| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HFD02-0007 | A. BUILDING: _____ B. WING _____ | 07/30/2019 |

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| L 000 | Initial Comments<br><br>An unannounced Long Term Care Survey was conducted at Washington Center for Aging Services from July 17, 2019 through July 30, 2019. Survey activities consisted of a review of 56 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 243.<br><br>An immediate jeopardy (IJ) was identified at 42 CFR§ 483.12(c)(2)-(4), Investigate/prevent/correct alleged violation, F610 on July 23, 2019, at 11:09 AM. The facility's Administrator provided a letter with supportive documentation (to include: termination of the employee involved in the incident, evidence of Abuse Training (Training for leadership, managers, and staff on abuse, residents with combative behaviors and residents rights; all units were checked to determine if other residents had preference as it pertains to the sexuality of the caregiver; the managers will monitor the care of residents who are combative using the behavioral monitoring tool; and the nurse managers and supervisors will continue to monitor the staffs that provide care to residents who exhibit combative behaviors noting a corrective action plan and the IJ was removed on July 24, 2019, at 4:07 PM.<br><br>A complaint investigation (C-19-067, DC00004836) was also conducted during the survey period of July 17, 2019, through July 30, 2019. | L 000 | Stoddard Baptist Global Care makes its best effort 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 of 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 Law. | |

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| L 000 | Continued From page 1<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>Abbreviations<br>AMS - Altered Mental Status<br>ARD - Assessment Reference Date<br>AV- Arteriovenous<br>BID - Twice- a-day<br>BIMS - Brief Interview for Mental Status<br>B/P - Blood Pressure<br>cm - Centimeters<br>CFR- Code of Federal Regulations<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CRF - Community Residential Facility<br>CRNP- Certified Registered Nurse Practitioner<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C- Discontinue<br>Dl- Deciliter<br>DMH - Department of Mental Health<br>DOH- Department of Health<br>EKG - 12 lead Electrocardiogram<br>EMS - Emergency Medical Services (911)<br>F - Fahrenheit<br>G-tube- Gastrostomy tube<br>HR- Hour<br>HSC - Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - Interdisciplinary team<br>IPCP- Infection Prevention and Control Program<br>LPN- Licensed Practical Nurse | L 000 | | |

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| L 000 | Continued From page 2<br>L - Liter<br>Lbs - Pounds (unit of mass)<br>MAR - Medication Administration Record<br>MD- Medical Doctor<br>MDS - Minimum Data Set<br>Mg - milligrams (metric system unit of mass)<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>MN midnight<br>Neuro - Neurological<br>NFPA - National Fire Protection Association<br>NP - Nurse Practitioner<br>O2- Oxygen<br>PASRR - Preadmission screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>PO- by mouth<br>POA - Power of Attorney<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt - Patient<br>Q- Every<br>QIS - Quality Indicator Survey<br>RD- Registered Dietitian<br>RN- Registered Nurse<br>ROM Range of Motion<br>RP R/P - Responsible party<br>SCC Special Care Center<br>Sol- Solution<br>TAR - Treatment Administration Record<br>Ug - Microgram<br>UR- Urinary Retention | L 000 | | |
| L 001 | 3200.1 Nursing Facilities<br><br>Each nursing facility shall comply with the Act, | L 001 | | |

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| L 001 | Continued From page 3<br>these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia.<br>This Statute is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to: thoroughly investigate an incident of abuse and/or neglect for Resident #164, implement measures to prevent potential abuse and/or neglect to other residents within the facility; and take appropriate corrective actions to keep other residents safe from possible abuse and/or neglect in one (1) of 56 sampled residents. The census on the first day of survey was 243.<br><br>Findings included ...<br><br>On July 23, 2019, at 11:09 AM an Immediate Jeopardy (IJ)-"L" was identified at 42 CFR§ 483.12 (c)(2)-(4), F610. On July 25, 2019 at 3:13 PM, the facility's Administrator provided a letter to the State Agency Survey team documenting the corrective action plan, as follows:<br><br>"The CNA identified in the complaint survey is no longer employed as of 7/16/2019.<br><br>All residents were checked and three residents who are combative and/or exhibit combative behaviors were identified. Additional training was provided on the spot for those staff members on 7/22/2019.<br><br>A meeting was conducted with the Administrator and the DON [Director of Nursing] on 7/23/2019 and 7/24/2019. Root cause analysis and | L 001 | Immediate Jeopardy - Removal Plan<br><br>**1. Immediate Action Taken – CNA care of resident**<br><br>CNA failed to stop caring for resident and failed to call for assistance for a resident who was combative<br><br>I. The CNA identified in the complaint survey is no longer employed as of 7/16/2019<br><br>II. All resident were checked and three residents who are combative and/or exhibit combative behavior were identified; additional training was provided on the spot for those staff members on 7/22/2019.<br><br>III. A meeting was conducted with the Administrator and the DON on 7/23/2019 and 7/24/2019. Root cause analysis and investigation principles as it pertains to Abuse were addressed. All components of abuse were discussed including the interpretation of "willful" and its relationship to abuse. Abuse training and care of combative resident (training) was started on 7/21/2019 for all staff and currently in progress. | 9-30-19 |

