All licensed nurses will be retrained to monitor and ensure that cannula tubes are present at the bedside. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 051	Continued From page 12 The History and Physical examination dated September 1, 2014 revealed Resident #98 ' s diagnoses included: hypertension, gastro esophageal reflux, diabetic gastro paresis, diabetes mellitus, seizure disorder, constipation, anemia and chronic pain. MDS: Annual Assessment July 17, 2014- Resident was coded for respiratory/trach/oxygen under Section O. A review of the resident ' s care plan revealed: Problem: " S/P [status post] Tracheostomy related to impaired breathing mechanics, Respiratory distress. Interventions include: "tube out procedures: Keep extra trach tube and obturator at bedside ... " The physician's order dated September 30, 2014 directed, " O2 (oxygen) humidifier at 28% trach mask to maintain 02 sat (saturation) >90%. Oxygen continuous 5L/min via tracheotomy mask. There was no evidence that an order was written to specify the size trach cannula to be used for this resident. October 30, 2014 at approximately 11:20 AM, a tour of Resident #98 ' s room was conducted. It was noted that there was no extra cannula at the resident ' s bedside or in his/her room. This observation was made in the presence of Employee #24 who acknowledged the findings at the time of the observation. A tour of the 7th floor nursing unit ' s clean supply closet was conducted. There were no extra cannulas available in the event of an emergency. Employee # 25 was present at the time of the observation and acknowledged the	L 051		

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L 051	Continued From page 13 findings. In addition, there was no evidence that the charge nurse assessed the resident ' s room to ensure that emergency tracheostomy supplies were readily available. A face-to-face interview was conducted with Employee #25 on October 30, 2014 at approximately 3:00 PM. After assessing resident trach supplies; he/she acknowledged that there was not an extra cannula at resident's bedside if needed in an emergency. The record was reviewed on October 30, 2014. 3. The charge nurse failed to consistently assess Resident 347 ' s respiratory status when interventions were implemented to manage complaints of shortness-of-breath [sob]. Physician ' s orders dated October 9, 2014 directed, " Iprat/Albut Inh sol 0.5/3 mg [Ipratropin/Albuterol inhalation solution used to treat bronchospasm associated with COPD] 1 vial via nebulizer every 6 hours as needed for shortness of breath ...Continuous Oxygen 2 liters/min for sob (short of breath)/COPD (chronic obstructive pulmonary disease) ... oxygen sats (saturations) q (every) shift. " A review of the October 2014 medication administration records [MAR] revealed Resident #347 received, Iprat/Albut Inh sol 0.5/3 mg 1 vial every 6 hours for SOB on October 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 29, 30, and 31. On each occasion facility staff documented " reason- resident sob and the results were	L 051	1. Resident #347 has been assessed for respiratory distress. Resident was not harmed by this deficient practice. 2. The medical records of all residents with orders for nebulizer treatment were reviewed. Any deficient practice was corrected. 3. All licensed nurses will be retrained on assessment and documentation of respiratory status (oxygen saturation) for residents with shortness of breath pre and post administration of nebulizer treatment. Training will include lung fields, sputum characteristics and use of accessory muscles etc. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 051	Continued From page 14 effective." The clinical record lacked evidence that staff assessed the resident ' s oxygen saturation levels prior to and post the respiratory treatment to determine the effectiveness. Additionally, there was no evidence of consistent assessments related to resident ' s respiratory status [e.g. assessment of lung fields, characteristics of sputum; use of accessory muscles etc.] on occasions when he/she complained of shortness of breath. A face-to-face interview was conducted with Employee #9 on November 3, 2014 at approximately 11:30 AM. He/she acknowledged the findings. The record was reviewed on November 3, 2014. D. Based on observation, record review and interviews for one (1) of 44 sampled residents, it was determined that the charge nurse failed to ensure that the resident received foot care and services to trim nails and provide preventive care, to avoid foot problems for Resident #76 who is diabetic. The findings include: 1.The charge nurse failed to ensure that Resident #76 received services to trim nails and provide preventive care, to avoid foot problems. A face-to face interview was conducted with Resident #76 on October 27, 2014 at approximately 10:00 AM. The resident stated that he/she is a diabetic and that his/her toenails were long and had not been cut.	L 051	1. Resident #76 received foot care by a podiatrist after the deficient practice was identified. 2. All other diabetic residents were assessed for the need for podiatry services. All licensed staff were retrained on assessment of diabetic residents to ensure their needs for foot care are addressed. The facility now offers contracted podiatry services. Diabetic residents will be routinely assessed to determine the need for a podiatry referral and provision for such service will be made. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 051	Continued From page 15 On November 5, 2014 at 9:15 AM Resident #76 ' s feet were observed in the presence of Employee #9. The resident ' s toe nails were elongated and several of the toe nails curled inward toward the skin. A review of the resident's clinical record lacked evidence that he/she had been seen by a podiatrist since he/she was admitted to the facility. A face-to face interview was conducted on November 5, 2014 at approximately 9:30 AM with Employee #9. He/she acknowledged the findings. The record was reviewed on November 5, 2014. There were was no evidence that the charge nurse provided preventive foot care to Resident #76. E.Based on record review, resident and staff interview for three (3) of 44 sampled residents, it was determined that the charge nurse failed to maintain clinical records in accordance with accepted professional standards and practices that are complete, accurately documented, readily assessable; and systematically organized as evidenced by failure to include the quarterly and rehabilitation screens in the resident's medical record for one (1) resident, failed to complete the potential for bowel/bladder retraining form for one (1) resident and maintain the hemodialysis communciation forms on the active clinical record for one (1) resident. Residents' #27, 106, and 133.	L 051	1. Resident #106 is currently provided with a communication sheet which can be readily filed in the residents' chart upon his/her return from dialysis. Resident #133's assessment for bowels and bladder was completed. Resident #27 is currently receiving shower/bath with documentation. Resident #133 currently has a completed assessment on bowel and bladder. 2. A review of all resident charts was done to determine completion of medical records and other documentation. Specifically, an audit of the following was done as indicated: -Bowel and bladder retraining -ADL care -Hemodialysis communication (book). Any identified deficient practices were corrected. All licensed personnel and CNAs will be retrained on required documentation and proper medical record keeping specific to the following: -Bowel and bladder retraining -ADL care -Hemodialysis communication (book). Educational reinforcement will be provided and corrective actions will be taken when necessary. 3. Quality indicators have been developed to address the 3 identified Issues. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 051	Continued From page 16 The findings include: 1. The charge nurse failed to document Resident #27 ' s refusal of showers on the ADL (Activities of Daily Living) flow sheet. During a resident interview conducted on October 27, 2014 at approximately 3:42 PM, when [he/she] was asked, " Do you choose how many times a week you take a bath or shower? He/she responded, " No". I would like to take a shower in the morning and in the evening. I can ' t remember the last time I have taken a shower. I get a bed bath every day. " A face-to-face interview was conducted with Employee #27 at approximately 3:00PM on November 4, 2014 regarding the aforementioned findings. He/she stated the resident get showers. [His/her] shower days are Tuesdays and Fridays. Further stated, sometimes he//she refuses. According to the admission MDS (Minimum Data Sets) dated September 29, 2014, the resident was coded as " somewhat important " to choose between a tub bath, shower, bed bath, or sponge bath under Section F0400 (Preferences for Customary Routine and Activities). A review of the comprehensive clinical record including nursing care plans, ADL sheets and nurses ' notes for October 2014, lacked evidence that the resident refused showers when	L 051		

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L 051	Continued From page 17 offered. There was no evidence that facility staff documented when Resident #27 refused showers. In addition, Employee #27 acknowledged the findings. The clinical record was reviewed on November 4, 2014. 2. The charge nurse failed to ensure that the established communication log for coordination of services between the nursing facility and the dialysis center was consistently recorded and completed for Resident #106. The physician ' s orders signed and dated September 29, 2014 revealed that Resident #106 received dialysis treatments on Monday, Wednesday and Friday. A review of the medical record revealed that the " Hemodialysis Communication " forms date October 10, 15 and 20, 2014 were on the record to communicate the status of the resident ' s health pre and post dialysis, were not consistently maintained on the clinical record. There was no documented evidence that the charge nurse maintained consistent documentation of the resident ' s health status pre and post dialysis treatment. A face-to-face interview was conducted on	L 051		

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L 051	Continued From page 18 November 4, 2014 at approximately 2:58 pm with Employee #9. He/she acknowledged the findings, and stated, " The resident lost the commutation book in September [2014] and an incident report was completed. " The record was reviewed November 4, 2014. 3. The charge nurse failed to maintain an accurate and complete medical record to include the potential for bowel and/or bladder retraining assessment and score for Resident #133. A review of the Bowel and Bladder Assessment form dated August 9, 2014 revealed the section " potential for bowel and/or bladder retraining " was incomplete. The score for the resident ' s potential to be retrained was missing. A face-to-face interview was conducted with Employee #17 on November 4, 2014 at approximately 11:00 AM. [He/she] acknowledged that the potential for bowel and/or bladder re-training section was not complete. There was no evidence that the charge nurse completed the Bowel and Bladder Assessment form. The medical record was reviewed on November 4, 2014. F.Based on an observation for one (1) of 44 sampled residents, it was determined that the charge nurse failed to ensure that delegated staff promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality as evidenced by: Facility staff failed to speak to a resident in a respectful manner. Resident #33.	L 051		

