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L 000	Initial Comments The Annual Licensure Survey was conducted at Unique Residential Care Center during the period of February 01, 2017 through 8, 2017. Survey activities consisted of a review of 38 residents' clinical records. The following deficiencies are based on observation, record review and staff interviews. 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 CFU- Colony Forming Unit 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	L 000	Unique Residential Care Center make its best efforts to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Laws.	

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L 000	Continued From page 1 Lbs. - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician's order sheet Prn - As needed Pt - Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L 051		

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L 051	Continued From page 2 (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to review and revise one (1) resident's care who sustained multiple falls. Resident #175. The findings include: The facility staff failed to review and revise a care plan for multiple falls with appropriate goals and approaches for Resident #175 . A review of the care plans last updated February 3, 2017 revealed that the care plan lacked evidenced of revision with appropriate goals and approaches for falls that occurred on October 24, 2016, November 20, 2016 and December 28, 2016	L 051	1. Resident# 175 care plan for fall was reviewed and updated with approaches. 2. Audits of residents with history of falls were reviewed to identify other residents that require updated fall care plans. Follow up will be completed as indicated. 3. Nurse Managers will be re-educated on the policy and procedures on care plan update. Nurse Manages or designee will conduct monthly audits of residents with falls to ensure care plans are updated with new interventions. 4. Audits of residents care plans with falls will be conducted monthly by Nurse Managers or designee for the next 3 months to monitor care plan updates. The results of the audit will be reported to QA committee monthly to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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L 051	Continued From page 3 . A review of the nursing notes revealed the following: "October 24, 2016- 8:30 PM- Resident called for help ... Resident was noted on the floor lying on [his/her] left side .... November 20, 2016-2:36 PM- Resident is observed lying on the floor of the courtyard on a right lateral position at 1328 (1:28 PM) by security guard at the court yard. Resident states that [he/she] tried to push [himself/herself] back from an edge in the courtyard while sitting on the wheelchair and fell ... December 28, 2016- 3:55 AM - Resident observed lying on the floor beside [his/her] bed ...When asked what happened; resident state's "I just feel like lying down on the floor." No visible injury noted... A face-to-face interview was conducted on February 1, 2017 with Employee #6 at approximately 1:00 PM. After review of the care plans, he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 6, 2017.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and	L 052		

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L 052	Continued From page 4 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 j) Prompt response to an activated call bell or call for help.	L 052		

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L 052	Continued From page 5 This Statute is not met as evidenced by: 1. Based on record review and staff interview for one (1) of 38 Stage 2 Sampled residents, it was determined that facility staff failed to accurately and consistently assess and/or monitor the skin integrity [surgical site] for Resident #262, which resulted in harm. The resident was admitted on 1/27/17, there was no evidence that the nursing facility identified and/or acted on any abnormalities with the wound; the resident was evaluated by an outside consultant during a routine follow-up appointment approximately 10 days post admission wherein the wound was determined to have deteriorated and required emergency management. The nursing facility's failure to assess the wound contributed to the wound deterioration requiring transfer to a local emergency department and same day "urgent" surgical intervention of the surgical wound . The findings include: Res #262 was admitted to the facility on January 27, 2017 status post-surgery of the lumbar spine. He/she was admitted with a surgical wound of the lower back for which a wound vac (negative-pressure wound therapy using a vacuum assisted drainage technique to remove blood or serous fluid from a wound or operation site) was administered for management of drainage from the lumbar surgical site during his/her hospital stay. During an evaluation of the resident's surgical site by an outside-of-the-facility consultant on Feb 6, 2017 (10 days' post admission to the nursing facility) the resident was assessed with "foul-smelling pus" draining from the surgical site and transferred to an acute care	L 052	1. Resident # 262 was sent from facility for pre-scheduled appointment with surgeon on February 6, 2017. As per facility assessment, there were no complication from wound noted before and during the transfer to appointment. 2. All residents with wounds will be assessed to ensure accurate comprehensive assessment and accurate documentation of wounds as per policy and procedure. Follow up will be completed as indicated. 3. Licensed nurses will be re-educated on policy and procedure regarding accurate/consistent assessment and documentation of wounds. 4. Audits of resident skin sheets and corresponding nurses' note will be done on residents with wounds to ensure there is accurate and consistent assessment and documentation of wounds. The result of the audit will be reported monthly to QA committee for next 3 months to monitor process towards improvement. This 309 deficiency will be discussed at next medical staff meeting.	4/6/17 4/6/17 4/6/17 4/6/17