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| L 001 | Continued From page 4<br><br>investigation principles as it pertains to Abuse were addressed. All components of abuse were discussed including the interpretation of "willful" and its relationship to abuse. Abuse training and care of combative resident (training) was started on 7/21/2019 for all staff and is currently in progress.<br><br>The managers will monitor the care of residents who are combative using the behavioral monitoring tool (see audit tools). The nurse managers and supervisors will continue to monitor the staff that provide care to residents who exhibit combative behaviors. Interventions will be implemented as indicated. The information will be provided to the DON who will provide this information to the QAPI committee quarterly and/or more frequently as indicated.<br><br>Family request female: The Unit Manager received individual counseling and training on 7/23/2019. Unable to retrospectively correct the occurrence.<br><br>All Unit Managers received training on 7/23/2019 and 7/24/2019 as it pertains to resident's rights, specifically their wish as it pertains to the caregiver.<br><br>All Units were checked on 7/23/2019, via the nursing management team to determine if other residents had preference as it pertains to the sexuality of the caregiver. One resident was identified on 7/23/2019 and the Unit manager ensured that it was incorporated in the care plan on 7/23/2019. The Interdisciplinary team was re-educated on care planning and updating the care plan as the resident's conditions changes following detailed assessment of the resident on 7/23/2019. | L 001 | IV. The managers will monitor the care of residents who are combative using the behavioral monitoring tool (see audit tools). The nurse managers and supervisors will continue to monitor the staffs that provide care to residents who exhibit combative behaviors. Interventions will be implemented as indicated. The information will be provided to the DON who will provide this information to the QAPI committee quarterly and/or more frequently as indicated.<br><br>**2. Immediate Action Taken - Resident and Family Wishes; specifically requesting for a female care giver**<br><br>Family request female – Manager not including in care plan resident preference as it pertains to care giver/Care Plan<br><br>I. The Unit Manager received individual counselling and training on 7/23/2019. Unable to retrospectively correct the occurrence.<br><br>II. A counselling form has been developed for the unit manager and has received training, and counselling. | 9-30-19 |

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| L 001 | Continued From page 5<br><br>Upon admission and care plan meeting/conferences, the managers will determine the needs of the residents, specifically if a resident request a female and/or male care giver. The resident who expresses the female/male will be checked to ensure that this request was honored. This will be done via the assignment sheet every shift and reported to the QAPI [Quality Assurance and Performance Improvement) committee quarterly and/or more frequently as indicated. The nursing management audits the care plan monthly (see audit tool). When a care plan has not been updated the appropriate discipline is notified. This information is provided to the DON who presents this information to the QAPI committee quarterly and/or more frequently as necessary."<br><br>In-service/Training:<br><br>"Training of the Administrator and DON regarding Root Cause Analysis and Investigation Principles as it pertains to Abuse (training completed on July 24, 2019)<br>"Training of the Clinical Leadership Team (Training completed July 19, 2019)<br>"Evidence of Abuse Training (Training for leadership, managers, and staff on abuse, residents with combative behaviors done on July 19 2019-July 24, 2019)<br>"Training on assignment of male/female CNA per resident's wishes (Training completed July 24, 2019)<br><br>The IJ was abated after the team verified that the plan of correction was in place on July 25, 2019, at 4:07 PM, the Immediate Jeopardy was removed. Consequently, the State Agency amended the scope and severity of the deficient | L 001 | III. All Unit Managers received training on 7/23/2019 and 7/24/2019 as it pertains to resident's rights, specifically their wish as it pertains to the care giver.<br><br>IV. All Units were checked on 7/23/2019 via the nursing management team to determine if other residents had preference as it pertains to the sexuality of the care giver. One resident was identified on 7/23/2019 and the Unit manager ensured that it was incorporated in the care plan on 7/23/2019. The Interdisciplinary team was re-educated on care planning and updating the care plan as the resident's conditions changes following detailed assessment of the resident on 7/23/2019. | 9-30-19 |

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| L 001 | Continued From page 6<br>practice to an "F."<br><br>Policy Title: Prohibition of Abuse; ADM01-003; Revised January 2019 stipulates,<br><br>"A. Stoddard Baptist Global Care, Inc. promotes the residents rights to be free from abuse, neglect, misappropriation of resident property and exploitation ...No abuse or harm of any type will be tolerated and residents and staff will be monitored for protection ...<br><br>Prevention: 4. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect.<br><br>Identification: ...Because some cases of abuse are not directly observed, understanding resident outcomes of abuse could assist in identifying whether abuse is occurring or has occurred. Possible indicators include, but are not limited to: 1) an injury that is suspicious because the source of the injury is not observed or the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time.<br><br>Investigation: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegations; 6. Providing complete and thorough documentation of the investigation."<br><br>Protection: 1. In the interim of the investigation process, the alleged abuser may be suspended from work until an official notice is issued for | L 001 | V. Upon admission and care plan meeting/conferences, the managers will determine the needs of the residents, specifically if a resident request a female and/or male care giver. This information would be communicated to the interdisciplinary team including the weekend supervisors. The resident who expresses the female/male will be checked to ensure that this request was honored. This will be done via the assignment sheet every shift and reported to the QAPI committee quarterly and/or more frequently as indicated. The nursing management audits the care plan monthly (see audit tool). When a care plan has not been updated the appropriate discipline is notified. This information is provided to the DON who presents this information to the QAPI committee quarterly and/or more frequently as necessary. | 9-30-19 |

