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	HFD02-0030	A. BUILDING: _____ B. WING _____	11/09/2015

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L 000	Initial Comments The Annual Licensure Survey was conducted on November 2, 2015 through November 9, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 47 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor	L 000	Please begin typing here....	

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L 000	Continued From page 1 MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 031	3207.6 Nursing Facilities The physician shall prescribe a planned regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindications for the health and safety of the resident; (e)Resident therapeutic activities; and	L 031		

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L 031	Continued From page 2 (f)Plans for continuing care and discharge. This Statute is not met as evidenced by: Based on observation, interview and record review of one (1) of 47 Stage 2 sampled residents, it was determined that the physician failed to include in the total plan of care, the rationale related to prescribing a nicotine patch outside of the manufacturer ' s recommendations for Resident #44. The findings include: The physician failed to include in the total plan of care, the rationale related to prescribing the nicotine patch outside of the manufacturer ' s recommendations for Resident #44. Manufacturer ' s Fact Sheet stipulated the following: Clear Nicotine Transdermal System Patch 14 mg delivered over 24 hours - Stop Smoking Aide. Warnings: when using this product do not smoke even when not wearing patch. The nicotine in your skin will still be entering your bloodstream for several hours after you take it off..." A review of the clinical record revealed a History and Physical examination signed by the physician October 1, 2015 that revealed Resident #44 is a smoker with diagnoses that included, Hypertension, Diabetes, Coronary Artery Disease, and CVA (Cerebrovascular accident) with left Hemiplegia. Resident #44 was observed smoking in front of the main entrance of the facility on Wednesday, November 4, 2015 at approximately 5:00 PM.	L 031	1. The physician's order for a nicotine patch for resident #44 has been discontinued. 2. The medical records of all residents with nicotine patches have been reviewed to ensure the risks and benefits of smoking while wearing the patch, have been explained to each resident and/or/ responsible party. Any identified issues were corrected. 3. All licensed staff will be in-serviced on resident's rights. (i.e., risk and benefits of treatments) 4. To prevent future occurrences, the Clinical Manager/designee will audit physician orders and care plans, to ensure risk/benefit for medications have been addressed. Results of audits will be forwarded to the DON and presented at the quarterly Quality Assurance Committee (QAC) meeting. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

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L 031	Continued From page 3 During a medication pass observation on November 5, 2015 at 10:15 AM the nurse was observed applying a Clear Nicotine Transdermal patch to Resident#44 ' s skin. There was no evidence that the physician included, in Resident #44 ' s total plan of care, the rationale related to prescribing the nicotine patch outside of the manufacturer's recommendations. The record revealed that the physician was aware of the resident's smoking activities. The clinical record lacked evidence that Resident #44 ' s physician provided information related to the risks and benefits of smoking while wearing the nicotine transdermal patch prior to the initiation of treatment. A face-to-face interview was conducted with the Medical Director on November 6, 2015 at approximately 9:00 AM. When informed of manufacturer ' s recommendations regarding risks and benefits and that Resident # 44 has been observed smoking on multiple occasions during survey. He/she stated, "I am aware of manufacturer recommendations but feel the potential benefits outweigh the risks". When queried if risks and benefits were explained to resident and/or responsible party, he /she stated they were not. He/she acknowledged the aforementioned findings. The clinical record was reviewed on November 5, 2015.	L 031		2/9/16
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 4 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that the charge nurse failed to initiate a care plan with goals and approaches to address Resident #15's refusal to wear tennis shoes. The findings include: A review of the " Physician ' s Order " dated October 2, 2015 directed, " Patient to wear tennis shoes while in w/c [wheelchair] for positioning. An observation of Resident #15 was conducted on November 4, 2015 at 9:15 AM and 3:20 PM. The resident was observed sitting in his/her	L 051	1. The resident was not harmed by the deficient failure. The physicians order for tennis shoes was discontinued due to resident non-compliance. 2. Physician orders for all resident specific to tennis shoes were audited to ensure care plans were developed with goals and approaches. Any identified deficiencies were corrected. 3. To prevent future occurrences, licensed staff will be re-educated on physician orders and developing care plan with goals and approaches. 4. Compliance monitoring will be conducted by the clinical manager/designee. Monitoring will be added as a quality indicator and reviewed daily during stand-up meetings for 3 months and quarterly at the QA Committee. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