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L 052	Continued From page 6 hospital for emergency surgical intervention for wound washout and debridement. A review of the facility's assessments of the resident's altered skin lacked evidence of deterioration or lack of healing. Additionally, the documented assessments reviewed in the resident's medical record lacked evidence of accuracy, completeness and consistency as follows: According to the "Discharge/Transfer Summary" from the hospital dated January 27, 2017 15:48 (3:48 PM), the resident's discharge diagnoses included "Acute postoperative pain, Morbid Obesity, [status post] spinal fusion [of the vertebral column thoracic through sacral region] for scoliosis and Anemia ...Hospital Course... POD (Post-op day) #13 (1/25/17); The inferior aspect of [his/her] incision began to leak. [His/Her] incision was partially reopened at bedside, and a wound vac was placed. POD #15; ...Subsequently deemed medically stable, and discharged to subacute rehab. [His/her] current wound vac was placed on 1/25. It will be clamped for transport to the facility. [His/her] wound vac should be changed twice weekly with small black granulofoam. Please keep [his/her] bulk off the lily pad. Decision can be made by wound care team at facility regarding when they feel it is appropriate to change to wet to dry dressings." The nursing admission note dated January 27, 2017 at 7:12 PM revealed "Resident admitted to [skilled facility named] from [acute hospital named] at this time; resident arrived BIBA (brought in by ambulance) from [name hospital] this pm; resident has a medical history significant for respiratory failure post op; anemia due to acute blood loss; acute post-operative pain;	L 052		

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L 052	Continued From page 7 history of spinal fusion for scoliosis; morbid obesity; presently resident presents as alert and oriented x [times] 3; ... integumentary inspection reveals s/p (status post) surgical site to back extending from cervical to sacral spine with staples in place wound closure; s/p surgical site to abdomen measuring 16cm in length.. MD (Medical Doctor) notified and verified all orders ... MD gave wound care orders until wound vac to be implemented ..." The physician prescribed a wound vac to manage Resident #262's surgical wound as noted in the following admission order: January 27, 2017 "1/27/17 (no documented per physician) ....Turn and position every 2 hours, chart by shift, OOB (Out of bed) with assistance, Reverse Trendelenburg when in bed, do not flex, OK to sit upright in chair, Current wound vac (negative-pressure wound therapy using a vacuum assisted drainage technique to remove blood or serous fluid from a wound or operation site) placed on 1/25/17, wound vac to be changed twice weekly with small black granulofoam, keep bulk off lily pad, wound care team to decide when appropriate to change to wet-dry dressing ..." The physician prescribed an alternate treatment to manage the resident's surgical wound after licensed nursing staff advised him/her of their inability to carry out the aforementioned order for the wound vac: January 27, 2017 (1/27/17) - 7:30 PM directed; " ... Wound care to back - Cleanse [with] DWC (Dermal Wound Cleaner), Apply Xerofoam to	L 052		