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L 051	Continued From page 19 The findings include: At approximately 11:30AM on October 31, 2014 Employee #16 was observed taking Resident #33's roommate to the room to administer medication. As they entered the room, Resident #33 stated, "Get him/her out of here. Take him/her out of here. [He/she] needs to stay in the Dayroom during the day so I can get some rest. [He/she] keeps me awake all night." As the employee and the resident ' s roommate left the room the employee laughingly said to Resident #33, "If you continue to complain I will leave [him/her] in here with you." A face-to-face interview was conducted with Employee #16 immediately after the incident. When queried why he/she had spoken to the resident in that manner the employee stated, "I did not mean to be disrespectful, but we usually play like that. [He/she] usually does not mind. I am sorry and I will apologize to [him/her]." Employee #16 failed to speak to the resident in a respectful manner.	L 051	1. The DON apologized to both residents for disrespectful communication encountered by the employee and counseled the employee for disrespectful and unprofessional communication. The employee also apologized to the residents. 2. A review of the complaint log was done to determine whether any complaints involving disrespectful and unprofessional communication occurred. No unprofessional episodes of this type were identified. Staff will be retrained on resident abuse and neglect to include residents' dignity and respect and speaking to residents in a professional manner. 3. Random observations between staff and residents' will be monitored to ensure professional communication occurs. Resident complaints involving unprofessional communication will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15
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	L 052		

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L 052	Continued From page 20 supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and	L 052		

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L 052	Continued From page 21 j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A.Based on observations, record review and interviews for four (4) of 44 sampled residents, it was determined that sufficient nursing time was not given to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by failure to: ensure that one (1) resident was consistently assessed and monitored for strict fluid restriction and aspiration precautions; administer medications consistent with one (1) resident ' s prescribed medication regimen and diagnoses; assess oxygen saturation levels as prescribed for one (1) resident and ensure that a modified dosage of medication was administered as prescribed one (1) resident. Residents' #131, 137, 114 and 34. The findings include: 1. Sufficient nursing time was not given to consistently assess and monitor Resident #131 for prescribed fluid restrictions, abdominal girth and aspiration precautions and there was no evidence of assessments related to the status of the resident ' s fluid balance (e.g. Intake & Output). The resident ' s diagnoses included Hepatic Cirrhosis, Ascites and Edema. The following are definitions according to " Lippincott Manual of Nursing Practice " Ninth Edition:	L 052	1. The newly hired Director of Nursing implemented plans to correct deficient staffing. The facility is now staffed to meet resident clinical care needs in accordance with regulatory requirements by using regular staff, overtime and other resources. 2. The DON received management approval to hire additional nursing staff to meet resident needs and regulatory agency requirements. The facility is currently hiring additional nurses. When necessary, overtime will be used and schedule modifications will continue to be made until sufficient staff is hired. All new hires will receive orientation in all aspects of nursing to address resident clinical needs. 3. The Director of Nursing will monitor staffing daily to ensure compliance & care delivery as ordered and required. The daily nursing staffing ratio will be added as a quality indicator and will be will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON. 1/14/15	

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L 052	Continued From page 22 Hepatic Cirrhosis - chronic progressive disease of the liver with diffuse destruction of hepatic cells. Clinical manifestations include fluid retention (edema) and Ascites. Ascites - an accumulation of serious fluid in the peritoneal cavity (distention of the abdomen). Clinical manifestations - excess fluid volume; shortness of breath; aspiration pneumonia; Nursing interventions - recording accurate intake and output of fluid; monitor vitals, measure and record abdominal girth daily and weights daily, fluid/sodium restrictions and diuretics as prescribed. Aspiration- is the inhalation of oropharyngeal (throat) secretions and/or stomach contents into the lungs ...Patients at risk and factors associated with risk ...Gastro Intestional conditions- hiatal hernia, intestinal obstruction, abdominal distension. Clinical manifestations - frothy sputum ... Nursing interventions -elevate head-of-bed, place patient in upright position." Intake and Output [I&O] - a quantitative assessment of the amount of fluids a patient consumes and excretes; cumulative [e.g. periods of 24-hours]. A review of the clinical record for Resident #131 revealed the resident was admitted on July 30, 2014. A history and physical examination signed by the physician on July 31, 2014 revealed the resident's diagnoses included: End Stage Liver Disease, HIV (human immunodeficiency virus) Aids (acquired immune deficiency syndrome), Ascites s/p (status/post) paracentesis, Cirrhosis, Ascites Gastrointestinal (GI) Bleed,	L 052		

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L 052	Continued From page 23 Encephalopathy and Esophageal Candidiasis. A review of systems included: " Lung sounds diminished with wheezing at bases " and " 2+ (two plus) edema. " [Pitting, swelling in tissues beneath the skin - retention of fluid] A review of the Physician's orders read as follows: July 30, 2014 - "Advance Directives- full code; Diet-regular; Weigh weekly x 4 (times four) then monthly weights, aspiration precautions; Fluid restriction to 1200 cc per day... Medications-Aldactone 50 mg daily for hypertension [Diuretic - Used to treat hypertension and edema]; Lasix 40 [mg] 1 tablet po daily [for] edema ... " [Diuretic - used to treat fluid retention]. Interim Order form dated July 31, 2014, " 1) 1200 ml daily fluid restriction; 2) Discontinue Lasix 40 mg po daily; 3) [start] Tosemide 40 mg po daily [Diuretic] 5) Strict I&O..." [Intake and output]. Interim order dated August 3, 2014, "2 gram /low sodium diet, Fluid restriction clarification- 1200 ml daily; Fluid Restriction (720 ml to come from kitchen daily, 240 ml each meal, nursing to provide 480 ml fluid daily)" Interim order dated August 6, 2014, "Measure abdominal girth every day; Please document I&O in MAR [medication administration record], please schedule paracentesis in interventional radiology -Ascites" The clinical record lacked evidence that facility staff consistently assessed and monitored	L 052		

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L 052	Continued From page 24 Resident #131 ' s Ascites and fluid status [e.g. retention] as evidenced by the following nurse's progress notes: The nurse ' s admission assessment dated July 30, 2014 8PM read, " at 7:30 PM [resident] admitted ....lungs clear, abdomen soft, no distended, bowel sound present 1 + 4 quadrant ...skin intact but has old [illegible] wound on bilateral extremities ...condition stable ... " SIC [Note: there was no documentation to reflect the presence of Ascites and/or edema]. July 31, 2014, 11:30 PM - " Resident alert and responsive ...able to make needs known to staff ...appears confused, due nursing care provided. " August 1, 2014, 6:00 AM - " alert stable " August 1, 2014, 11:30 PM - " Alert improving on how s/he is responding verbally ...Due meds accepted fluid encouraged ...will continue to monitor. " August 1, 2014, 6:00 AM - " Alert and Responsive " August 2, 2014, 6:00 AM - " Resident alert & verbal no c/o [complaint of] pain or acute distress noted total care ... " August 2, 2014, 2:00 PM - " Resident stable alert verbally responsive total care provided by nurse...no discomfort s/p day 3 of admission. " August 3, 2014, 4:30 AM - " Resident is alert and verbally responsive ...still adjusting to the unit no acute changes noted ...has periods of	L 052		

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L 052	Continued From page 25 intermittent confusion but able to make needs known. " August 3, 2014, 3:00 PM - " Resident stable. Alert verbally responsive ...continued on [unable to read] isolation... " August 4, 2014 4AM, - " Resident is alert and verbally responsive able to make needs known on contact isolation ... " August 6, 2014, 6AM - " Resident alert and verbal ...stable Temp 97.9 " [temperature] August 6, 2014 11:12 AM, " Resident alert, verbally responsive no acute distress noted. On ABT [antibiotic] ...no adverse reaction noted temp 97.6. " August 6, 2014 at 11:25 AM- "While on routine rounds [Employee #32] Nurse Supervisor called my attention to assist resident...upon entering the room the resident lay flat in bed restless moaning and foaming from the mouth staff repositioned resident and elevated head of bed and suctioned ..vs [vital signs] 125/68 RR [respiration rate] 20 p [pulse rate] 76 O2 sat [oxygen saturation] 94%, T [temperature] 97.8. A quick decision was made to send resident to the ER [emergency room] [Employee #32 notified ER] following altered mental status while transferring the resident to the ER resident was observed to be unresponsive at the elevator...CPR (Cardiopulmonary resuscitation) was started as we proceeded straight to the ER...Emergent resuscitation done at the ER was unsuccessful and resident was pronounced dead at 12:42 AM, NP (nurse practitioner) ...notified R/P [responsible party]."	L 052		

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L 052	Continued From page 26 SIC A review of progress notes documented by the Nurse Practitioner's [NP] read as follows: August 6, 2014 [NP note] revealed: F/U [follow up] Ascites found patient lying in bed...Pt reports that s/he is uncomfortable denies n/v [nausea or vomiting] abdomen seems visibly bigger ...Chest clear ...Ascites worsened ...schedule TAP [paracentesis] by interventional radiology LLE-reinforced with staff need for TEDS [compression stockings] to be worn measure abdomen girth QD [daily] ...reinforce with staff to keep accurate account of I&O. SIC August 7, 2014 " Was notified by nurse [Nurses Name] at 6 AM that pt was found foaming at the mouth last night and was taken to the ER immediately ...Patient was pronounced dead at 12:42 AM by ER MD ...I spoke to ER (medical doctor's name) who confirmed. Further review of the clinical record revealed a form designated to record assessments of Intake &Output, entitled " Daily Fluid Input and Output. " The I&O form for Resident #131 revealed the resident ' s name was recorded at the top, however; the contents of the form remained blank. There was no evidence that staff assessed Resident #131 ' s intake and output status. The clinical record lacked evidence that facility staff consistently assessed and monitored the status of complications associated with Resident #131 ' s diagnosis of Hepatic Cirrhosis such as fluid retention and Ascites. There was no evidence that the physician ' s orders for strict I&O; abdominal girth assessments, fluid	L 052		