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L 051	Continued From page 5 wheelchair in the dayroom and wearing gray non-skid socks without tennis shoes. A face-to-face interview was conducted with Employee #5 on November 6, 2015 at approximately 12:00 PM regarding the aforementioned concerns. He/she acknowledged the findings, and further stated that resident does not like to wear the shoes; and would rather wear the non-skid socks. A review of the care plan section of the active clinical record revealed that there was no care plan initiated to address the resident ' s refusal to wear tennis shoes. Facility staff failed to initiate a care plan with goals and approaches to address Resident #15 ' s refusal to wear tennis shoes. The clinical record was reviewed on November 6, 2015. B. Based on record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that the charge nurse failed to review and revise one (1) resident's care plan with goals and approaches to address their program related to smoking cessation. Resident #68 The findings include: Facility staff failed to ensure that the smoking care plan for Resident #68 was revised to ensure that the smoking interventions were tailored to address the resident ' s smoking needs. A review of Resident # 68 ' s care plans revealed, " Focus: Resident is a smoker care plan last revised on 09/11/2015 ... Goal: Resident urge to smoke will decrease in 90 days. Interventions [included] ...Encourage resident to	L 051		2/9/16

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L 051	Continued From page 6 attend classes on how to stop smoking, date initiated 06/11/2012" A face-to-face interview was conducted with the social worker on November 6, 2015 at 12:40 PM, He/she stated, " The resident did not attend a smoking class. " A face-to-face interview was conducted with the social worker coordinator on November 9, 2015 at approximately 1:30 PM. He/she stated, " Smoking cessation classes are not offered here. " A review of the clinical record (nursing notes, physician ' s orders, reports of consultation and social work progress notes) There was no documented evidence that the resident ever attended smoking cessation classes; and there was no evidence that facility staff revised the care plan approaches tailored to the address the residents specific smoking cessation needs. A face-to-face interview was conducted with the Employee # 2 November 6, 2015 at 12:40 PM. He/she acknowledged the findings. The record was reviewed on November 6, 2015. C. Based on observations, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that the charge nurse failed to ensure that one (1) resident wore tennis shoes in accordance with physician's orders. Resident #15 The findings include: 1. Facility staff failed to ensure that Resident #15 wore tennis shoes in accordance with physician's	L 051	1. Care plan for this resident was reviewed to ensure that current goals and approaches address resident's smoking ability and smoking status. 2. Care plans for all residents who smoke were evaluated to determine the resident's smoking status and ensure that goals and approaches were identified and addressed the resident's smoking status. 3. To prevent future occurrences the social services staff will be re-educated on the smoking policy. Social workers will audit care plans specific to smoking on a routine basis and forward the results of their audit to the DON 4. Social Services department will conduct compliance monitoring of the resident care plans for 3 months and submit results to the DON. The Social Services department will also document and present findings to include corrective actions to the DON who will present at the quarterly quality assurance meeting. The QAC will ensure oversight and corrections of any identified issues. 5. Responsible person:DON	2/9/16

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L 051	Continued From page 7 orders. According to an annual history and physical dated May 30, 2015, Resident #15 had diagnoses which included: Hypertension, Hx [History of] debility, [History of] Hyperkalemia, Renal Insufficiency, and Depression A physician ' s order dated October 2, 2015 directed, " Patient to wear tennis shoes while in wheelchair for positioning. " Observations of Resident #15 on November 4, 2015 at 9:15 AM and 3:20 PM revealed that the resident was sitting in his/her wheelchair in the dayroom and was wearing gray non-skid socks without tennis shoes. A face-to-face interview was conducted with Employee #5 on November 6, 2015 at approximately 12:00 PM regarding the aforementioned concerns. He/she acknowledged the findings. The clinical record was reviewed on November 6, 2015.	L 051	1. The resident was not harmed by the deficient failure. The physicians order for tennis shoes was discontinued due to resident non-compliance. 2. Physician orders for all resident specific to tennis shoes were audited to ensure care plans were developed with goals and approaches. Any identified deficiencies were corrected. 3. To prevent future occurrences, licensed staff will be re-educated on physician orders and developing care plan with goals and approaches. 4. Compliance monitoring will be conducted by the clinical manager/designee. Monitoring will be added as a quality indicator and reviewed daily during stand-up meetings for 3 months and quarterly at the QA Committee. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that	L 052		