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| L 001 | Continued From page 7<br><br>clearance to return to work or otherwise by Human Resources. 6. Protection from retaliation.<br><br>Reporting:<br>...The results of all investigations are reported to the administrator or his or designated representative ...and if the alleged violation is verified appropriate correction action must be taken.<br><br>...2. Resident abuse is a ground for immediate termination refer to Employee Handbook".<br><br>Employee Handbook revised January 2015, page 5, stipulates, "Abuse Prohibition policy: Actions of such may result in immediate termination ..."<br><br>Record Review<br><br>Review of Resident #164's medial record showed she was admitted to the facility on November 29, 2016. The Quarterly Minimum Data Set (MDS) dated June 3, 2019, under Section A1000 (Race/Ethnicity) the resident was coded as Asian, Native Hawaiian or other Pacific Islander. Under Section A1100 (Language) the resident was coded as needing and wanting an interpreter to communicate with a doctor or health care staff and preferred language Chinese. She was assessed with severely impaired cognitive skills for daily decision making in Section C (Cognitive Patterns). She was assessed as requiring extensive assistance of two (2) persons for bed mobility, transfers, dressing, toileting, personal hygiene and totally dependent for bathing under Section G (Functional Status). Disease diagnoses listed in Section I include: Diabetes Mellitus, Dementia, Chronic Kidney Disease, Urinary Incontinence, Deficiency in Vitamin D, | L 001 | 3.**INVESTIGATION – Decision Making**<br><br>Facility Administration – identification of Abuse and actions taken during/following an investigation<br><br>I. Meeting held with Administrator and DON by the Corporate Clinical and Administrative Team on 7/23/2019 and 7/24/2019.<br><br>II. Reviewed other residents and/or unusual occurrences that involved an investigation. One case identified and leadership implementing new investigation process.<br><br>III. The facility developed a new Investigation Protocol on 7/21/2019. The Administrative and Nursing Management team were educated regarding the new process. The Corporate office developed with conjunction of Senior Leadership team the Adult Protection Statement. This document will be utilized to ensure that residents with allegations of abuse and/or evidence abuse will be thoroughly evaluated. The Administrator and DON were re-educated regarding Abuse and it was determined that the clinical leadership team, Human Resource Manager, Director of Social Services, DON, QAPI, Director, Staff development and the Administrator would be involved in the decision making process. | 9-30-19 |

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| L 001 | Continued From page 8<br>and Restlessness and Agitation.<br><br>Further review of the record showed a nurse's note dated June 16, 2019, at 12:30 PM: "Writer was called by CNA [Certified Nursing Assistant/Employee #4] to come to resident room, when asked CNA said, "He was trying to give care to resident when she became combative and in the process of turning, resident hit her head on the side rail of the bed. Happened at 11:35 am. Writer went and assessed resident and noted a swelling on her left face. Supervisors were informed. [Nurse Practitioner- Name] was called, who gave orders for resident to be transported via EMR [emergency response]/911. To the nearest ER [emergency room]. [Resident #164] is alert and unable to explain what happened. Her diagnosis include but not limited to Dementia, with behavioral disturbance, HTN [hypertension], DM [diabetes mellitus] agitation and aggression. On assessment resident noted with swelling of the left fore head near the left eye with a cut on the left upper lip with minimal bleeding which was cleansed with normal saline. Ice pack applied to the left forehead swelling. V/S [vital signs] laying 138/69, P [pulse] 74, T [temperature] 97.7, Sp02 [peripheral capillary oxygen saturation] 98% on room air. V/S [vital signs] sitting B/P [blood pressure] 157/80, P 77, T [temperature] 98.2, R [respirations] 18. Pulse ox [oximetry] room air 97% FS [finger stick] 142 mg/dl [milligrams per deciliter]. Tylenol 2 tabs 325 mg [milligrams] was administered for pain 4/10 and was very effective. Neuro [neurological] check initiated. RP [Responsible Party] made aware."<br><br>Continued review of the record showed the [Hospital Name], computed tomography report dated June 16, 2019, showed Resident #164 | L 001 | III. Cont.<br><br>Any employee who has been reported and/or suspected of abuse and/or neglect will be removed from the schedule until the detailed report has been completed.<br><br>IV. Any investigations conducted during the month will be reviewed by the Investigation Committee. This committee ensures that all aspects of the Investigation are complete. This is reported to the QAA Committee Quarterly and/or more often as needed. | |

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| L 001 | Continued From page 9<br>sustained trauma, Left periorbital soft tissue swelling. Associated displaced fracture lamina papyracea (orbital fracture). Minimal blood in the left ethmoid sinuses.<br><br>Resident #164 was discharged from the facility on June 26, 2019.<br><br>Review of Employee #4's Personnel Record<br><br>" Review of Employee #4's statement dated June 20, 2019 showed, " Incident report on the 16th of June. I went into [Resident #164] room to clean her up, in the process of cleaning her, she became combative and hit her face on the bedrail which caused swelling on her face. So I decided to report the situation to the charge nurse immediately. I was not contacted on this during the week."<br>"Review of Employee #4's time card showed he arrived at work on June 16, 2019 at 9:29 AM, punched out at 1:30 PM punched back in at 2:00 PM and punched out for the shift at 3:48 PM.<br>"The "Personnel Report of Change" dated June 21, 2019 showed, the Employee #4 was suspended for three (3) days (6/21/19, 6/22/19, and 6/23/19).<br>"In-service records showed Employee #4 attended in-services on "Prohibition of Resident Abuse and Neglect, Managing Resident with Dementia and Aggressive Behavior, Cultural Competency, and Resident Safety during ADL (activities of daily living) care" on June 25, 2019, (five days after the incident).<br>"The "Personnel Report of Change" dated July 16, 2019 showed, the Employee #4 was terminated from the facility on July 16, 2019. | L 001 | | |