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L 052	Continued From page 27 restrictions and aspiration precautions were followed through. There was no evidence that sufficient nursing time was given to implement nursing interventions to monitor the extent of fluid retention for Resident #131 and there were no nursing assessments to depict the resident had edema or Ascites as reflected in the physician ' s assessment. Facility staff failed to consistently follow aspiration precautions. Resident #131 was found unresponsive lying flat in bed [contrary to aspiration precautions], foaming from the mouth seven (7) days post admission. He/she was transferred to the emergency department and expired. Staff Interviews: A face-to-face interview was conducted with Employee #9 on November 4, 2014 at 9:50 AM. Employee #9 was queried as to why the resident's symptoms of edema and intake and output was not strictly monitored. Employee #9 stated, " I am aware of this resident and that [he/she] was not on the unit very long before [he/she] was transferred out. Employee #9 acknowledged that the intake and output was not assessed as per physician's orders. Additionally, he/she acknowledged that the resident should not have been lying flat in [his/her] bed because of the possibility of aspiration and that the head of bed should have been elevated at all times. A face-to-face interview was conducted with Employee # 11 on November 4, 2014 at 12:15 PM. Employee #11 was queried about Resident #131 ' s course of treatment during [his/ her] stay on the unit. Employee #11 stated, "Resident	L 052		

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L 052	Continued From page 28 #131' s prognosis was very poor upon admission to the facility, as [his/her] labs were abnormal, and [he/she] was edematous...When the initial history and physical was done August 6, 2014, Strict Input and Output [I&O] was again ordered because Resident # 131 ' s I&O ' s was not being monitored. The resident was very ill...with multiple co-morbidities. When last examined [he/she] was edematous and stated that [he/she] was uncomfortable. After the examination I ordered measuring of [abdominal] girth and spoke to staff about recording the I&O. Subsequently, the resident was pronounced dead at 2:40 AM on August 7, 2014. " Sufficient nursing time was not given to provide care and services consistent with the care requirements for Resident #131. Physician ' s orders for strict I&O, fluid restrictions, aspiration precautions and abdominal girth assessments were not followed. The resident was found unresponsive and subsequently expired. The medical record was reviewed on November 4, 2014. 2. Sufficient nursing time was not given to ensure that medications were administered as prescribed for Resident #137, as evidenced by inaccurately transcribing medications that resulted in the delivery and administration of unintended medications. A review of the "History and Physical" examination dated October 1, 2014 revealed that Resident #137 ' s diagnoses included: Hepatic encephalopathy, Alcohol liver disease, Diabetes Mellitus, Seizure disorder, Anemia of chronic disease and debility.	L 052		

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L 052	Continued From page 29 Resident #137 was admitted September 30th and discharged October 29, 2014. A review of the Admission Physician's Order sheet dated September 30, 2014 revealed that the resident was prescribed the following medications: Zonegran 1 tablet po daily for seizures Folic Acid 1 mg 1 tablet po daily as a supplement Keppra 500 mg 2 tablets po BID for seizures Protonix 40 mg 1 tablet po daily for GERD (Gastroesophageal reflux disease) Sodium bicarbonate 1300 mg 1 tablet po BID as a supplement KCL (potassium chloride) 20 mEq 1 tablet po daily as a supplement Magnesium Oxide 400 mg 1 tablet po BID as a supplement Glipizide 10 mg 1 tablet po daily for Diabetes Mellitus Aspirin 81 mg 1 tablet po daily for Blood thinner Lantus 100 unit 25 SQ (subcutaneos) units qhs [every day at hour of sleep] for Diabetes Mellitus Benadryl 25 mg 1 capsule po every 8 hours prn for itching A review of the October 2014 Medication Administration Record revealed that nursing staff transcribed the following medications: Zonegran 1 tablet po daily for seizures Folic Acid 1 mg 1 tablet po daily as a supplement Keppra 500 mg 2 tablets po BID for seizures Protonix 40 mg 1 tablet po daily for GERD (Gastroesophageal reflux disease) Sodium bicarbonate 1300 mg 1 tablet po BID as a supplement KCL (potassium chloride) 20 mEq 1 tablet po	L 052		

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L 052	Continued From page 30 daily as a supplement Magnesium Oxide 400 mg 1 tablet po BID as a supplement Glipizide 10 mg 1 tablet po daily for Diabetes Mellitus Aspirin 81 mg 1 tablet po daily for Blood thinner Lantus 100 unit 25 SQ (subcutaneos) units qhs [every day at hour of sleep] for Diabetes Mellitus Benadryl 25 mg 1 capsule po every 8 hours prn for itching Atazanavir Sulfate (used to treat HIV)300 mg po daily Ritonavir (used to treat HIV)100 mg po daily Emtricitabine /Tenofovir (used to treat HIV) 1 tab po daily. A comparison review of the physician admission orders as it relates to the October MAR revealed that three (3) medications, Atazanavir, Ritonavir and Emtricitabine were not prescribed for Resident #137. However, the MAR revealed that these (aforementioned) medications were dispensed by the pharmacy and administered daily to Resident #137 on October 2, 3, 4 and 5, 2014. Further review of the clinical record revealed a [typed] medication order sheet with a heading that indicated the sheet derived from another facility [the facility ' s name was recorded at the top of the form] and the identifying name recorded in the lower right corner of the sheet was not the name of Resident #137 [it was the name of another patient/resident]. The medications listed on the order sheet were Atazanavir, Ritonavir and Emtricitabine. A telephone interview was conducted with Resident # 137 at approximately 3:00PM on	L 052		

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L 052	Continued From page 31 November 4, 2014. The resident was queried whether he/she had encountered any problems with his/her medications while residing in the facility. (The resident was discharged home on October 29, 2014.) He/she responded, " Yes, they gave me some HIV medications and I do not have HIV. " How did you know they were HIV medications? The resident said he/she told the nurse, "This is a lot of pills. I do not recognize some of them." The nurse told him/her, "These are your medications from admission." The resident said he/she knew the medications were HIV medications." In response to the question, " are you still taking those medicines? " Resident #137 replied, " No, The nurse practitioner fixed it. The nurses called him/her because I refused to take two other pills. He/she asked me if I had HIV. I told him/her no and he/she discontinued the HIV medicines. My doctor came to see me and told me I got somebody else ' s HIV medicines. I could have stayed longer but after all of that, I told them to send me home. " A face-to-face interview was also conducted with Employee #21 at approximately 4:45PM on November 3, 2014. The employee acknowledged being responsible for faxing the orders to the pharmacy and failing to clarify the medication orders with the physician. He/she stated that he/she recognized the medications as Antiviral that are used for treating HIV and left a message for the physician that s/he was concerned about three (3) of the resident ' s medications. The employee added, " When the physician called back, it was around 10:00PM. I was busy and did not remember to discuss the medications and/or my concerns about them. I did not administer the medications because they	L 052		

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L 052	Continued From page 32 were given in the morning and I only work in the evening. " A face-to-face interview was conducted with Employee #11 at approximately 3:00PM on November 3, 2014. The employee was queried why he/she discontinued Resident #137 ' s medications. The employee responded, " The resident informed me that he/she was receiving medications he/she had never received before and did not know why he/she was receiving those medications. I investigated and discovered that the medications (Atazanavir, Ritonavir and Emtricitabine) are used for the treatment of HIV. I knew that the resident was HIV negative (had seen the negative test result) but I asked the resident his/her HIV status. He/she confirmed that it was negative. I discontinued the medications immediately and informed the attending physician. " Sufficient nursing time was not given to ensure Resident #137 received only medications that were prescribed by the physician as evidenced by inaccurately transcribing three (3) medications that resulted in the delivery and administration of medications that were not prescribed for a period of four (4) days. The resident received unintended medications for a period of four (4) days. The record lacked evidence that the resident sustained any untoward effect from receiving medications that were not prescribed. Employees #20, 21 and 22 all acknowledged that Resident #137 ' s medications were inaccurately transcribed which resulted in the delivery and administration of medications that were not prescribed. The record was reviewed on October 31, 2014.	L 052		

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L 052	Continued From page 33 3. Sufficient nursing time was not given to follow physician ' s orders to assess oxygen saturation levels every shift for Resident #34. A review of the Resident #34 ' s medical record revealed physician orders dated September 27, 2014 which directed Continuous Oxygen 2L/min [liters/minute] for SOB [Shortness of Breath]. ; 02 SATS [oxygen saturation levels] every shift, original order dated January 25, 2014. A review of the Medication Administration Record [MAR] for November 2014 identified the order for 02 SATS every shift. The MAR revealed nurses ' initials were recorded in designated spaces, however; there was no evidence of the oxygen saturation results. A face-to-face interview was conducted with Employee #7 on November 4, 2014. A query was made regarding the notation of the oxygen saturation results. Employee #7 indicated that staff are encouraged to document the saturation results on the MAR. In addition, the staff would record the results on the Blood Pressure Monitoring Sheet which has a column for the SP02 [peripheral capillary oxygen saturation]. A second query was made regarding the November 2014 monitoring sheet. Employee #7 was unable to provide that sheet. A review of the August, September and October 2014 Blood Pressure Monitoring Sheet revealed a column for the SP02 results. All of the sheets lacked consistent evidence of assessing the resident ' s oxygen saturation every shift. There was no evidence that facility staff followed	L 052		