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L 052	Continued From page 8 surgical site, cover with Bordered Foam Dressing until wound vac placed... The physician's history and physical examination ["Admission Assessment form"] dated January 29, 2017 revealed; "Chief Compliant/Reason for Admission: Rehab (Rehabilitation) and 24-hour care ... male/female with morbid obesity, Recent medical course ... S/P (Status Post) Laminectomy (surgery that creates space by removing the lamina- the back part of the vertebra that covers your spinal canal) and Spinal Fusion..." A written statement dated February 8, 2017 [no time indicated] written by Employee#21 [clinical manager - registered nurse] revealed; "Resident arrived to [named skilled nursing facility] on 1/27/17 with wound vac dressing in place. I was informed by Director of Admissions that day that I was only to attach the wound vac device to the dressing on the resident. However, the wound vac device would not attach to the dressing due to differing connections/attachments. I then notified the Director of Nursing who instructed me to call the Medical Director. I then called the Medical director who gave wound care orders [wet-to-dry dressing until wound vac available]." A review of Resident#262's clinical record revealed inconsistencies regarding the implementation of the wound vac. Licensed nursing staff recorded that the wound vac was initiated on January 27, 2017. However, according to interview and record review, the wound vac was not implemented until January 30, 2017 as evidenced by the following: Wound/skin sheet dated January 27, 2017:	L 052		

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L 052	Continued From page 9 "Date of Onset/Origin: January 27, 2017- Site/Location: Lower Back (Lumbar); Type of Wound: Surgical; Exudate Type: Serious; Odor: None; Exudate amount: Large; Wound Bed: Pink/Beefy Red, Comments: Wound vac applied ... Nurse's entry: "January 30, 2017- 04:31 PM- ... Resident's wound vac in place and draining. Staples and surgical site intact with no sign of infection..." Wound/skin sheet dated January 30, 2017: January 30, 2017 - Site/Location: Lower Back (open area); Type of Wound: Other: Surgical (wound vac); Size: 4cm x 2cm; Depth: 1 cm; Exudate Type: Serosanguineous; Odor: None; Exudate: Amount: Moderate; Wound Bed: Pink/Beefy Red, Date notified physician: 1/30/17, Comments: wound vac applied, functioning and draining well. The history and physical examination documented by the physician on January 29, 2017 revealed the following under the section labeled skin: "surgical wound lumbar area ...sacral wound ..." There was no evidence of a comprehensive assessment regarding the characteristics of the resident's wound(s). Additionally, there were no successive notes recorded by the primary care physician. Subsequent to the physician's visit of January 29, 2017, the prescribed wound treatment orders were modified to include the use of a highly absorbent dressing as noted below: January 29, 2017 (1/29/17) - 5:00 PM- ... "(1)	L 052		

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L 052	Continued From page 10 Please clean lower back (Lumbar) surgical wound [with] normal saline- Apply Maxorb Extra Alginate (highly absorbent dressing used for moderate to heavily drainage wounds) on wound area cover [with] Derma rite daily [times] 10 days... As noted above, the wound vac was applied on January 30, 2017 and according to nurse's notes, was draining as noted in the following nurse's entry: February 2, 2017 at 10:56 PM "... wound vac in place draining serosanguinous, Staples and surgical site intact ..." The wound vac was 'dislodged' on February 3, 2017 (4 days post implementation of the wound vac) as noted by the following nurse's entry: February 3, 2017 at 6:49 PM "While resident was having x-ray AP (Anterior-Posterior) lateral, T-spine (Thoracic Spine) and L-spine (Lumbar Spine). Wound vac became dislodged. [MD named] notified, new order to D/C (Discontinue) wound vac and restart previous dressing changes until wound Vac replacement arrives. Dressing applied as ordered ..." The nurses' notes lacked consistent documentation depicting the characteristics of the resident's surgical wound at the time of dislodgement, there was no information regarding the type of exudate as evidenced by the following wound/skin sheet dated February 3, 2017: February 3, 2017: Site/Location: Lower back (open area) surgical wound; Type of Wound: Other: Surgical; Size: 4 cm x 2cm; "0" depth; Exudate Type: no assessment recorded (space was blank); Odor: None; Exudate amount: Small;	L 052		