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| L 001 | Continued From page 10<br><br>There was no evidence facility staff failed to immediately remove Employee #4 from the facility after the incident to ensure the safety of all residents, as evidence below:<br><br>"The incident occurred at approximately 11:35 AM on June 16, 2019. According to the Employee's time card, he worked the duration of the shift (until 3:48 PM).<br><br>"There was no documentation of Employee #4's suspension until June 21, 2019 (five days after the incident occurred. (The Employee did not work during this period.)<br><br>"On June 27, 2019, Employee #4 was allowed to return to work, and assume his duties as a CNA.<br><br>Interviews:<br><br>During a face-to-face interview with the Unit Manager (assigned to the unit of Resident #164) on July 19, 2019, at 2:13 PM, she stated, "I was the manager at the time of the incident with the CNA, it was a weekend on Sunday .... the supervisor called me there was an incident that occurred on your floor and we called 911. The CNA take took care of her an abrasion during care, the face is swollen and we put on ice packs we have to send her out 911. I do not know why Employee #4 was taking care of her because the family requested that they did not have a male they told this to me. The family requested to have another [Employee Name] and that weekend she was off. Employee # 4 knew he was not supposed to take care of the resident. Employee #4 came in late and the other CNA switched [the resident assignment] ...the charge nurse did not know that he switched the resident | L 001 | | |

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| L 001 | Continued From page 11<br>[assignment]. She [the resident] is always is agitated ..."<br><br>The surveyor asked, "What do you do when a family make a request regarding patient care?" Most of the time we have an in-service to let them know what the family is requesting. I care plan it so everyone will know /they are well-informed so that the message is passed on ... Resident #1 is an unusual incident I don't tolerate abuse, why should I want to be abused, this is something I will regret. "<br><br>During a face-to-face interview with Employees' #1 and #2 on July 19, 2019 they stated, "We conducted the investigation of [Resident #1]. He [Employee # 4] was the only person involved in the incident. There were no witnesses. The Employee was suspended immediately. He was sent for education/in-services and returned to work on June 27, 2019 at 7:28 AM. We believe what he [Employee #4] said about what happened. He probably could have called for additional help. We maintain the actions of Employee #1 (CNA) were not abusive (willful) but a care issue. We still believe it's a care issue."<br><br>The writer asked, is it my understanding that the Resident only wanted female CNAs? Employees' #1 and #2 stated, "The unit manager got the note [from the family], the note was received before this incident requesting that the resident [Resident #164] not have a male CNA."<br><br>The writer asked, what was the outcome of the investigation? Employees' #1 and #2 stated, "The Employee needed further education on combative residents and dignity and monitoring during care." | L 001 | | |

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| L 001 | Continued From page 12<br><br>The writer asked, how were they monitoring Employee #4? Employees' #1 and #2 stated, "They were asking the charge nurses how the employee was doing. The monitoring started immediately [upon his return to work on June 27, 2019]. There was no monitoring tool. They would touch basis on the days he worked to ensure he was fine."<br><br>The writer asked, why was the Employee terminated on July 16, 2019? "Employee #1, stated, he was terminated on July 16, 2019, as a result of the DC Department of Health Complaint Investigation Report [C-19-057, DC-4819, harm level deficiency cited], gross negligence, carelessness, failure to follow the policy and procedure in the care of a resident. We could have done better."<br><br>Summary of Findings:<br><br>"The facility failed to provide an interpreter to communicate with the resident while providing health care services (ADL care) Per the MDS dated June 3, 2019.<br><br>"The facility failed to provide two (2) person physical assistant when performing adl care for Resident #4 on June 16, 2019, Per the MDS dated June 3, 2019.<br><br>"The facility staff failed to ask why Resident #164's family did not want male CNAs caring for the resident.<br>"The facility staff failed to have written documentation that staff were in-serviced on the family's wishes not to have male CNAs care for Resident #164.<br><br>"The facility CNA staff failed to follow their | L 001 | | |

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| L 001 | Continued From page 13<br><br>resident care assignments given by the Charge Nurse on June 16, 2019.<br>"Employee #4 (CNA) failed to stop caring for Resident #164 who became combative during ADL care on June 16, 2019.<br>"Employee #4 failed to call for assistance when Resident #164 became combative on June 16, 2019.<br><br>"The facility's investigation lacked evidence such as, the supervisor's written account of what occurred and how Employee #4 was supervised/managed after the incident, and a written statement from Employee #4 at the time of the incident stating what occurred during care of the resident. There was no formal written summary/conclusion of the facility's investigation.<br><br>"The facility administrative staff failed to thoroughly investigate and recognize the incident on June 16, 2019 as a likelihood of abuse or neglect. The administrative staff, however, identified the incident on June 16, 2019 as a "care issue".<br><br>The facility's administration received the survey findings from the [DC Department of Health] complaint report, and as a result of the findings Employee #4 was terminated on July 16, 2019 for gross negligence, carelessness, and failure to follow the policy and procedure in the care of a resident. Employee #4 worked 33 hours providing care to other residents from June 27, 2019 to July 16, 2019, prior to being terminated.<br><br>During the face-to-face interview on July 23, 2019 approximately at 2:15 PM, Employees' #1 and #2 acknowledged the findings. | L 001 | | |