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L 052	Continued From page 8 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 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 staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to ensure that one (1) resident wore tennis shoes in accordance with physician's orders. Resident #15	L 052	1. The resident was not harmed by the deficient failure. The physicians order for tennis shoes was discontinued due to resident non-compliance. 2. Physician orders for all resident specific to tennis shoes were audited to ensure care plans were developed with goals and approaches. Any identified deficiencies were corrected. 3. To prevent future occurrences, licensed staff will be re-educated on physician orders and developing care plan with goals and approaches. 4. Compliance monitoring will be conducted by the clinical manager/designee. Monitoring will be added as a quality indicator and reviewed daily during stand-up meetings for 3 months and quarterly at the QA Committee. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: DON	2/9/16

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L 052	Continued From page 9 The findings include: 1. Facility staff failed to ensure that Resident #15 wore tennis shoes in accordance with physician's orders. According to an annual history and physical dated May 30, 2015, Resident #15 had diagnoses which included: Hypertension, Hx [History of] debility, [History of] Hyperkalemia, Renal Insufficiency, and Depression A physician ' s order dated October 2, 2015 directed, " Patient to wear tennis shoes while in wheelchair for positioning. " Observations of Resident #15 on November 4, 2015 at 9:15 AM and 3:20 PM revealed that the resident was sitting in his/her wheelchair in the dayroom and was wearing gray non-skid socks without tennis shoes. A face-to-face interview was conducted with Employee #5 on November 6, 2015 at approximately 12:00 PM regarding the aforementioned concerns. He/she acknowledged the findings. The clinical record was reviewed on November 6, 2015. B. Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to ensure that one (1) resident who was admitted with and indwelling urinary catheter [Foley] received appropriate treatment and services to restore or improve normal bladder function to the extent possible as evidenced by failure to follow through	L 052		

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L 052	Continued From page 10 with a physician ' s order for a urology consultation; additionally facility staff failed to consistently secure the resident ' s indwelling catheter tubing as directed by the physician. Resident #139 The findings include: Facility staff failed to ensure that Resident #139 was seen for a follow up urology consult in accordance with the physician's orders. Additionally, facility staff failed to consistently secure the indwelling catheter tubing as directed by the physician. A. A review of the clinical record revealed that Resident #139 was admitted to facility on August 24, 2015 with diagnoses that included BPH (benign prostatic hyperplasia) with urinary retention. A review of the hospital discharge summary dated August 23, 2015 revealed " Patient has a history of BPH (benign prostatic hyperplasia) and was previously discharged from [Hospital Name] with a Foley. Throughout admission, multiple voiding trials were attempted. Patient retained urine, however and the Foley was replaced ...On discharge, patient was maintained on a Foley and advised to follow up with urology as an outpatient. " Physician ' s Orders: The physician ' s "Admission Order Sheet" dated and signed August 26, 2015 directed that the Resident be scheduled with urologist for follow up care regarding urinary retention and indwelling Foley catheter.	L 052	1. Resident was seen by urologist on November 17, 2015. Foley catheter is strapped to resident's leg shift per physician's order 2. Medical records for all residents, with indwelling Foley catheters were audited to ensure that nursing interventions have been initiated and appropriate treatment and services to restore or improve normal bladder function have been implemented. Any identifications issues were corrected. All new admissions and re-admissions with indwelling catheters will be reviewed to ensure that a comprehensive assessment is developed and implemented to ensure appropriate nursing interventions, treatment and services. 3. To prevent future occurrences, all licensed staff will be trained on use of Foley Catheters, treatment, appropriate intervention, urinary tract infections and Bladder rehabilitation retraining. 4. Performance will be reviewed during daily stand-up meetings for 3 months and during the quarterly QA Committee meetings. QAC will ensure oversight. 5. Responsible Individual: DON	2/9/2016