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L 052	Continued From page 11 Wound Bed: Pink/Beefy Red; Plan of Care Updated: Wound vac dislodged when doing X-ray- 45 staples intact ..." Physician's wound treatment order post wound vac dislodgement: February 3, 2017 (no time indicated) - - Telephone order: D/C (Discontinue) wound vac- Clean surgical wound on lower back [with] NSS (Normal Saline Solution), Apply Maxorb Exra Alginate on wound Area-cover with Derma rite daily and PRN (as needed) ..." The medical record lacked evidence that the physician assessed and reevaluated the resident's wound(s) after the dislodgment of the wound vac. There was no evidence that staff consistently monitored the status of Resident #262's surgical site post dislodgement. Nurse's notes revealed wound treatments were performed daily, however; there was no evidence of comprehensive assessments of the characteristics of the surgical wound subsequent to the dislodgment of the wound vac. Nurse's notes read as follows: 2/3/2017- 11:18 PM "... wound dressing intact. X-ray result was received no evidence of fracture reported ..." 2/4/2017- 06:54 AM "... wound dressing intact ..." 2/4/2017-04:15PM "... Tolerated dressing change to back surgical wound with minimal discomfort. 2/4/2017-11:27 PM "... wound dressing intact ...	L 052		

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L 052	Continued From page 12 02/5/2017- 06:41 AM " ... Spinal incision dressing intact with no drainage or odor ..." 02/5/2017-05:24 PM - "Wound dressing intact. Serosanguineous drainage noted" 02/06/2017- 12:05 AM "... wound dressing intact with Serosanguinous drainage noted ..." 02/06/2017-06:40 AM- "... spinal incision dressing is drained. Dressing is cleaned with normal saline and dressed. Resident is cleaned and made ready for [his/her] appointment this AM. SIC (written as documented)" A review of the treatment administration record [TAR] for February 2017 revealed the nurse's initials in the slot for February 6, 2017 indicative that the wound treatment was performed prior to the resident's departure for an appointment outside to the facility. Note, as per physician's order dated February 1, 2017 "f/u [follow up] with Neurosurgeon [named] for staple removal on Monday, February 6, 2017 at 9:00 AM." An assessment conducted by an out-of-facility consulting physician at approximately 10:48 AM on February 6, 2017 (within hours of leaving the facility) characterized Resident #262's wound as "actively draining foul smelling purulence [exudate]." The Neurosurgery (outside consulting physician) note dated February 6, 2017 read: "... discharged from [hospital named] on 1/27/17 presenting to [MD named] clinic today for a postop check with signs and symptoms	L 052		

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L 052	Continued From page 13 concerning for wound breakdown including a ~ 10 cm segment of wound breakdown in the lumbar and sacral region with actively draining foul-smelling purulence. [He/she] was sent to the ED (Emergency Department) for wound washout in the OR (Operating Room) today ... Physical Exam ... Incision with ~10cm region of wound breakdown in the lower lumbar and sacral area with actively draining foul-smelling purulence ... Plan: Patient going to OR today as an add-on for wound washout and debridement ..." A review of the ED (Emergency Department) dated February 6, 2017 at 11:52 AM revealed; "Pt (Patient) presented to ED ...Pt reports [he/she] had back surgery in January 2017 ... Pt unable to stand independently. Pt arrived in w/c (wheelchair); 4 staff members [plus] [patient's relative named], assisted patient to the bed from wheelchair. Serousanguinous fluid (large amount dripped on the floor. Patient wound is approx. (approximately) 10 cm (centimeters) in length, width unable to determine ... Pt was transferred to OR (Operating Room) for wound vac placement." According to an "Operative Report" dated 2/6/2017 - 12:48 AM; "Pre-operative diagnosis: Lumbar wound; Post-operative diagnosis: Wound Dehiscence ..." In summary, Resident #262 was admitted to the facility with an intent for management of his/her post-operative surgical wound with a wound vac. The wound vac was applied for a period of 4 out of 10 days that the resident resided in the facility. On the 10th day post admission, the resident was assessed by an outside consultant who identified the surgical wound as deteriorated and sent the	L 052		