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| L 051 | Continued From page 14 | L 051 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(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:<br><br>Based on interview and record review for two (2) of 56 sampled residents, the charge nurse failed to revise care plan for one (1) resident diagnosed with penile erosion and laceration, for one (1) resident with percutaneous endoscopic gastrostomy (PEG) tube and for one (1) resident who sustained a fall with injury. . Residents' #58, #155 and #182<br><br>Findings included .... | L 051 | **1.1**<br><br>Resident #58 was reassessed immediately, by both the clinical team and the Medical Director. The penile injury and erosion resolved and resident was followed up by urology. Resident verbalizes that he has no pain or discomfort in the area. The existing care plan for resident #58 has been reviewed; is person centered and meets the needs of the residents.<br><br>**1.2**<br><br>A review of all residents with Foley catheters was conducted, no other resident was found to be affected by this practice.<br><br>**1.3**<br><br>The licensed staff have been re-educated regarding Foley Catheter Care. A competency has been developed to ensure licensed staffs are knowledgeable as it pertains to Foley Catheter Care. | 9-30-19 |

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| L 051 | Continued From page 15<br><br>1. The charge nurse failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #58 with an indwelling Foley catheter who developed an penile injury.<br><br>Resident #58 was admitted to facility on 1/27/15, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia, Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts.<br><br>A review of the Quarterly MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device.<br><br>A review of NP (Nurse Practitioner) progress note dated 5/31/2019 revealed, " ...10:36 PM Pt with UR, observed during day, unable to pee, Foley reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side Avoid diaper when patient has Foley (to lacerate penis)." | L 051 | **1.4**<br><br>The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that Person-centered care planning is in place. This includes monitoring the residents who have Foley catheter's care plan. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly.<br><br>**2.1**<br><br>Resident #155 was reassessed immediately. The care plan has been revised and updated to include her PEG tube.<br><br>**2.2**<br><br>A review of residents with a PEG tube was conducted. No other residents were found to be affected by this practice.<br><br>**2.3**<br><br>The licensed staffs have been re-educated regarding ensuring care plan in place for residents with PEG tube. | 9-30-19 |

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| L 051 | Continued From page 16<br>There was no evidence the charge nurse revised care plan to include care of penile laceration and erosion.<br><br>The findings were acknowledged during a face-to-face interview with Employee #3 (Unit Manager) on July 29, 2019 at 11:00 AM.<br><br>2. The charge nurse failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #155 percutaneous endoscopic gastrostomy (PEG) tube.<br><br>Resident #155 was admitted to the facility on 4/17/19 with diagnoses which include Type II Diabetes Mellitus without Complications, Hypertension, End Stage Renal Disease, and Gastro-esophageal Reflux without Esophagitis.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 6/1/19 showed resident Brief Interview for Mental Status (BIMS) is coded as "6" to indicate moderately impaired cognition. Further review of the MDS showed Section K [Swallowing/Nutritional Status] Nutrition Approach resident is coded as having a "feeding tube."<br><br>On 7/25/19 at 3:00 PM review of the care plan failed to show goals and approaches for care of Resident #155 percutaneous endoscopic gastrostomy (PEG) tube.<br><br>During an interview on 7/25/19 at 3:00 PM, Employee# 13 acknowledged the findings. | L 051 | **2.4**<br><br>The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that care plans are person centered and meet the needs of the residents, including residents who have PEG tubes. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly.<br><br>**3.1**<br><br>Resident #182 is no longer in the facility. Facility unable to retrospectively correct this deficiency.<br><br>**3.2**<br><br>A review of residents with recent falls was conducted. The care plans were in compliance.<br><br>**3.3**<br><br>The licensed staff have been re-educated regarding updating and revising care plans following a fall. | 9-30-19 |

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| L 051 | Continued From page 17<br><br>3.The charge nurse failed to update/revise the care plan with resident-centered goals and approaches for care of Resident #182 who sustained a fall with injury.<br><br>Resident #182 was admitted to the facility on May 15, 2019, with diagnoses that include Chronic Kidney Failure, Benign Prostatic Hyperplasia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anemia, Parkinsons Disease, and Congestive Heart Failure.<br><br>A review of Resident #182's admission Minimum Data Set [MDS] dated 5/22/19, showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "11" which indicated the resident had moderate cognitive impairment. Section G [Functional Status] resident is coded as "3" extensive assistance (resident involved in activity staff provide weight-bearing support) for bed mobility, transfer, locomotion on the unit and locomotion off the unit.<br><br>A review of the Resident's progress note dated 7/7/19 showed the following:<br>7/9/19 1:51 PM Nurse Practitioner Progress note; "Pt c/o pain today at left leg ... x-ray ordered ... pain with ROM at left leg at knee part, had pain earlier at left hip, slight swelling left leg and lower thigh, x-ray left leg."<br><br>7/10/19 9:52 AM Nurse's late entry for 7/9/19 "Resident is status post fall day 3/3. Seen by the NP ...due to complaint of pain on the left hip that radiates to the lower extremity. As result, x-ray of the left hip, left femur and left knee was ordered. | L 051 | **3.4**<br><br>The Nurse Managers monitor the care plans monthly. The audit tool is utilized to ensure that Person-centered care planning is in place, including a care plan for residents with falls. This information is submitted to DON/ADON and is submitted to the QAPI committee quarterly. | |