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L 052	Continued From page 34 the physician ' s order to assess the resident's 02 SATS [oxygen saturations] every shift. The record was reviewed November 4, 2014. 4. Sufficient nursing time was not given to modify [increase] an antiparkinson medication, Sinemet in accordance with physician ' s orders for Resident #114. On October 27, 2014 at approximately 11:50 AM, Resident #114 was observed shaking while lying in bed. A review of the August 2014 physician ' s orders revealed Resident #114 ' s mediation regimen included Sinemet 25/100 one (1) tablet by mouth three times daily [original order June 12, 2014] for Parkinson ' s. A subsequent Physician's orders dated September 3, 2014 directed, " d/c [discontinue] Sinemet. [start] Sinemet 25/100 2 [two] tabs [tablets] p.o. [by mouth] tid [for] Parkinson ' s disease [dose modified; increased from 1 tablet to 2 tablets]. A review of the September and October 2014 medication administration records [MAR] revealed that the resident received Sinemet 25/100 mg one (1) tablet three times a day. There was no evidence that sufficient nursing time was given to ensure that staff administered the modified dosage of Sinemet 25/100 mg 2 tablets three times daily as prescribed for a period of approximately 61 days. On November 3, 2014 at approximately 5:00 PM	L 052		

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L 052	Continued From page 35 an observation of the medication storage for Resident #114 was conducted. It was observed that one Sinemet 25/100 mg tablet was available in the 9:00 AM, 1:00 PM and 5:00 PM packages to be administered to the resident. Employee #14 acknowledged the findings at the time of the observation and that Resident #114 did not receive the Sinemet 25/100 two tablets as ordered by the physician. The record was reviewed on November 3, 2014. B. Based on observation, record review and staff interview for two (2) of 44 sampled residents, it was determined that sufficient nursing time was not given to ensure that residents in the dayroom were supervised and free of accidents as evidenced by two (2) residents were observed in a physical altercation while not being monitored. Residents'#38 and #63. The findings include: 1. Sufficient nursing time was not given to ensure that residents in the dayroom were supervised and free of accidents as evidenced by two (2) residents were observed in a physical altercation while not being monitored. On November 4, 2014 at approximately 3:00 PM during an isolated general observation of the activity area, a member of the survey team observed Residents #38 and #63 unsupervised and engaged in a physical altercation in the dayroom. Resident #63 was aggressively pulling on Resident #38 ' s right arm and holding onto	L 052	1. The newly hired Director of Nursing implemented plans to correct deficient staffing. The facility is now staffed to meet resident clinical care needs in accordance with regulatory requirements by using regular staff, overtime and other resources. 2. The DON received management approval to hire additional nursing staff to meet resident needs and regulatory agency requirements. The facility is currently hiring additional nurses. When necessary, overtime will be used and schedule modifications will continue to be made until sufficient staff is hired. All new hires will receive orientation in all aspects of nursing to address resident clinical needs. 3. The Director of Nursing will monitor staffing daily to ensure compliance & care delivery as ordered and required. The daily nursing staffing ratio will be added as a quality indicator and will be will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON. 1/14/15	

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L 052	Continued From page 36 [his/her] blue and white sweater [he/she] was wearing. Resident #38 was reclining in a blue Geri chair, staring up towards the ceiling without any movement during the physical altercation. The activity/dayroom room was unsupervised, there was no staff present. There were a total of eight (8) residents in the dayroom. Employees #16 and #17 were informed of the physical alteration. They immediately went into the activity room and separated Resident #68 from Resident #38. Resident #38 was immediately removed from the dayroom and taken to [his/her] room. There was no evidence of untoward physical harm to Resident #38. A face-to-face interview was conducted with Employee #17 on November 4, 2014 at approximately 3:30 PM. When queried where the assigned staff was member for the day room at the time of the incident. He/she stated, " Employee #30 was assigned to the activity room from 3:00 PM-3:30 PM. However, [he/she] was on break, and did not tell anyone. " The observation and clinical record was conducted on November 4, 2014. Sufficient nursing time was not given to ensure that residents in the activity/day room were supervised and free from accidents.	L 052		

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L 052	Continued From page 37 C.Based on observations made during an environmental tour of the facility on November 4, 2014 at approximately 10:00 AM, it was determined that facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by failure to maintain a clean environment in the 7th floor laundry room. The findings include: A tour of 7th floor laundry room [where resident personal laundry is processed] was conducted on November 4, 2014 at approximately 10:00 AM. There was an accumulation of dust behind the washer and dryer in one (1) of one (1) washer and dryer observed. There was no documented evidence of policies or procedures to address the cleaning and maintenance of the room and equipment. The observations were made in the presence of Employee #34 who acknowledged the findings at the time of the observation. D.Based on observation, record review and staff interview for one (1) of 44 sampled residents, it was determined that sufficient nursing time was not given to consistently record percentages of meal consumption, verify significant weight changes and ensure the accuracy of weighing mechanisms [bed scale verse chair scale] for Resident #27 who was assessed with potential significant weight loss in a period of 30 days. The findings include: Sufficient nursing time was not given to ensure	L 052	1. The Laundry Room was cleaned and is no longer being used to clean resident clothing. 2. Services of an outside contractor have been retained to provide laundry services for residents' personal clothing. The laundry room will be assessed for cleanliness during routine weekly environmental rounds. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4.Responsible Individual: DON 1. The newly hired Director of Nursing implemented plans to correct deficient staffing. The facility is now staffed to meet resident clinical care needs in accordance with regulatory requirements by using regular staff, overtime, schedule modifications and other resources. 2. The DON received management approval to hire additional nursing staff to meet resident needs and regulatory agency requirements. The facility is currently hiring additional nurses. When necessary, overtime is used and schedule modifications will continue to be used until sufficient staff is hired. All new hires will receive orientation in all aspects of nursing to address resident clinical needs.	1/14/15

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L 052	Continued From page 38 consistent recording of percentages of meal consumption, verify significant weight changes and ensure the accuracy of weighing mechanisms [bed scale verse chair scale] for Resident #27 who was assessed with potential significant weight loss in a period of 30 days. According to the facility ' s policy entitled, "Resident ' s Weights" , Policy No: NS04-058, page 3 of 4, Effective Date: December 1, 2008 stipulates: " Addressing Significant Weight Changes: ...1) Validation of significant weight changes: all residents with a significant weight change will be re-weighed under the supervision of a licensed nurse within 48 hours ... Conveying Information about the Weight Change- [#] 3. The dietitian will review all related information and documentation to look for evidence of identified causes of the weight... [#]6. Should it be determined that the weight loss is medically unavoidable based on the discussion by the physician, dietitian, nurse and other team members, a note by the respective disciplines containing supportive documentation should be written ... Follow-Up: [#] 1. The licensed nurse and dietitian will document the decisions related to a significant weight change in their respective section of the resident record. The care plan will also be updated, with input from the dietitian and interdisciplinary team, to reflect new goals/approaches for managing the weight change ... " Resident #27 was admitted to the facility on September 16, 2014 with diagnoses which	L 052	3. The Director of Nursing will monitor staffing daily to ensure compliance & care delivery as ordered and required. The daily nursing staffing ratio will be added as a quality indicator and will be will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 052	Continued From page 39 included new onset of seizures, cerebral vascular accident with residual deficits (right hemi paresis), poor oral intake, hypertension, morbid obesity, depression, diabetes mellitus and debility. The admission orders dated and signed September 18, 2014 directed, "Treatments: Weight weekly x4 [times four] then monthly and prn (as needed). Functional Level- Assistant with eating. " Review of the physician ' s interim orders revealed the following: " September 18, 2014 at 3:00 PM directed, " Zofran 4mg IM (Intramuscular) [every] 6 hours prn (as needed) [for nausea and vomiting]. September 19, 2014 at 3:00 PM directed, " Transfer resident to ER (Emergency Room) due to N/V (nausea and vomiting). October 31, 2014 - Please reweigh [patient] today. [Check] weekly wt [weights]. November 3, 2014- Food diary for 3 days. Please put in chart for review. Megace 625mg (milligram) /5 ml (millimeters); po (by mouth) daily for poor appetite. " Throughout the survey the resident was observed eating. However, there was no supervision or assistance from staff noted. Resident was eating slowly with left hand.	L 052		