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L 052	Continued From page 11 Interim order form dated October 21, 2015 directed, " Urology consult with [physician ' s name] at [Hospital Name] for benign prostatic hypertrophy indwelling Foley catheter." Physician's orders dated and signed October 26, 2015 directed, " Consults - Urology appt (appointment) with [Name of physician] call [phone number] to schedule." A review of Resident # 139' clinical record lacked evidence of an appointment with the urologist for follow up care regarding urinary retention and indwelling urinary catheter. A face-to-face interview was conducted with Employee #12 on November 4, 2015 at approximately 11:00 AM. The employee was queried regarding the order to schedule a urology consult. He/she acknowledged that Resident #139 ' s urology consult had not been scheduled as initially ordered in August 2015 when he/she was admitted into the facility. A face-to-face interview was conducted with Medical Director on November 5, 2015 at approximately 9:00 AM. He/she acknowledged that Resident # 139 should have been seen by the urologist prior to this meeting. A follow up interview was conducted with Medical Director on November 5, 2015 at approximately 11:00 AM. He/she stated, " The [Resident] has been scheduled for a follow up Urology consultation on November 17, 2015." The record was reviewed November 6, 2015. C. Facility staff failed to provide sufficient nursing time to ensure that Resident #139 ' s indwelling	L 052		

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L 052	Continued From page 12 catheter tubing was secured with a leg strap as ordered by the physician. A review of the physician's order dated and timed November 1, 2015 at 7:00PM directed, " Strap Foley catheter [tubing] to leg with strap q (every) shift. " A review of the resident's nurses noted dated and timed November 1, 2015 at 7:00 PM revealed " Around 6:30 PM while giving resident care CNA (certified nursing assistant) noted blood smear on resident ' s diaper and informed writer. On assessment resident was noted with slight irritations around the urethra. Catheter strap was applied to hold Foley in place to avoid further irritation. Resident was educated to avoid moving catheter pulling while trying move around the room ..." Observation: A tour of the 6th floor nursing unit was conducted on November 3, 2015, at approximately 8:45 AM. At this time Resident #139 was observed ambulating in hallway carrying his/ her Foley catheter bag with clear yellow urine in the tubing and drainage bag at waist level. Resident # 139 was observed ambulating in hall on November 3, 2015 at approximately 1:00 PM carrying his/her Foley catheter bag in his/her right hand clear yellow urine was in the tubing and bag at waist level. There was no evidence that facility staff consistently secured Resident #139 ' s indwelling catheter tubing with a leg strap as ordered by the physician.	L 052	1. The Nurse Practitioner was inserviced on Resident's Rights and preserving/enhancing dignity while providing care. Resident#139 was provided a dignity cover for the urine drainage immediately upon discovery. 2. All staff have been instructed to intervene when a Resident's dignity is compromised and immediately report incident to facility leadership. All residents with indwelling catheters were checked to ensure coverage of urine drainage bag. Any identified issues were corrected. 3. To prevent future occurrences, all staff will be in serviced on Residents rights and preserving/enhancing dignity. 4. Random observations of the day rooms will be made to ensure that all residents are treated with dignity and respect for 3 months. Monitoring of residents with foley catheters will be added as a quality indicator for review during daily stand-up meetings for 3 months and addressed at quarterly Quality Assurance meeting. The Quality Assurance Committee will ensure oversight and correction of any identified issues. 5. Responsible individual: DON	2/9/16

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L 052	Continued From page 13 A face-to-face interview was conducted with Employee #12 on November 5, 2015 at approximately 11:00 AM. He/she was queried regarding the indwelling catheter leg strap to secure Resident #139 ' s tubing. He/she acknowledged the aforementioned findings. The record was reviewed November 5, 2015.	L 052	1. The facility is now staffed to meet the maximum daily average. We have hired additional nurses.	
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the Nursing Facility failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day on three (3) of eight (8) days reviewed and the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on two (2) of the eight (8) 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	L 056	2. The DON received management approved to hire additional nursing staff to meet resident needs and regulatory agency requirement when necessary, overtime will be used and schedule modifications will continue to be made until sufficient 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 and care delivery as ordered and as required. The daily nursing staffing ratio is a quality indicator and is 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 individuals: DON	2/9/16