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L 052	Continued From page 14 resident to the hospital for emergency management and surgical intervention. There was no evidence that facility staff, who observed the resident's wound hours prior to the outside consulting physician, identified any abnormalities or failure of the resident's wound to heal. Staff failed to accurately assess and consistently characterize the resident's wounds and recorded inconsistencies in wound treatments. Additionally, the clinical manager identified that the resident was admitted with the vac dressing in place. However, he/she could not attach the tubing to create a negative vacuum pressure to assist with drainage of the surgical wound to promote healing. A face-to-face interview was conducted with the Director of Nursing on February 8, 2017 at approximately 2:30 PM regarding the date the wound vac was re-applied. He/she states that the wound vac was connected on January 30, 2017. Further stated, that she/he received a phone call (on January 27, 2017) from the Employee#21 [clinical manager - registered nurse] regarding his/her inability to connect the wound vac because of "tubing issue." Employee#21 was instructed to inform the physician to get orders and document the "concern/inability to connect tubing". When queried; what made the difference in the wound vac being applied three (3) days later; he/she stated that a new wound vac kit was used. After review of the clinical record, he/she acknowledged the aforementioned findings. The clinical record was reviewed on February 8, 2017. 2. Based on observation, record review and staff	L 052		

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L 052	Continued From page 15 interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident's Midline Inserted Catheter was flushed and monitored in accordance with the attending physician's order. Resident #221. The findings include: 2a. Facility staff failed to flush a midline catheter in accordance with the physician's orders for Resident #221. An interim physician's order dated January 24, 2017 at 6:00 PM directed: " Consent for Midline, (2) Insert a midline IV (Intravenous) Zosyn 2.25GM every 8 hourly [times] 7 days for UTI (Urinary Tract Infection) ..." According to a "Physician Progress Note" dated January 30, 2017 Resident #221's "chief complaint was "UTI"... Plan/Impression: Complete course of antibiotic..." A review of the Mid-Line Catheter Protocol dated and signed by the physician on January 25, 2017 revealed: " Flushing Protocol: Use SASH (Saline, Antibiotic, Saline, Heparin) Technique ... Intermittent Meds, 5 Ml (millimeters) NSS (Normal Saline Solution) before med, 5 ml NSS after med; Then 5 ml 100 Unit/ml Heparin Flush; Treatment Protocols: Change tubing q (every) 24 hours primary and secondary intermittent ..." The January, 2017 Central - Catheters flow sheets and the MAR [Medication Administration Records] lacked evidence (spaces left blank) that	L 052	1. Review of resident #221 was conducted and resident did not have any adverse effect. 2. Resident mid line was removed on Feb 8, 2017, and there is no other resident with similar order. 3. Licensed nurses will be re-educated on policy and procedure regarding monitoring of midline catheter according to physician order. 4. Audits of resident (s) with mid line will be conducted to ensure there is documentation regarding midline catheter monitoring according to physician order. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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L 052	Continued From page 16 facility staff flushed the resident's mid line catheter on January 26, 27, 28 and 29, 2017. A face-to-face interview was conducted on February 7, 2017 with Employee #10 at approximately 10:30 AM. After review of the above he/she acknowledged the findings. The record was reviewed on February 7, 2017 2b. Facility staff failed to monitor Resident #221's Midline Catheter in according to physician orders. A review of the Central-Line Catheters protocol signed by the physician on January 25, 2017 directed: "Measure Arm Circumference 27 inches above insertion site on admission, PRN (as needed) and Q (every) 7 (seven) days with dressing change, Measure external catheter length on admission, with each dressing change and PRN, Q 7 days with dressing change ...." The [external consultant's named] Vascular Access Patient Information sheet dated January 25, 2017 revealed; ".... Side: Right; Vein: Branchial- External CM (circumference measurement) -0; Arm Circumference at Site: 27 cm (centimeters) ..." A nurse's note dated January 31, 2017 at 12:33 AM revealed; "... Dressing change done for midline to right upper arm with central line kit. Resident tolerated procedure well. Area cleanse aseptically and new dressing placed, dated and initialed. Resident continues with current plan of	L 052		