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L 052	Continued From page 40 Observed was food left untouched on plate. A review of the admission Minimum Data Set [MDS], dated September 29, 2014 revealed that under Section G, Functional Status, G0110- Activities of Daily Living Assistance- Resident #27 was coded as requiring set up help only without help or staff oversight in eating. Section - G0400, Functional Limitation in Range of Motion, the resident was coded as "1" [impairment on one side] for A. Upper extremity (shoulder, elbow, wrist, hand). Under Section I (Active Diagnoses) the resident was coded with diagnoses that included: Cerebrovascular Disease, Hemiplegia (paralysis on one side) affecting unspecified side." A review of the facility ' s weight log book revealed the following weights for Resident #27: September 16, 2014 (admission weight) - 295 pounds September 20, 2014- 295 pounds September 24, 2014- 280 pounds October 4, 2014- 282 pounds - Re-weigh 257 pounds October 13, 2014 - 251 pounds October 20, 2014 - Refused [to be weighed] October 27, 2014 - weight missing October 31, 2014 - 255.4	L 052		

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L 052	Continued From page 41 Resident had a 15 pound weight loss from September 20, 2014 to September 24, 2014. There is a weight variance of 38 pounds from September 16, 2014 (admission) to October 4, 2014, which is indicative of a 12.9% weight loss within 18 days. Clinical record lacked evidence that a re-weigh was conducted within 48 hours according to facility ' s policy on September 24, 2014 after a 15 pounds weight variance. The re-admission nutrition risk assessment dated September 20, 2014 revealed the following: Feeding Ability: Self Feeding; Appetite-Poor, Meal Intakes (average) - < 25% (less than 25 percent), Interpretation of abnormal labs (s): [No] labs. Comments: Discussed poor appetite with resident, who is responsive (nods head/ murmurs) but will not speak full sentences. [He/she] says [he/she] has not been feeling hungry. Would not give food preferences. Risk Assessment: At Risk for Unintended [weight] loss: Yes (reasons) [related to] po (food by mouth) < (less) than 25 [percent]. Care Plan: Weight Goal: [weight loss 1-3 pounds per week until BMI (Body Mass Index) WNL (within normal limits). Other Goals: PO. (greater) than 75%. Estimate needs on Reassessment, including fluids. Interventions: Registered Dietitian added Boost Plus TID (three times a day) and will add snacks TID (three times a day). Monitoring monthly weights (and weekly weights x 4 weeks per protocol). No further intervention at this time. "	L 052		

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L 052	Continued From page 42 A review of the Interdisciplinary Progress Notes revealed the following: " September 17, 2014 - 3PM (nursing) - Consumed 25% of breakfast; 25% of lunch September 18, 2014 - 1:30 PM (nursing) - Resident ' s appetite is still poor, ate zero percent. Unable to hold down food in [his/her] stomach. Zofran 4mg po administered. September 18, 2014 10 PM- (nursing) -Dinner less than 25% September 20, 2014 3:00 PM- (nursing) - Resident refused breakfast and lunch. September 20, 2014- 3:30 PM- (nursing) - Resident refused to eat breakfast and lunch. Emesis noted x1. September 20, 2014 - 11:20 PM - (nursing) - Resident is stable [Status Post] ER (Emergency Room) September 22- September 26, 2014 (nutrition care progress notes) - Weekly [weight] + 280 [pounds]. Admit [weight] reported as 295 lbs on 9/20/14. Resident was weighed on 9/24/14 per nurse documentation, It is impossible for the resident to have gained 15 [pounds] in two days. PO (By mouth) of trays [approximately] 25% per nurse. Resident is drinking supplements. Will continue [weights]/question accuracy. Will assess need for further intervention once baseline [weight] is established. September 27, 2014 10:00 PM (nursing)-	L 052		

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L 052	Continued From page 43 Appetite at dinner less than 25%. Fluid tolerated and supplement. September 29, 2014 - (nursing)- Patient ate less than 25% of [his/her] lunch. And breakfast during the shift. October 8, 2014 - (nutrition) -Monthly weight was 257-282 pounds; BMI- 47-51.7 -Obese. Weight trends; -4 to -13% at 30 days (potential for significant weight loss, question weight accuracy [related to] large discrepancy between October weight /reweight at 90 days, -6 to -14% (also potential significant weight loss). October 13, 2014 (nutrition) -weekly weight = 251 pounds (2.3% to -11%) weight loss. RD collected food preferences and encouraged eating. Discussed POC (plan of care) with resident and CNA (certified nursing assistant). Resident reports not having a large appetite if weight loss continues to be significant, may be worth considering an appetite stimulant. Resident to continue on nutrition alert. October 15, 2014- [Patient] seen bedside with food tray for lunch. The OT [Occupational Therapist] notes the patient has not eaten all of the food and the food was eaten a strange manner. The OT asked the [patient] if there was any difficulty with self-feeding. The [patient] stated, " No. " [Patient] refused to continue self-feeding. .. October 20, 2014 (nutrition) - Weekly weight- resident refused. Will remain on Nutrition Alert List.	L 052		

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L 052	Continued From page 44 October 27, 2014 (nutrition) - Weekly weight missing. Question whether resident refused. Will remain on Nutrition Alert List. November 3, 2014 (nutrition) - Weight= 255.4 [pounds] large weight discrepancies noted. Discrepancies in staff reporting of resident ' s po intake as well. [Employee #11] has ordered a three (3) day food diary with supervision to observe intake patterns. RD will be requesting and reporting a reweight on the resident, as well as continuing Nutrition Alert /weekly weights. Physician progress notes: No date/no time/no signature- Type of visit- Periodic- Weight- Stable. A review of the clinical record revealed nurse practitioner ' s notes for September 19, 2014 and October 16, 2014. Clinical record lacked evidence that resident ' s weight loss/variance was included in his/her total plan of care. Initial Interdisciplinary Team Note dated September 30, 2014- 11:30 AM revealed, " Dietitian gave an over-view of resident ' s diet and [his/her] current weight. POA (Power of Attorney) reported that resident does not eat as much as [he/she] did in the past. Dietician acknowledged that resident has lost weight this quarter and he/she will remain on a low sodium and DM (Diabetes Mellitus) diet. " Diet = Consistent Carbohydrate /Cardiac with Boost	L 052		

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L 052	Continued From page 45 plus TID (three times a day) and snacks TID as added by RD (Registered Dietitian) on September 20, 2014. Nurse reports 100% po breakfast, 50-75% po lunch, high variance of intake for dinner, 100 po snacks and resident not receiving Boost. RD to check with kitchen, as order is written and appears on Medi tech printout. Will continue monitoring weights, adding to Nutrition Alert List (weekly weights) until stable weight is evidenced. Goal is for weight loss of 1-2 pounds/week until BMI [within normal limits] with PO > 75% estimated needs. No further intervention at this time. There was no documentation of the resident ' s physician being made aware of the resident ' s decreased appetite and/or weight loss according to the facility ' s policy. A review of the Meal Percentages revealed the following: Date Breakfast/Lunch/Dinner September 17, 2014- not recorded/not recorded/ 0% September 18, 2014- not recorded/not recorded/not recorded September 19, 2014 - not recorded/not recorded/not recorded September 20, 2014 - not recorded/not recorded/not recorded September 21, 2014- not recorded/not recorded/not recorded September 22, 2014 - not recorded/not recorded/25% September 23, 2014 - not recorded/not	L 052		

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L 052	Continued From page 46 recorded/25% September 24, 2014 - 0%/0%/25% September 25, 2014- not recorded/not recorded/not recorded September 26, 2014 - not recorded/not recorded/not recorded September 27, 2014- not recorded/not recorded/not recorded September 28, 2014 - 25%/75%/not recorded September 29, 2014- 0%/0%/not recorded September 30, 2014 - 20%/not recorded/50% October 1, 2014 - not recorded/not recorded/not recorded October 2, 2014 - not recorded/not recorded/not recorded October 3, 2014 - not recorded/not recorded/50% October 4, 2014 - 25%/25%/25% October 5, 2014 - 25%/not recorded/not recorded October 6, 2014 - 25%/25%/50% October 7, 2014 - 25%/75%/not recorded October 8, 2014 - 75%/25%/not recorded October 9, 2014 - not recorded/not recorded/not recorded Facility staff failed to consistently monitor Resident #27 ' s meal percentage for breakfast, lunch, dinner and snacks. A review of the resident ' s care plan revised on October 6, 2014 revealed: " Poor oral intake; Goal: resident will be free from weight loss in the next 90 days. Interventions: Encourage resident to eat or drink every meal. Assist in feeding as needed. Monitor resident ' s weight every week or as recommended. Notify MD/NP [medical doctor/nurse practitioner] with weight loss. Notify	L 052		

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L 052	Continued From page 47 family: encourage to bring in food [he/she] likes eating. " A face-to-face interview was conducted with Employee #12 on October 31, 2014 at approximately 11:09 AM regarding the resident ' s weight variance. Employee #12 stated that he/she consulted with the two certified nursing assistants who do all the weights. Employee #12 informed them about the large variances in the weights. When queried, if he/she notified the doctor and or nurse practitioner. Employee #12 stated, " I sent out a nutrition alert message to the doctors and management team on October 13, 2014. " A face-to-face interview was conducted on October 31, 2014 at approximately 12:21 PM with Employee #11 regarding the aforementioned concerns. He/she stated that the weights are inaccurate. When asked about the e-mail from the dietitian; he/she stated that he/she did not recall getting an e-mail from the dietitian. Further stated with a significant weight loss; there should have been communication directly to him/her. A face-to-face was conducted with Employees # 3, #11, and #27 on October 31, 2014 at approximately 2:00 PM regarding the aforementioned findings. All acknowledged the findings. A follow-up face-to-face interview was conducted with Employee #11 on November 3, 2014 at approximately 11:00 AM. He/she acknowledged that [he/she] did receive the e-mail. However, " it was not opened, which was an oversight. " The clinical record was reviewed on November 3, 2014.	L 052		