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L 056	Continued From page 14 November 3, 2015 at approximately 3:00 PM. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/Advanced Practice Registered Nurse for two (2) of eight (8) days reviewed as outlined below. October 31, 2015 it was determined that the facility provided RN coverage at a rate of 0.4 hours. November 1, 2015 it was determined that the facility provided RN coverage at a rate of 0.4 hours. The facility failed to meet the four and one tenth (4.1) hours of direct nursing care per resident per day, for three (3) of eight (8) days reviewed as outlined below: October 30, 2015 it was determined that the facility provided direct nursing coverage at a rate of 3.1 hours. October 31, 2015 it was determined that the facility provided direct nursing coverage at a rate of 3.5 hours.	L 056		

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L 056	Continued From page 15 November 1, 2015 it was determined that the facility provided direct nursing coverage at a rate of 3.2 hours. A face-to-face interview/review was conducted with Employee #16 on November 9, 2015 at approximately 3:00 PM. He/she acknowledged the findings. 3219.1 Nursing Facilities	L 056		
L 099	Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on November 2, 2015 at approximately 9:30 AM and on November 4, 2015 at approximately 9:40 AM and on November 9, 2015 at approximately 1:15 PM, it was determined that the facility failed to store and prepare foods under sanitary conditions as evidenced by three (3) of 11 expired packs of chicken broth, four (4) of eight (8) dusty fire suppression heads, 27 of 27 pans that were stored wet, one (1) of three (3) third-pans and two (2) of 15 half-pans that were dented, two (2) of 15 half-pans and three (3) of nine (9) shotgun pans that were soiled and marred. The findings include: 1. Three (3) of 11 packs of chicken broth were expired as of October 29, 2015.	L 099		

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L 099	Continued From page 16 2. Four (4) of eight (8) fire suppression heads were soiled with dust particles. 3. Three (3) of three (3) third pans, 15 of 15 half-pans and nine (9) of nine (9) shotgun pans were stored wet. 4. One (1) of three third-pans and two (2) of 15 half-pans were dented. 5. Two (2) of 15 half-pans and three (3) of nine (9) shotgun pans were soiled. These observations were made in the presence of Employee #28 who acknowledged the findings.	L 099	1. The Executive Sous Chef in serviced utility team on storage standards and proper cleaning procedures. 2. All inventory was checked for expiration dates. The Fire Suppression hoods have been cleaned. The dented pans have been discarded Food Services Director has conducted environmental rounds to identify and correct any deficient practice. 3. To prevent future occurrences the Food Service Director/designee will conduct monthly environmental rounds and document findings. Performance will be reported to the quarterly Quality Assurance committee meeting. QAC will ensure oversight and corrections of any identified deficiencies. 4. Responsible Individual: Food Service Director	
L 104	3219.6 Nursing Facilities Each food service employee shall wear either a hair net or other head covering. This Statute is not met as evidenced by: Based on dining and kitchen observations made on November 2, 2015 at approximately 9:30 AM and on November 4, 2015 at approximately 9:40 AM and on November 9, 2015 at approximately 1:15 PM, it was determined that the facility failed ensure that each food service employee wear a hair net as evidenced by one (1) staff member who failed to wear a beard cover while serving food on the tray line. The findings include: One bearded staff member was serving food on the tray line without a beard cover.	L 104	1. The staff member has been provided with beard restraints to use along with wearing a hair net. 2. All male staff have been provided with beard covers. 3. To prevent future occurrences the Food Service Director/designee will reeducate male staff regarding importance of beard covers. 4. Random checks will be made for 3 months.Performance will be reported to the quarterly Quality Assurance committee meeting. QAC will ensure oversight and corrections of any identified deficiencies. 5. Responsible Individual: Food Service Director	2/9/16
L 186	3230.2 Nursing Facilities	L 186		2/9/16