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L 052	Continued From page 17 care." A review of the Central-Line Catheters monitoring flow sheets, MAR (Medication Administration Record) and Nurses Notes from January 31, 2017 through February 2, 2017 lacked any evidence of measurements of the resident's upper arm circumference or the external catheter length according to the midline catheter protocol. A face-to-face interview was conducted on February 7, 2017 with Employee # 8 at approximately 10:30 AM. After a review of the above clinical record he/she acknowledged the aforementioned findings. The record was reviewed on February 7, 2017.	L 052		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on an observation, and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to practice in a manner to prevent potential contamination/spread of infection as evidenced by an observation of an employee walking on the bedside floor mat, and two (2) sharps containers were filled above the full line located on the 3 south Unit, and to ensure that one (1) employee was pre- screened for communicable disease prior to employment;. Resident #72.	L 091	1. Employee walking on the floor mat did not result in resident adverse effect. 2. No other staff member was observed walking on floor mat. 3. Nursing staff will be in-serviced not to walk on the floor mat. 4. Audits will be conducted monthly to monitor staff not walking on floor mats. The result of the audit will be reported to QA committee for the next 3 months to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17

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L 091	Continued From page 18 The findings include: 1. Facility staff failed to practice in a manner to prevent potential contamination/spread of infection as evidenced by an observation of an employee walking on Resident #72's floor mat. During the initial tour of the facility at approximately 10:00 AM on February 1, 2017 Employee #16 was observed walking across the floor mat on the right side of Resident #72's bed. A face-to-face interview was conducted on with Employees #16 and Employee #7 at the time of the observation, the employees acknowledged the finding. 2. Facility staff failed to decrease the spread of infection as evidenced by two (2) sharps containers filled beyond the full line on the 3 South Unit. During a tour of the 3 South Unit conducted on February 7, 2017 at approximately 2:30 PM with Employees #8, #19, and #20, it was observed that the sharps containers in rooms 309 and 311 were filled and stored for use beyond the full line. Employees #8, #19, and #20 acknowledged the finding during the observation.	L 091	1. Sharp container was immediately emptied, and did not result in any resident adverse effect. 2. Audits on all sharp containers was conducted to ensure no other sharp container was full. Identified sharp containers were changed immediately. 3. Nursing staff will be in-serviced to make sure sharp containers are changed when full per policy. 4. Audits of all sharp containers will be conducted monthly to ensure sharp containers are changed timely when full. The result of the audits will be reported to QA committee for the next 3 months to monitor process towards improvement. 1. Employee # 12 is no longer an employee. 2. Director of HR conducted an audit on new employees to identify anyone who requires TST for baseline or initial testing. 3. Director of HR and HR assistant will be re-educated on policy and procedure on administration of Two-step testing (TST) for new hires. 4. HR Director will conduct a monthly audit for provisions of TST for new hires. The result of each of the audits will be reported to QA committee for the next 3 months to monitor process towards improvement.	2/7/17 4/6/17 4/6/17 4/6/17 4/6/17 4/6/17 4/6/17 4/6/17

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L 091	Continued From page 19 3. Facility staff failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by: a failure to ensure that one (1) of 9 (nine) newly hired employees was screened for communicable disease such as, Mycobacterium Tuberculosis (TB) upon hire and prior to providing direct care to resident's in the facility. Employee #12. Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting, 2005. Morbidity and Mortality Weekly Reports (MMWR) 2005:54(RR17); 1-141 stipulates: "Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection. " <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm> "TB Screening Procedures... all HCWs (health care workers) should receive baseline screening upon hire ...HCWs should receive TB screening	L 091		