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| L 051 | Continued From page 18<br><br>X-ray was done at 3 pm, preliminary x-ray result showed resident has fracture of the left femur NP was notified An order to transfer resident to the emergency room ... ."<br><br>A review of the care plan initiated on 5/17/19 showed "resident at risk for falling r/t [related] cognitive impairment, unsteady gait and diagnosis of Parkinson disease. On 5/25/19 ... resident was observe on the floor with no injury."<br><br>Further review of the fall care plan on July 25, 2019 failed to show any evidence that the facility reviewed and revised the care plan after the resident sustaineda fall with injury on July 7, 2019<br><br>During a face-to-face interview with Employee #13 on 7/26/19, at 1:44 PM, he acknowledged the findings | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(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; | L 052 | **1.1**<br><br>The staffs were immediately in-serviced on Solarium Coverage. Resident #182 is no longer in facility therefore unable to retrospectively make any changes in his care needs.<br><br>**1.2**<br>A review of all Solariums was conducted; no other Solariums were impacted by this practice. | 9-30-19 |

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| L 052 | Continued From page 19<br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities;<br><br>(f)Encouragement and assistance to:<br><br>(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;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, including oral acre; and<br><br>j)Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br><br>A. Based on record review and staff interview for one (1) of 56 sampled residents, facility failed to ensure one (1) resident who was identified as a fall risk received adequate supervision. The resident was left unattended in the solarium where he subsequently fell from his wheel chair and sustained a left Femur fracture. Resident #182<br><br>Findings included... | L 052 | **1.3**<br>The nursing staff were re-educated regarding Solarium coverage including roles and responsibility when assigned to the Solarium.<br><br>**1.4**<br>Monitoring the Solarium is a part of the QI monitoring program. The nursing management team conducts evaluation of Solarium at least once a week. This information is presented to the QAPI committee quaterly. | 9-30-19 |

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| L 052 | Continued From page 20<br><br>A review of the Resident's Clinical record showed that on July 7, 2019, at 11: 00 AM Resident #182 was left unattended in the solarium where he subsequently fell from his wheel chair and sustained a left Femur fracture.<br><br>Resident #182 was admitted to the facility on May 15, 2019, with diagnoses that includes Chronic Kidney Failure, Benign Prostatic Hyperplasia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Anemia, Parkinsons Disease, and Congestive Heart Failure.<br><br>A review of Resident #182's admission Minimum Data Set [MDS] dated 5/22/19, showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "11" which indicates the resident had moderate cognitive impairment. Section G [Functional Status] resident is coded as "3" extensive assistance with one (1) person physical assist for bed mobility, transfer, locomotion on the unit and locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code "0" indicates No impairment. Section J I700 Fall History on Admission/entry was coded as"1" to indicate that the resident had a fall 2 - 6 months prior to his admission to the facility.<br><br>A review of the care plan initiated on 5/17/19 showed "resident at risk for falling r/t [related] cognitive impairment, unsteady gait and diagnosis of Parkinson disease. On 5/25/19 ... resident was observe on the floor with no injury." There was no mention that Resident #182 had a fall on 7/7/19.<br><br>A review of the Resident's progress note showed the following: | L 052 | | |

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| L 052 | Continued From page 21<br><br>7/7/19/ 1:41 PM "Writer [RN Supervisor] was called to unit 3 green and noted resident in a sitting position in front of his wheel chair in the solarium. Upon assessment resident denied pain or discomfort, no injury noted, denied hitting his head able to move his upper arm and lower extremities without difficulty to his baseline. ... Resident was asked how he got to the floor he said that he did not know"<br><br>7/9/19 1:51 PM NP's [Nurse Practitioner's] Progress note showed "Pt c/o pain today at left leg ... x-ray ordered ... pain with ROM at left leg at knee part, had pain earlier at left hip, slight swelling left leg and lower thigh, x-ray left leg."<br><br>7/10/19 9:52 AM [RN] late entry for 7/9/19 "Resident is status post fall day 3/3. Seen by the NP ...due to complaint of pain on the left hip that radiates to the lower extremity. As result, x-ray of the left hip, left femur and left knee was ordered. X-ray was done at 3 pm, preliminary x-ray result showed resident has fracture of the left femur NP was notified An order to transfer resident to the emergency room ... ."<br><br>A review of the result of the stat x-ray of left femur, left knee, left hip and pelvis on 7/9/19 ordered by NP showed "Impression: Acute Fracture of the Proximal Left Femur."<br><br>A face to face interview was conducted on 7/26/19 at 1:55 PM with Employee #19 [CNA] who stated, "I was in the solarium watching and monitoring residents when my coworker in the room next to the solarium asked me for help to put a resident in chair. I left the solarium to the room right outside the solarium to help with another resident. While in the room I heard | L 052 | | |