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L 052	Continued From page 48 Sufficient nursing time was not given to consistently record Resident #27's meal consumption percentages and failed to consistently reassess significant weight variances to ensure the accuracy. Additionally, there was no evidence of consistency in the use of weighing mechanisms [bed scale verse chair scale] for Resident #27 who was assessed with potential significant weight loss of over 30 days. E.Based on observations, record reviews, staff and resident interviews , it was determined that sufficient nursing time was not given to ensure that sufficient nursing staff was available provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The findings include: During the survey, the following areas of concerns were indentified: CFR 483.20, F281, Professional Standards: facility staff failed to meet professional standards of care as evidenced by failure to provide nursing interventions, care and services consistent with the needs of one (1) resident and the inaccurate transcription of medications that	L 052	1. The newly hired Director of Nursing implemented plans to correct deficient staffing. The facility is now staffed to meet resident clinical care needs in accordance with regulatory requirements by using regular staff, overtime, schedule modifications and other resources. 2. The DON received management approval to hire additional nursing staff to meet resident needs and regulatory agency requirements. The facility is currently hiring additional nurses. When necessary, overtime is used and schedule modifications will continue to be used until sufficient staff is hired. All new hires will receive orientation in all aspects of nursing to address resident clinical needs. 3. The Director of Nursing will monitor staffing daily to ensure compliance & care delivery as ordered and required. The daily nursing staffing ratio will be added as a quality indicator and will be will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 052	Continued From page 49 resulted in the delivery and administration of medications that were not prescribed for one (1) resident. CFR 483.25, F309, Provide Care and Services for highest well being: facility staff failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care as evidenced by failure to: ensure that one (1) resident was consistently assessed and monitored for strict fluid restriction and aspiration precautions; administer medications consistent with one (1) resident ' s prescribed medication regimen and diagnoses; assess oxygen saturation levels as prescribed for one (1) resident and administer modified medication dosage in accordance with physician's orders for one (1) resident CFR 483.25 (k), F328, Treatment/Care for Special Needs: failed ensure the management of tracheostomy [trach] and respiratory care as evidenced by failing to ensure that extra and/or replacement trach cannulas of the correct size were at the bedside or readily accessible in the event of an emergency for two (2) residents and failed to consistently assess the respiratory status of one (1) resident when interventions where implemented to manage episodes of shortness-of-breath.	L 052		

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L 052	Continued From page 50 CFR 483.25 (h), F323, Free of Accident Hazards/Supervision/Devices: failure to ensure that residents in the dayroom were supervised and free of accidents as evidenced by two (2) residents were observed in a physical altercation while not being monitored. 483.25 (i)(l), F325 Nutrition: failed to consistently record percentages of meal consumption, verify significant weight changes and ensure the accuracy of weighing mechanisms [bed scale verse chair scale] for one (1) resident who was assessed with potential significant weight loss in a period of 30 days. CFR 483.25(l) F329, Unecessary Drugs: failed to ensure that one (1) resident was free from unnecessary medications as evidenced by the inaccurate transcription of three (3) medications that resulted in the delivery and administration of unprescribed medicines. CFR 483.75, F492, Comply with Federal State and Local and local laws and regulations: facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. There was no evidence that sufficient nursing staff was consistently available to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each	L 052		

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L 052	Continued From page 51 resident.	L 052		
L 056	3211.5 Nursing Facilities Nursing personnel, licensed practical nurses, nurse aides, orderlies, and ward clerks shall be assigned duties consistent with their education and experience and based on the characteristics of the patient load. This Statute is not met as evidenced by: A. 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 of direct nursing care per resident per day on seven (7) of nine (9) days reviewed and the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on nine (9) of the nine (9) 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 4, 2014 at approximately 3:55 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	L 056	1. The newly hired Director of Nursing implemented plans to correct deficient staffing. The facility is now staffed to meet resident clinical care needs in accordance with regulatory requirements by using regular staff, overtime, schedule modifications and other resources. 2. The DON received management approval to hire additional nursing staff to meet resident needs and regulatory agency requirements. The facility is currently hiring additional nurses. When necessary, overtime is used and schedule modifications will continue to be used until sufficient staff is hired. All new hires will receive orientation in all aspects of nursing to address resident clinical needs. 3. The Director of Nursing will monitor staffing daily to ensure compliance & care delivery as ordered and required. The daily nursing staffing ratio will be added as a quality indicator and will be will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 056	Continued From page 52 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 nine (9) of nine (9) days reviewed as outlined below. On Saturday, October 25, 2014 it was determined that the facility provided RN coverage at a rate of 0.2 hours. On Sunday, October 26, 2014 it was determined that the facility provided RN coverage at a rate of 0.2 hours. On Monday, October 27, 2014 it was determined that the facility provided RN coverage at a rate of 0.4 hours. On Tuesday, October 28, 2014 it was determined that the facility provided RN coverage at a rate of 0.5 hours. On Wednesday, October 29, 2014 it was determined that the facility provided RN coverage at a rate of 0.3 hours. On Thursday, October 30, 2014 it was determined that the facility provided RN coverage at a rate of 0.5 hours. On Friday, October 31, 2014 it was determined that the facility provided RN coverage at a rate of 0.3 hours. On Saturday, November 1, 2014 it was determined that the facility provided RN	L 056		

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L 056	Continued From page 53 coverage at a rate of 0.2 hours. On Sunday, November 2, 2014 it was determined that the facility provided RN coverage at a rate of 0.3 hours. The facility failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day, for seven (7) of nine (9) days reviewed as outlined below: On Saturday, October 25, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.2 hours. On Sunday, October 26, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.0 hours. On Monday, October 27, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.4 hours. On Tuesday, October 28, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.5 hours. On Friday, October 31, 2014 it was determined that the facility provided direct nursing coverage at a rate of 6 hours. On Saturday, November 1, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.7 hours. On Sunday, November 2, 2014 it was determined that the facility provided direct nursing coverage at a rate of 3.4 hours.	L 056		

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L 056	Continued From page 54 A face-to-face interview/review was conducted with Employee #26 on November 4, 2014 at approximately 4:30 PM. He/she acknowledged the findings. The record was reviewed on November 4, 2014. B.Based on observations during the survey period, it was determined that the facility failed to afford each resident an opportunity to purchase stamps and other supplies in a gift shop, resident store or a gift shop cart that was accessible. The findings include: The District of Columbia Municipal Regulations for Nursing Facilities 3252.1 stipulates, " Each facility shall provide a gift shop or resident store for a minimum of two (2) hours a day, five (5) days per week, or a gift shop cart must be accessible two (2) hours per day, five (5) days per week, and; " The District of Columbia Municipal Regulations for Nursing Facilities 3252.2 stipulates, " Various services provided shall afford each resident an opportunity to purchase items such as magazines, candies, small gifts, postage stamps, stationery, writing implements, and other supplies. "	L 056	1. The facility has a temporary gift shop cart available to residents. 2. The gift shop cart contains stamps, snacks and other items. It will be periodically replenished with a mixed variety of items until a permanent gift shop vendor is located on the premises. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. Responsible Individual: DON	1/14/15

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L 056	Continued From page 55 During a resident council interview conducted with Resident #73 on November 3, 2014 at approximately 3:25 PM. When queried if there were other questions or concerns, he/she stated, " We keep asking when is the gift shop is going to come back. They (Administration) keep saying it ' s going to open each month. It has been closed since July of this year [2014]. We have to go outside to the post office to get stamps." Observations of the facility were conducted. There was no evidence of a gift shop, resident store or a gift shop cart that was accessible to the residents during the survey period to allow resident to purchase stationery, postage stamps, writing implements, magazines and small gifts from October 26, 2014 through November 5, 2014. A face-to-face interview was conducted with Employee #8 on November 3, 2014 at approximately 4:45 PM. He/she acknowledged that there was no gift shop, resident store or a gift shop cart that was accessible for the residents; and he/she goes out to purchase stamps for the residents.	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	L 091		