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L 091	Continued From page 20 annually (i.e., symptom screen) for all HCWs and testing for infection with M. tuberculosis for HCWs with baseline negative test results...HCWs with a baseline positive or newly positive...should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually". The facility staff failed to ensure that Employee #12 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #12's personnel file revealed the following: Job Title: Registered Nurse Date of Hire: December 6, 2016 There was no evidence that Employee #12 was offered or received the two-step Purified Protein Derivative (PPD) skin test [a test that determines if you suffer from tuberculosis], a chest x-ray or the Tuberculosis Symptom Screening Questionnaire prior to or upon employment. The file was reviewed on February 7, 2017.	L 091		
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws, regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute is not met as evidenced by: Based on observation and staff interview, of two	L 167		

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L 167	Continued From page 21 (2) of eight (8) nursing unit wound treatment carts, it was determined that facility staff failed to ensure all resident biologicals were stored in a locked compartment. Units 2 North and 2 South. The findings include: 1. During the inspection of the 2 South and 2 North treatment carts conducted on February 1, 2017 at approximately 10:15 AM, multiple tubes of resident ointments, creams and shampoos were observed stored unlocked in the treatment carts. There was no evidence that the resident biologicals were adequately secured. A face-to-face interview was conducted with Employees #7 and #17. Both employees acknowledged the findings. The observation was made on February 1, 2017.	L 167	1. All units' treatment carts were checked to ensure proper locking system is in place. Treatments carts were locked, no resident was effected. 2. Audits of all treatment carts will be conducted to ensure staff are locking carts per facility policy. 3. Nursing staff will be re-educated on making sure all treatment carts are locked when not in use as per facility policy 4. Audits of all treatment carts will be conducted weekly to ensure carts are locked. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement.	2/1/17 4/6/17 4/6/17 4/6/17
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name, age, sex, date of birth, race, marital status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers;	L 201		

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L 201	Continued From page 22 (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (I)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in	L 201	1. Resident# 98 inventory list was immediately updated and was not effected.	2/7/17
			2. Audits of residents' inventory lists were reviewed by Social Service to ensure no other resident was affected, none were found.	4/6/17
			3. Administrator / Designee will in service IDT team on regulation to remind them of the quarterly requirements regarding inventory of resident personal items.	4/6/17
			4. Administrator/Designee will conduct a monthly audit of residents' inventory. The result of the audit will be reported monthly to QA committee for the next 3 months to monitor process towards improvement.	4/6/17

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L 201	Continued From page 23 accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the president's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 38 Stage 2 sampled resident's it was determined that facility staff failed to ensure that an inventory list of the resident's possessions was maintained. Resident #98. The findings include: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3231.12 "Each medical record shall include the following information...(q) A current inventory of the residents' personal clothing, belongings and valuables ..." A resident interview was conducted on February 1, 2017 at approximately 11:30 AM with Resident #98. In response to a query, were you encouraged by staff to bring in any personal items, the resident responded "No".	L 201		

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L 201	Continued From page 24 A review of the resident's clinical record lacked evidence of an inventory list to identify items maintained by the resident. A face-to-face interview was conducted on February 7, 2017 at approximately 1:00 PM with Employee #7. After review of the above aforementioned he/she acknowledged the findings. The record was reviewed on February 7, 2017	L 201		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on February 6, 2017 between 10:30 AM and 3:30 PM, it was determined that the facility failed to maintain resident's environment free of accident hazards as evidenced by a surge protector that was observed in use and unmounted in one (1) of 47 resident's rooms and a surge protector that was stored on top of the resident's dresser and did not have the lens cover to the on/off switch. The findings include: 1. A surge protector was observed in use, on the floor of room #315B and needed to be mounted. 2. A surge protector was observed in use, on top of a resident's dresser in room #219B and was missing the lens cover to the on/off switch.	L 214	1. The cited surge protectors in rooms 315B and 219B were replaced on 2/7/2017 and installed with facility approved surged protectors. 2. Inspections conducted on 2/7/2017 of all the rooms in the facility did not find any other similar cases as cited. 3. The admission and nursing staff will continue to remind family members that the facility will provide and install all surge protectors in the building. And they will be discouraged from bringing their own units into the facility. Nursing and Housekeeping staff will report to Engineering if any unmounted surge protector is observed. 4. The Facility Director and or Asst. Director shall monitor and conduct weekly audits. The findings shall be reported at the QA meetings monthly for the next 3 months to monitor process towards improvement.	2/7/17 2/7/17 4/6/17 4/6/17