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| L 052 | Continued From page 22<br><br>someone say resident on the floor in solarium and ran back in there he was sitting on the floor in front of wheel chair. On Tuesday I was giving AM care when I went to move him he says ouch, ouch. I asked what was wrong he pointed to left side of hip. I called charge nurse and she came to see him."<br><br>Another face to face interview was conducted on 7/26/19 at 1:59 PM with Employee #20 [CNA] who stated, "I was in [resident,s name] room getting her ready to get out of bed, [CNA name] in solarium covering residents in solarium. I had went to her to ask her to help me put [resident's name] in chair. She did and while in room another resident called out patient on floor. We both ran out to solarium he was sitting up on the floor beside his wheel chair. He did not complain staff came and assessed him."<br><br>The evidence showed that facility failed to ensure one (1) resident who sustained a fall with an injury received adequate supervision to prevent an accident as evidenced by the staff assigned to watch and monitor the residents in the solarium left him unattended.<br><br>During a face-to-face interview with Employee #13 [unit manager] on 7/26/19, at 1:44 PM, he acknowledged the findings and stated, "The staff assigned to the solarium left to help a coworker although we educate them not to leave residents in the solarium alone."<br><br>B. Based on record review and staff interviews for two (2) of 56 sampled residents, the facility failed to provide competent nursing staff to care for one (1) resident with an indwelling Foley catheter who developed an penile injury; and failed to ensure nursing staff has specific | L 052 | | |

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| L 052 | Continued From page 23<br>competencies and skills to assess and care for one (1) resident who is dialysis-dependent and has a arteriovenous (AV) fistula graft site. Residents' #58 and #175.<br><br>Findings included...<br><br>1. Facility failed to provide competent nursing staff to care for Resident #58 with an indwelling Foley catheter who developed an penile injury.<br><br>"Wound, Ostomy and Continence Nurses Society. (2016). Care and management of patients with urinary catheters: A clinical resource guide. MT. Laurel: NJ. Author" "Securement Devices: ...Indwelling catheters should be secured to avoid traction on the catheter, which causes irritation and trauma to the urethra(e.g., urethritis, necrosis, erosion, stricture) ...monitor the urethra daily for irritation, erosion, or urine leakage and assess the skin integrity under the securement device."<br><br>Resident #58 was readmitted to facility on 12/21/18, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia, Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts.<br><br>A review of the Comprehensive MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person | L 052 | **1.1**<br><br>Resident #58 was reassessed by the clinical team and the Medical Director. It was determined that the area identified was not lacerated and appeared old. Resident was sent out for urology appointment for further follow-up. Resident verbalized no discomfort. The staffs assigned to provide care to Resident #58 were immediately re-educated.<br><br>**1.2**<br><br>A review of residents with Foley Catheters was conducted; no other residents were noted to be impacted by this practice.<br><br>**1.3**<br><br>The licensed nursing leadership team was re-educated and Competency of staff was conducted as it pertains to provision of appropriate and sufficient Foley catheter care, assessments and reassessments to prevent Harm.<br><br>**1.4**<br><br>An audit tool was initiated in monitoring residents with Foley Catheters; ensuring that catheter care is done and documentation in place. This information is provided to the QAPI committee quarterly. | 9-30-19 |

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| L 052 | Continued From page 24<br>support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device.<br><br>A review of the care plan for Foley Catheter due to Urinary Retention showed it was initiated on 1/23/2019. Goal: resident will have catheter care managed appropriately ...not exhibiting signs of urinary tract infection or urethral trauma. Approach: ...report signs of UTI ...manipulate tubing as little as possible during care ...provide catheter care ...use catheter strap ...use leg bag as needed ..."<br><br>A review of Medical Record Revealed:<br><br>A physician's order dated 12/7/2018, "Insert Foley for UR [urinary retention]." "Urology consult for UR" 12/10/2018."<br><br>"Urology Consult-1/3/2019, Diagnosis; Urinary Retention with chronic indwelling Foley catheter and urethral erosion."<br><br>A review of NP (Nurse Practitioner) progress note dated 5/31/2019, revealed, "...10:36 PM Pt with UR, observed during day, unable to pee, Foley reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side avoid diaper when patient has Foley (to lacerate penis)."<br><br>5/31/2019 - Interim Order, "Please avoid diaper when pt. has a Foley (cause Laceration of penis) Foley inserted routine Foley care q shift." | L 052 | | 9-30-19 |

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| L 052 | Continued From page 25<br><br>A review of NP Progress note dated 6/4/2019, "...Pt with Foley catheter with ulcer of glans purulent drainage from penis ..."<br><br>6/5/2019- Interim Order, "D/C order to avoid diaper when pt. has a Foley Use diaper to make it loose to prevent laceration."<br><br>"Urology Consult for possible Suprapubic catheter (6/20/2019) ...Progress note Urinary retention UTI [Urinary ...Penile erosion ...plan for SP [Suprapubic] tube placement under local ..."<br><br>"Urology consultation for urinary retention at [Hospital Name] at 1:30 PM with [Physician name] (07/03/19). Change Foley catheter q 6 weeks obtain medical records or other history to determine if there are reasonable alternative to indwelling Foley catheter ..."<br><br>7/5/2019- Urology Consult findings: S/P tube inserted under u/s (ultrasound) guidance New diagnosis: Urinary Retention managed with SP tube ...urethral erosion.<br><br>7/9/ 2019- Interim Order" urology F/U [follow up] for Suprapubic Cath ..."<br><br>Upon review of the nursing progress notes dated April 1, 2019 through July 30, 2019 showed no evidence the facility staff assessed the resident's genital-urinal status for complications (irritation and trauma to the penis or urethra) regarding indwelling Foley catheter prior to or after the penile laceration and erosion occurred and was documented by Nurse Practitioner resulting in the surgical insertion of the suprapubic catheter | L 052 | | |