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L 186	Continued From page 17 Each resident shall be encouraged, but not required, to participate in the resident activities program. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 47 Stage 2 sampled residents, it was determined that facility staff failed to ensure that the resident had an ongoing program of activities that met the residents needs in accordance with the comprehensive assessment as evidence by the resident not participating in out-of-room activities. Resident #16. The findings include: A family interview was conducted on November 4, 2015 at approximately 10:25 AM with Resident #16. A query was asked to the family member, " Does staff encourage [resident name] to attend activities and provide assistance to attend them? " The family member responded " No, they [facility] do not get [him/her] up and [he/she] does not come out of the room for activities. " A review of the medical record revealed that Resident #16 was admitted to the facility on April 6, 2015 with diagnoses which included Diabetes Mellitus, Hypertension, Debility ... " A review of the Quarterly MDS [Minimum Data Set] with an ARD [Assessment Reference Date] of July 15, 2015 and September 18, 2015 revealed Section G Functional Status G0110 " Activities of Daily Living (ADL) Assistance F. locomotion off unit: how resident moves to and returns from off-unit-locations (e.g areas set aside for dining, activities or treatments). If facility has only one floor, how residents moves to and from distant areas on the floor. If not wheelchair,	L 186	1. Resident #16 has been reassessed to ensure that an activities program is designed to meet his/her interests and physical, mental and psychological well-being. The resident was not harmed by the deficient practice. 2. Each resident was reassessed to ensure that his/her recreational therapeutic needs are met. Any identified issues were corrected. 3. Staff will be re-educated on the delivery of therapeutic activities. Staff competencies will be developed. 4. Monitoring will be added as a quality indicator for review during daily stand-up meetings for 3 months and Quarterly meetings. The QA committee will ensure oversight and correction of any identified deficiencies. Quality Assurance Committee meetings. 5. Responsible individual: DON	2/9/16

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L 186	Continued From page 18	L 186		

self-sufficiency ne in chair) was coded : self performance 8 (eight) : Activity did not occur: activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 days; and support : 8 ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time for that activity over the entire 7 day period. "

A review of the residents facility " Activity Assessment " date April 7, 2015 revealed the resident preferred " Arts and crafts, board games, Discussions/speakers, entertainers, gardening, movies, television, outings, sing-a-longs, socials ... "

A review of the resident's care plan with a review date of October 29, 2015 revealed, " [resident ' s name] is dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] physical limitations, immobility, cognitive deficits... "

The resident was observed on several occasions throughout the survey period in room and lying in bed with the television on. No other interaction was observed.

A face-to-face interview was conducted with Employee #26 on November 10, 2015 at approximately 11:30 AM. A query was made regarding the resident ' s family member ' s concern of the resident not getting up out of the bed and out of the room for activities. Employee #26 stated, that is a concern, we really need for the staff to get the resident up, into the geri-chair and out-of-the rooms to attend the activities.

Recreation Progress Notes:

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L 186	Continued From page 19 A review of the Recreational Progress Note dated August 5, 2015 revealed " [Resident ' s name] does not participate in out of the room activities, probably due to [him/her] have pneumonia and no strength to be motivated to participate ...[His/her] brother will be used along with the Residents Council to advocate for [resident ' s name] to be out of bed and out of room 1-2 [times] a week ... " A review of the " 6th floor 1to 1 Visitation Log " dated June 25, 2015 revealed " visit with [resident name] walk to [his/her] bed side to say hello. [resident name] seem to be asleep. Just made sure that [his/her] T.V. [television] was on in case [he/she] wakes up for sound. " A review of the " 6th floor 1to 1 Visitation Log " dated July 4, 2015 revealed " one to one visit with [resident name] said hello and happy 4th of July, ...I encourage [him/her] to some day get out of bed to visit the day room, and so did [his/her] [family member] ... " A review of the " 6th floor 1 to1 Visitation Log " dated August 20, 2015 revealed " visit with [resident name] was laying look at T.V. I ask[ed] how [he/she] was doing and [he/she] just shake [his/her] head I read the sport[s] page ...left [him/her] listening to music [his/her] roommate was playing ... " There was no evidence that the facility made efforts to ensure that the resident had an ongoing program of activities that met the residents needs in accordance with the comprehensive assessment as evidence by the resident not participating in out-of-room activities. The record was reviewed on November 9, 2015.	L 186		