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L 214	Continued From page 25 These observations were made in the presence of Employee #3 who confirmed the findings	L 214		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made on February 6, 2017 between 10:30 AM and 3:30 PM, it was determined that the facility failed to maintain a resident's call bell in good working condition as evidenced by a non-functioning call bell that failed to emit an alarm when tested in resident room #417A. The findings include: The call bell in resident room #417A failed to initiate an alarm when tested, one (1) of 47 resident's rooms.	L 306	1. The defective call bell module in room 417A was replaced immediately after it was discovered. Resident was not affected. — 2/6/17 2. Call bells in the other rooms were tested the same day and no other defective units were discovered. — 2/7/17 3. The maintenance staff will continue to do daily audits so they could immediately repair/replace any defective call bell accessories. Nursing and Housekeeping staff will be re-educated to report any defective call bell to engineering immediately. — 4/6/17 4. The facilities director and or his Assistant Director shall monitor and conduct weekly audits. The findings shall be reported at the QA meetings monthly for the next 3 months to monitor process towards improvement. — 4/6/17	

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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 306	Continued From page 26 This observation was made in the presence of Employee #3 who confirmed the finding.	L 306	1. From Feb. 13th – Feb. 17th the exhaust vents in rooms122, 401,402,408,417, 423, and 433 were removed and the interior ducts were cleaned. (2) The two exhaust vents in rooms 122 and 423 were removed and cleaned. (3) Resident comforter in Room #208B was not soiled, however, had stain marks and was replaced immediately.	2/20/17 2/6/17
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 on February 6, 2017 between 10:30 AM and 3:30 PM, it was determined that the facility failed to maintain a sanitary environment as evidenced by exhaust vents that were soiled on the inside in seven (7) of 47 resident's rooms, exhaust vents that were soiled on the outside in two (2) of 47 resident's rooms and a soiled comforter on top of a resident's bed in one (1) of 47 resident's rooms. The findings include: 1. Exhaust vents in seven (7) of 47 resident's rooms were soiled on the inside with dust particles: Rooms #122, #401, #402, #408, #417, #423 and #433. 2. Exhaust vents in two (2) of 47 resident's rooms were soiled on the outside with dust particles: Rooms #122 and #423. 3. The comforter used to cover the resident's bed in room #208B was soiled with several stain marks. One (1) of 47 resident's rooms. These observations were made in the presence	L 410	2. (1,2)Inspection of all vents were conducted during the above listed time frame. Any vent meeting the deficient practice was removed for cleaning of ducts and registers. (3 Nurse Manager/ Designee conducted an audit of resident comforters to ensure no other residents had stained comforter on their bed. None was found. 3. (1,2)The exhaust vents and ducts inspection will be added to the maintenance daily rounds inspection sheet. The maintenance personnel will conduct daily inspections of all vents on all floors. (3)CNAs have been in-serviced on not using stained comforters on residents' bed. Laundry supervisor will discard identified stain comforters. 4. (1,2)The Facility Director and or Asst. Director shall monitor and conduct weekly audits. The findings shall be reported at the QA meetings for the next 3 months to monitor process towards improvement. (3)All Directors/Managers who enters resident rooms will report any identified stained comforters to Unit/Clinical Managers and Laundry Supervisor. Director of Nursing will report on stained comforters monthly. The findings shall be reported at the QA meetings for the next 3 months to monitor process towards improvement.	4/6/17 4/6/17 4/6/17 4/6/17 4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0010	A. BUILDING: _____ B. WING _____	02/08/2017

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L 410	Continued From page 27 of Employee #3 who confirmed the findings.	L 410		