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L 091	Continued From page 56 chapter. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on November 4, 2014 at approximately 10:00 AM, it was determined that the Infection control Program failed to ensure that the residents ' personal laundry was handled with appropriate measures to prevent cross-contamination and potential spread of infection. The findings include: The Infection control Program failed to ensure that the residents ' personal laundry was handled with appropriate measures to prevent cross-contamination and potential spread of infection. A tour of 7th floor laundry room [where resident personal laundry is processed] was conducted on November 4, 2014 at approximately 10:00 AM. There was an accumulation of dust behind the washer and dryer in one (1) of one (1) washer and dryer observed. A face-to-face interview was conducted with Employee # 34 on November 4, 2014 at approximately 10:00 AM. He/she stated, " I water coming from the boiler is 125 degree [Fahrenheit]. There was no evidence that facility staff recorded water temperatures to determine if residents ' personal laundry being process was properly sanitized by maintain hot water temperatures of 160 degrees Fahrenheit for 25 minutes.	L 091	1. The Laundry Room was cleaned and is no longer being used to clean resident clothing. 2. Services of an outside contractor have been retained to provide laundry services for residents' personal clothing. The laundry room will be assessed for cleanliness during routine weekly environmental rounds. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 091	Continued From page 57 There was no documented evidence of policies or procedures to address the cleaning and maintenance of the room, equipment and processing of personal clothing for residents ' that are on isolation. A face-to-face interview was conducted with Employee # 33 on November 4, 2014 at approximately 10:20 AM. He/she stated, " I wash the residents' clothing that does not have family." The observations were made in the presence of Employee #34 who acknowledged the findings at the time of the observation. The Infection control Program failed to ensure that the residents ' personal laundry was handled with appropriate measures to prevent cross-contamination and potential spread of infection.	L 091	1. Each Food Service deficiency was corrected. 2. A tour of the Food Services Dept. was conducted to identify and correct any other outstanding issues. 3. Weekly rounds will be performed to identify and correct deficient practices. Performance will be reported to the QA Committee for routine oversight. 4. Responsible Individual: DON	1/14/15
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 October 27, 2014 at approximately 9:15 AM, it was determined that the facility failed to prepare, store, and serve food under sanitary conditions as evidenced by two (2) of two (2) soiled rolling racks next to the dishwashing machine, a bent access door to one (1) of one (1) ice machine in the main kitchen, one (1) of one (1) soiled gas	L 099	1. (1) The storage rolling rack was cleaned. (2) The gas stove was cleaned. (3) The temperature logs were labeled. (4) The bent ice machine door will be repaired. 2. All kitchen equipment repairs and cleanliness relating ice machine door, storage rolling racks and temperature logs were inspected for compliance. Any identified deficiencies were corrected. 3. Weekly rounds will be performed to identify and correct identified deficiencies. Performance will be reported to the QA Committee for routine oversight. 4. Responsible Individual: DON	1/14/15

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L 099	Continued From page 58 stove and unidentified refrigerator and freezer temperature logs in August and September 2014. The findings include: 1. Two (2) of two (2) rolling racks stored by the dishwashing machine were soiled. 2. The access door to one (1) of one (1) ice machine was bent and did not provide a tight fit when closed. 3. The top of one (1) of one (1) gas stove was soiled. 4. Temperature logs to refrigerators and freezers for the months of August and September were not labeled to identify which unit they were associated with. These observations were made in the presence of the dietary supervisor, Employee #18 who acknowledged the findings.	L 099		
L 141	3226.1 Nursing Facilities Unless administered under a self-administer order, all medication shall be prepared and administered only by a licensed physician or by a licensed nurse. This Statute is not met as evidenced by: Based on record review, staff and resident interviews for one (1) of 44 sampled residents, it was determined that the interdisciplinary team failed to evaluate that it was safe for Resident # 73 to self administer medications. The findings include:	L 141	1. Over the counter medications for resident #73 were discarded after the care team determined that it was unsafe for the resident to self-administer medications. The resident was not harmed by the deficient practice. The resident was counseled against self-procurement and hoarding of over the counter medication for personal use.	

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L 141	Continued From page 59 During a tour of the facility on October 20, 2014 at approximately 11:00AM Resident #73 stated, " I keep my own supply of medications because they don ' t give me my medicines when I ask for them. " The resident was asked whether he/she usually informed the staff when he/she took the medications. He/she responded, "No, but they know that I have them." A face-to-face interview was conducted with Employee #9 at approximately 3:00PM on October 28, 2014. The employee was queried whether he/she was aware that the resident had "over the counter medications " at his/her bedside. The employee responded, " No, but we have had problems with this resident trying to keep and take his/her own medications in the past. We even informed the physician of the problem." Employee #9 was then queried whether the Interdisciplinary Team had met to discuss the problem and whether the resident had been evaluated for safety to self-medicate? The employee responded, " No. " An observation of the medications was conducted in the presence of Employee #23 who retrieved the medications from the resident. The items in the bag were as follows: Ibuprofen 50 tablets Expiration date (Exp.) 8, 2015 (August) Assured Xtra Strength Pain Relief PM/Pain Reliever Night Time Sleep Aid 24 Caplets Exp. 2, 2016 (February) Allergy Plus Sinus Headache 12 caplets Exp. 3, 2016 (March) Assured Allergy/Compare to Benadryl 36 tablets Exp. 2, 2016 (February)	L 141	2. All other residents with the potential to obtain unauthorized over-the-counter medication were interviewed. No deficient practice was noted. 3. Residents with the potential to obtain unauthorized, over-the-counter medication will be monitored by the Clinical Manager or designee who will prompt the interdisciplinary team to determine the safety of the resident to self-administer medications. The Administrator will notify all residents during the next Resident Council Meeting not to procure & self-administer medication unless it is ordered by an attending physician. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 141	Continued From page 60 Allergy Relief/Loratadine Disintegrating 24 hr. (hour) relief (10) tablets Exp. 4, 2015 (April) A review of the October 2014 physician ' s order form and the interdisciplinary care plan were reviewed. There was no evidence that interdisciplinary team determined that it was safe for the resident to self administer medications. A face-to-face interview was conducted with Employee #9 at approximately 3:00PM on November 3, 2014. The employee acknowledged the finding. The record was reviewed on November 3, 2014. The interdisciplinary team failed to determine that it was safe for the resident to self administer medications.	L 141	1. Resident #76 received foot care by a podiatrist after the deficient practice was identified.	
L 169	3228.1 Nursing Facilities Each facility shall have a written agreement for obtaining regular podiatry services with a podiatrist licensed in the District of Columbia. This Statute is not met as evidenced by: Based on observation, record review and interviews for one (1) of 44 sampled residents, it was determined that facility staff failed to ensure that the resident received foot care and services to trim nails and provide preventive care, to avoid foot problems for Resident #76 who is diabetic. The findings include: Facility staff failed to ensure that Resident #76 received services to trim nails and provide	L 169	2. All other diabetic residents were assessed for the need for podiatry services. All licensed staff were retrained on assessment of diabetic residents to ensure their needs for foot care are addressed. The facility now offers contracted podiatry services. Diabetic residents will be routinely assessed to determine the need for a podiatry referral and provision for such service will be made. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 169	Continued From page 61 preventive care, to avoid foot problems. A face-to face interview was conducted with Resident #76 on October 27, 2014 at approximately 10:00 AM. The resident stated that he/she is a diabetic and that his/her toenails were long and had not been cut. On November 5, 2014 at 9:15 AM Resident #76 ' s feet were observed in the presence of Employee #9. The resident ' s toe nails were elongated and several of the toe nails curled inward toward the skin. A review of the resident's clinical record lacked evidence that he/she had been seen by a podiatrist since he/she was admitted to the facility. A face-to face interview was conducted on November 5, 2014 at approximately 9:30 AM with Employee #9. He/she acknowledged the findings. The record was reviewed on November 5, 2014. There were was no evidence that facility staff provided preventive foot care to Resident #76.	L 169	1. Resident #76 received foot care by a podiatrist after the deficient practice was identified. 2. All other diabetic residents were assessed for the need for podiatry services. All licensed staff were retrained on assessment of diabetic residents to ensure their needs for foot care are addressed. The facility now offers contracted podiatry services. Diabetic residents will be routinely assessed to determine the need for a podiatry referral and provision for such service will be made.	
L 170	3228.2 Nursing Facilities Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees. This Statute is not met as evidenced by: Based on observation, record review and interviews for one (1) of 44 sampled residents, it was determined that facility staff failed to ensure that the resident received foot care and services to trim nails and provide preventive care, to	L 170	3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. Weekly audits will be performed for 3 months. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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L 170	Continued From page 62 avoid foot problems for Resident #76 who is diabetic and in-inservice training for nursing employee. The findings include: Facility staff failed to ensure that Resident #76 received services to trim nails and provide preventive care, to avoid foot problems and in-service training for nursing employees. A face-to face interview was conducted with Resident #76 on October 27, 2014 at approximately 10:00 AM. The resident stated that he/she is a diabetic and that his/her toenails were long and had not been cut. On November 5, 2014 at 9:15 AM Resident #76 ' s feet were observed in the presence of Employee #9. The resident ' s toe nails were elongated and several of the toe nails curled inward toward the skin. A review of the resident's clinical record lacked evidence that he/she had been seen by a podiatrist since he/she was admitted to the facility. A face-to face interview was conducted on November 5, 2014 at approximately 9:30 AM with Employee #9. He/she acknowledged the findings. The record was reviewed on November 5, 2014. There were was no evidence that facility staff provided preventive foot care to Resident #76 and /or in-service training for nursing employees.	L 170		

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L 189	Continued From page 63	L 189		
L 189	3230.5 Nursing Facilities The responsibilities of the director of the activities program or his or her designee shall include, but not be limited to, the following: (a)To provide direction and quality guidelines of the program (b)To develop and maintain a plan for the program and procedures for implementing the plan; (c)To plan and budget for the program, including the number and levels of employees to be hired and the equipment and supplies to be purchased; (d)To coordinate and integrate the program with other resident care services provided in the facility and in the community; (e)To assist in the development of and participate in staff orientation and annual education programs for all staff in the facility; (f)To develop a written monthly activities schedule in a large print calendar that includes date, time and location of each scheduled activity; (g)To post the activities schedule on the first working day of each month at each nursing unit, at a height that can be clearly seen by residents in wheelchairs; (h)To assure that visually, hearing and cognitively impaired residents know about posted activities;	L 189		