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L 214	Continued From page 20	L 214	1. The residents were not harmed by this deficient practice. Residents #45, #95, #134,#44 and #134 were assessed via the facility's smoking policy and have a current smoking evaluation and care plan in place National Fire Protection Association approved Ashtrays have been purchased and placed in designated smoking area. Signs identifying designated smoking areas are in place. 2. All residents that smoke have been assessed according to facility's smoking policy and have a current smoking evaluation and care plan in place. 3. All staff will be in-serviced on ensuring that facility is free of potential accident hazards. 4. To prevent future occurrences, the Administrator will conduct weekly Environmental rounds to ensure signs for designated smoking area and NFPA receptacles remain in place. Identified issues will be immediately addressed and documented in the work order system for scheduled correction. QAC will ensure oversight and corrections of any identified deficiencies. Performance will be reported at the Quarterly Quality Assurance committee meeting. 5. Responsible Individual: Administrator	2/9/16
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations, record review and staff interview, it was determined that facility staff failed to ensure that the facility was free of potential accident hazards as evidenced by the lack of adequate receptacles to ensure the safe disposal of smoking materials for 16 of 16 residents that engaged in smoking activities. The findings include: According to National Fire Protection Association (NFPA) 2000 Edition, 19.7.4..."3) Ashtrays on noncombustible material and safe design shall be provided in all areas were smoking is permitted. 4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking in permitted." A review of the facility ' s records revealed that sixteen (16) of 117 residents residing in the facility engaged in smoking activities. A review of the facility ' s smoking policy read as follows: Smoking Policy, # ADM01-028, Effective date 10/20/15 stipulates: Smoking is only permitted in a designated outdoor smoking area. Smoking cessation is	L 214		

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L 214	Continued From page 21 encouraged and interventions are implemented as per physician orders. Purpose: 1. To limit smoking to a specific area for the safety of smokers. 2. To provide a safe and comfortable environment for non-smokers. Procedure: A: General 3. An area designated as a smoking area will be separate from patient care areas (e.g., outdoors), will be well ventilated. 4. Smoking (including electronic cigarettes) will only be allowed in designated areas. H: Safety Measures 1. Designated smoking area will have ashtrays to dispose of smoking materials 2. Security will maintain a " Fire Blanket " at the entrance desk to be used on a resident in case of smoking accident. 3. Staff member working with supervised smokers will carry " Fire blanket " to designated smoking are while escorting smokers. 4. Staff member will carry a two way radio to communicate with security in case of emergencies. 5. Security will maintain a fire extinguisher at the entrance desk to be used to extinguish a fire as a	L 214		

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L 214	Continued From page 22 result of a smoking accident. On November 5, 2015 at approximately 1:15 PM in the presence of Employee #1, the facility's designated outdoors smoking area was observed. Two (2) residents were observed smoking while seated in chairs along the sidewalk adjacent to the main entrance of the facility. Employee #34 was observed standing proximal to the smoking area holding a red bag labeled " fire blanket " and one (1) plastic black ash tray without a cover was observed atop the red bag. There was no cigarette waste (i.e. butts) observed in the ash tray; however multiple cigarette butts were observed scattered along the concrete sidewalk. Employee #1 stated that the staff person supervising smoking activities would offer the residents use of the ashtray. However; s/he acknowledged that the single plastic black ash tray was inadequate and did not encourage and/or ensure the practice safe disposal of cigarette waste. Observations: Residents were observed smoking in front of or near the main entrance of the facility and surrounding areas as follows: On November 3, 2015 at approximately 08:30 AM, three (3) Residents #45, #95 and #134 were observed smoking cigarettes in front of the main entrance doors of the facility. [There was no smoking receptacle or signage that designated this area as a smoking area]. On November 4, 2015 at approximately 2:00 PM, Residents # 44 and #134 were observed in front of the main entrance doors smoking cigarettes.	L 214		

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L 214	Continued From page 23 [There was no smoking receptacle or signage that designated this area as a smoking area]. Resident # 44 was observed smoking in front of the main entrance door on Wednesday, November 4, 2015 at approximately 5:00 PM. [There was no smoking receptacle or signage that designated this area as a smoking area]. On November 5, 2015 at approximately 8:30 AM, Residents #45, and #95 were observed sitting in wheelchairs smoking cigarettes on side walk in front on main there was no smoking receptacle or smoking signage present. On November 5, 2015 at approximately 1:00 PM, Resident #44 was observed smoking cigarettes on side walk in front on main entrance there was no smoking designated signage present. Throughout the survey period cigarette butts were observed scattered along the surface of the sidewalk proximal to the main entrance of the facility. Facility staff failed to ensure that the designated smoking area was equipped with adequate receptacles for the safe disposal of cigarette waste. There was no evidence of signage to designate the area proximal to the main entrance of the building as the " smoking area. "	L 214		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive	L 410		

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L 410	Continued From page 24 manner. This Statute is not met as evidenced by: Based on observations made on November 4, 2015 at approximately 3:00 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 soiled covers to the AC/Heat units in 10 of 26 resident ' s rooms, dusty bathroom vents in 11 of 26 resident ' s rooms, loose privacy curtains in ten (10) of 26 resident ' s rooms, stained privacy curtains in one (1) of 26 resident ' s rooms, torn privacy curtains in one (1) of 26 resident ' s rooms, a fire extinguisher that needed to be recharged on the sixth floor, marred walls in three (3) of 26 resident ' s rooms and a non-functioning door bell on the seventh floor. The findings include: 1. Covers for the Air Conditioner/Heating units were soiled and clogged with paint in five (5)of 26 resident's rooms. Rooms # 619, 644, 702, 718, and 722 2. Bathroom vents were soiled with dust on the inside and outside in 13 of 26 resident's rooms. Rooms #601, 604, 610, 616, 619, 625, 629, 641, 644, 702, 718, 750, and 755. 3. Privacy curtains were hanging loosely off the hooks in seven (7) of 26 resident's rooms. Rooms # 601, 641, 637, 702, 718, 752, and 755 4. Two (2) of two (2) privacy curtains were stained in room #644.	L 410	(1) Covers for the Air Conditioner /Heating units in rooms 619, 644, 702, 718 and 722 were ordered. (2) The bathroom vents for rooms # 601, 604, 610, 619, 625, 629,641, 644, 702, 718,750 and 755 were cleaned on the inside and out. (3) Hooks were adjusted for privacy curtains in rooms # 601, 641,637, 702, 718,752 and 755. (4) Privacy curtains in rooms # 644-A and 644B will be replaced (5) Privacy curtain in room #656 (B) will be replaced. (6) The fire extinguisher located across from room #623 has been replaced (7) The marred walls in resident rooms have been repaired (8) The doorbell to the rehabilitation department has been repaired Environmental rounds were conducted on both units to identify and correct any outstanding issues. Performance will be monitored during weekly environmental rounds. Identified issues will be immediately addressed or documented in the work order system for scheduled correction. Environmental issues will be added as a quality indicator for review during daily stand-up meetings and addressed during the quarterly Quality Assurance committee meetings. Responsible individual: Administrator	2/9/16

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 _____	11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 25 5. One (1) of two (2) privacy curtain was torn in room # 656 (B). 6. The fire extinguisher located across from room #623 needed to be recharged. 7. Walls in three (3) of 26 resident's rooms were marred. 8. The door bell to the rehabilitation department was not functioning. These observations were made in the presence of Employees #29 and/or #30 who acknowledged the findings.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made on November 4, 2015 at approximately 10:00 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen in dietary services during a tour of the main kitchen. The findings include: Flying insects were observed in the main kitchen area on November 4, 2015 at approximately 10:00 AM.	L 426	The Facility pest control company has sprayed for insect elimination. All drains and trash cans and drains have been cleaned. To prevent future occurrences the Food Services Director will conduct weekly rounds to identify and correct deficiencies. Performance will be reported to the quarterly Quality Assurance meeting. Responsible Individual: Director of Food Services.	2/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 426	Continued From page 26 These observations were made in the presence of Employee #28 who acknowledged the findings.	L 426		