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(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 189	Continued From page 64 (i)To assess the therapeutic activity needs and interests of each resident within fourteen (14) days of admissions; and (j)To participate in the development of an interdisciplinary care plan and reassess each resident's responses to activities at least quarterly after reviewing with each resident his or her participation in the activities program. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 44 sampled residents, it was determined that the director of the activities program or his or her designee failed to complete a comprehensive activity assessment on admission for Resident #27. The findings include: The director of the activities program or his or her designee failed to complete a comprehensive activity assessment on admission for Resident #27. A resident interview conducted on October 27, 2014 at approximately 3:45 PM. When queried, "Do the activities meet your interests?" He/she stated, "No. The activities do not." Resident #27 was admitted to the facility on September 16, 2014 and diagnoses included:	L 189	1. An Activity Assessment for resident #27 is now complete & is incorporated into his treatment plan & activity schedule. The resident was not harmed by the deficient practice. 2. Each resident activity assessment was audited to determine whether activity preferences were assessed & incorporated into his/her activity schedule. Any identified deficiency was corrected. 3. All resident admissions and re-admissions will be reviewed for presence of an activity assessment with documented preferences within 72 hours of admission. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15

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	HFD02-0030	A. BUILDING: _____ B. WING _____	11/05/2014

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L 189	Continued From page 65 New-Onset Seizure Disorder and History of Cerebral Vascular Accident (with right sided deficit). On October 30, 2014 and October 31, 2014 during the hours of 2:00 PM- 4:00PM; the resident was observed lying in his/her bed watching TV. On November 3, 2014 between the hours of 1:00 PM- 4:00 PM, the resident was observed out of bed in Geri -chair in the dayroom watching television with other residents. According to the admission Minimum Data Set (MDS) dated September 29, 2014, the resident was coded under Section F0300 (Preferences for Customary Routine and Activities) as listening to music [he/she] likes and doing [his/her] favorite activities as being very important. A review of the clinical record lacked a resident activity assessment to determine what activities the resident preferred. A face-to-face interview was conducted with Employee #8 on October 31, 2014 at approximately 4:00PM regarding the resident 's participation in activities. He/she stated, "He/she is invited to activities; however, he/she does not want to come out of [his/her] room." A follow-up face-to-face interview was conducted with Employee #8 on October 31, 2014 at	L 189		

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L 189	Continued From page 66 approximately 4:30 PM regarding the aforementioned findings. [He/she] stated, " [He/she] is invited to activities, but do not wish to come out of [his/her] room." When asked what were some of the resident 's activity preferences and if an activity assessment was conducted on admission, [he/she] after reviewing the chart stated, " No, a resident activity assessment was not conducted on the resident 's admission." The clinical record was reviewed on October 31, 2014. The director of the activities program or his or her designee failed to complete a comprehensive activity assessment on admission for Resident #27.	L 189		
L 377	3252.2 Nursing Facilities Various services provided shall afford each resident an opportunity to purchase items such as magazines, candies, small gifts, postage stamps, stationery, writing implements, and other supplies. This Statute is not met as evidenced by: Based on observations during the survey period, it was determined that the facility failed to afford each resident an opportunity to purchase stamps and other supplies in the gift shop. The findings include: During a resident council interview conducted with Employee # 73 on November 3, 2014 at approximately 3:25 PM. When queried if there were other questions or concerns, he/she stated;	L 377	1. The facility has a temporary gift shop cart available to residents. 2. The gift shop cart contains stamps, snacks and other items. It will be periodically replenished with a mixed variety of items until a permanent gift shop vendor is located on the premises. 3. Performance will be reviewed during daily stand-up meetings and during quarterly QA Committee meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. Responsible Individual: DON	1/14/15

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L 377	Continued From page 67 " We keep asking when is the gift shop is going to come back. They (Administrator) keep saying it ' s going to open each month. It has been closed since July of this year [2014]. We have to go outside to the post office to get stamps. " Observations were conducted to see if a gift shop, resident store or a gift shop cart was accessible to the residents during the survey period (October 26, 2014 through November 5, 2014). There was no evidence that a gift shop or gift cart was accessible for residents to purchase stationery, postage stamps, writing implements, magazines and small gifts. A face-to-face interview was conducted with Employee #8 on November 3, 2014 at approximately 4:45 PM. He/she acknowledged that there was no gift shop or gift cart accessible for the residents; and he/she goes out to purchase stamps for the residents.	L 377		
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 during an environmental tour of the facility on October 27, 2014 at approximately 2:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: loose call	L 410	1. (1) Call bell housings in rooms 610, 633 and 710 were secured. (2) The interior and exterior of exhaust vents in residents' rooms 610, 606, 724, 728 and 754 were cleaned. (3) The exhaust system on the 7th floor was repaired. (4) Privacy curtains in room 601, 610, 625, 658, 701, 710 and 718 were repaired. (5) The privacy curtains in rooms 625, 655, 658, 701, 724 and 758 were replaced.	

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L 410	Continued From page 68 bell housings in three (3) of 25 residents' rooms surveyed, dusty exhaust vents in six (6) of 25 residents' rooms surveyed, a faulty exhaust system on one (1) of two (2) resident's floor surveyed, loose privacy curtains in seven (7) of 25 residents' rooms surveyed, torn privacy curtains in six (6) of 25 residents' rooms surveyed, privacy curtains with no mesh in one (1) of 25 resident's room surveyed, a toilet seat cover dispenser that needed to be secured in the bathroom of one (1) of 25 resident's room surveyed, missing window blind slats in one (1) of 25 resident's room surveyed, a cluttered room in one (1) of 25 resident's room surveyed, soiled floor mats in two (2) of 25 residents' rooms surveyed and a broken stand-on weight scale on one (1) of two (2) resident's floor surveyed; and in one (1) resident's room the privacy curtain, the floor were soiled and one (1) of two (2) of the over-head light did not illuminate. The findings include: 1. Call bell housings in were hanging loose off the wall in resident room #610, #633, and #710, three (3) of 25 residents' rooms surveyed. 2. The interior and exterior of exhaust vents in residents' rooms #601, #606, #724, #728 and #754 were soiled with dust, five (5) of 25 resident ' s rooms surveyed. 3. The exhaust system on the seventh floor was out of order and needed to be reset. 4. Privacy curtains were hanging loose and detached from hooks in seven (7) of 25 residents' rooms including rooms # 601, #610, #625, #658, #701, #710, and # 718. 5. Privacy curtains were torn in six (6) of 25 residents rooms including rooms #625, #	L 410	(6) The 2 privacy curtains in room 744 were replaced. (7)The toilet seat over dispenser in room 625 was replaced. (8)The window curtain in room 724 was replaced. (9) Resident room 606 was de-cluttered. (10) The fall mats in room 724 and 728 were cleaned. (11) The stand up weight scale was repaired and calibrated. (12) Resident Room 622 was cleaned. Cups and food wrappers were removed. The privacy curtain was replaced. The overhead light was corrected. 2. Environmental rounds were conducted on both units to identify and correct any outstanding issues. 3. Performance will be monitored during weekly environmental QA rounds. Identified issues will be immediately addressed or documented in the work order system for scheduled correction. The new Director of Quality, a new full-time position, will ensure each department director receives a list of each identified deficiency.	

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L 410	Continued From page 69 655, #658, #701, #724, and #758. 6. Two (2) of two (2) privacy curtains in room #744 did not contain any mesh as required by Life Safety Code. 7. The toilet seat cover dispenser in room #625 was stored on the bathroom sink and needed to be attached to the wall. 8. A total of four (4) slats were missing in one (1) of one (1) window blind in room #724, one (1) of 25 resident ' s rooms surveyed. 9. Resident room #606 was cluttered with personal clothing such as shirts (15) and belts (4) that were hung onto the television mount and a walker, one (1) of 25 resident ' s rooms surveyed. 10. One (1) of one (1) fall mat in resident room #724 was soiled and two (2) of two (2) fall mats in resident room #728 were also soiled. 11. One (1) of one (1) stand-on weight scale on the seventh floor was out of order. 12. On October 30, 2014 at approximately 9:00 AM and environmental tour of room #622 was conducted. The following noted during the tour: one (1) of two (2) privacy curtains observed with brown stains, floors was noted to have dark spots and used cups and food wrappers, one (1) of two (2) of the over-head light did not illuminate. These observations were made in the presence of the environmental supervisor, Employee #19 who acknowledged the findings.	L 410	Environmental issues will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed during quarterly QA meetings. The QA Committee will ensure oversight and correction of any identified deficiencies. 4. Responsible Individual: DON	1/14/15
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	L 442		

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L 442	Continued From page 70 This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on October 27, 2014 at approximately 2:30 PM, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: damaged door gaskets in five (5) of five (5) steamers and a missing temperature control knob to one (1) of five steamers. The findings include: 1. Door gaskets to five (5) of five (5) steamers were worn and did not provide a tight fit when closed. 2. The temperature control knob to one (1) of five (5) steamers was missing. These observations were made in the presence of the dietary supervisor, Employee #18 who acknowledged the findings.	L 442	1. The door gaskets and temperature control knob was replaced. 2. All other gaskets and knobs were checked to determine the need for replacement. None were in need of repair or replacement. 3. All gaskets & knobs will be checked monthly for proper working order, wear and tear and the need for replacement. Any gasket or knobs requiring intervention will be repaired or replaced. Routine rounds will be performed to identify and correct identified deficiencies. Performance will be reported to the QA Committee for routine oversight. 4. Responsible Individual: DON	1/14/15