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| L 052 | Continued From page 26<br>directly in to the Residents bladder for further care.<br><br>Through record review, it was noted the resident was diagnosed with penial erosion on 1/3/19. There was no evidence that facility staff conducted an initial and ongoing genitourinary assessment (size, discoloration of skin, odor, swelling, pain, drainage) and treatment plan to promote healing. On 5/31/19, the resident was noted with a laceration to his penis from previous Foley catheter with ulcer at glans, with pain burning and purulent drainage from penis. On 7/5/19, the resident had a suprapubic catheter inserted due to urinary retention and urethral erosion.<br><br>The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee # 3 who stated she did not know what erosion was and would look it up on the internet."<br><br>2. Facility failed to ensure nursing staff has specific competencies and skills to assess and care for a dialysis-dependent arteriovenous (AV) fistula graft site. Resident #175.<br><br>Record review of the facility's undated policy titled, "Care of Resident Receiving Dialysis" showed "the nurse will check the thrill/bruit at the access site every shift."<br><br>Caring for a Patient's Vascular Access for Hemodialysis: Assess for patency at least every | L 052 | | |

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| L 052 | Continued From page 27<br>eight hours. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency. Auscultate the vascular access with a stethoscope to detect a bruit or "swishing" sound that indicates patency. Retrieved from: Nursing Management (2011).<br><br>Resident #175 was admitted to the facility on 10/26/11, with diagnoses which include Hypertension, End Stage Renal Disease dependence on Dialysis, Type II Diabetes Mellitus and Chronic Kidney Disease.<br><br>Review of the Comprehensive Minimum Data Set (MDS) dated 6/8/19, showed resident Brief Interview for Mental Status (BIMS) is coded as "15" to indicate cognitively intact. Further review of the MDS showed Section O [Special Treatments, Procedures and Programs] resident is coded as receiving dialysis.<br><br>Review of physician's order dated 7/2/19, showed "Resident has dialysis on Tuesdays, Thursdays and Saturdays for End Stage Renal Disease."<br><br>Review of resident's care plan showed, "Dialysis Dependent: monitor dialysis access site arteriovenous fistula (AV) to left arm for bruit, thrill and bleeding."<br><br>Review of the nursing assessment notes of the AV fistula site showed the following entries:<br><br>5/5/19: "Thrill/Trust present."<br><br>5/14/19: "No infection, thrill/trust present."<br><br>6/4/19: "Thrill/Trust present at this time." | L 052 | **2.1**<br><br>Resident #175 was reassessed. A review of resident's care needs was determined and care plan in place to ensure that resident's needs are met. The staffs assigned to provide care to Resident #175 were immediately re-educated.<br><br>**2.2**<br><br>A review of dialysis dependent residents with arteriovenous (AV) fistula graft was conducted; no other residents were impacted to be this practice.<br><br>**2.3**<br><br>The licensed nursing leadership team was re-educated and Competency of staff was conducted as it pertains to residents on dialysis with AV fistula grafts.<br><br>**2.4**<br><br>An audit tool was conducted monitoring residents with Dialysis and AV graft is done ensuring appropriate documentation in place. This information is provided to the QAPI committee quarterly. | 9-30-19 |

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| L 052 | Continued From page 28<br>6/11/19: "No infection noted, thrill/trust present."<br><br>7/16/19: "Thrill/Trust was present."<br><br>7/17/19: "Thrill/Trust present."<br><br>On 7/25/19, at 1:00 PM an interview with Employee #15 in the presence of Employee #14. Employee #15 was asked how do you assess the resident's AV graft site. Employee #15 stated, "I look for infection and bleeding." Employee #15 was asked what is a trust? Employee responded, "That is when the blood is going back and forth." Employee #15 was asked do you use a stethoscope when assessing the AV fistula site. Employee #15 responded, "No."<br><br>There is no evidence the nurse assessing the AV fistula has the skill or competency to provide care in accordance with professional standards of practice; review of the medical showed there was no harm to the resident.<br><br>At the time of the interview on 7/25/19, at 1:00 PM Employee#14 and Employee #15 acknowledged the finding.<br><br>C. Based on policy review, medical record review, and staff interviews for one (1) of 56 sampled residents, the facility failed to provide appropriate and sufficient catheter care and assessments and reassessments to prevent Harm for Resident #58 who was admitted with an indwelling Foley catheter which resulted in penile erosion and laceration.<br><br>Findings included... | L 052 | | |

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| L 052 | Continued From page 29<br><br>"Wound, Ostomy and Continence Nurses Society. (2016). Care and management of patients with urinary catheters: A clinical resource guide. MT. Laurel: NJ. Author" "Securement Devices: ...Indwelling catheters should be secured to avoid traction on the catheter, which causes irritation and trauma to the urethra(e.g., urethritis, necrosis, erosion, stricture) ...monitor the urethra daily for irritation, erosion, or urine leakage and assess the skin integrity under the securement device."<br><br>Resident #58 was readmitted to facility on 12/21/18, with diagnosis to include - Neurogenic bladder, Anemia, Heart Failure, Hypertension, Diabetes Mellitus, Hyperkalemia, Hyperlipidemia, Alzheimer's disease, Non Alzheimer's dementia, Depression, Cataracts.<br><br>A review of the Comprehensive MDS (Minimum Data Set) dated 4/16/19 showed, Section C (Cognitive) - BIMS score 05 indicating resident has severe cognitive impairment. Section G Functional Status the resident was coded as needing total assistance with one to two person support and care under toileting. Section H Bladder/Bowel - Appliances was coded to indicate resident has indwelling urinary draining device.<br><br>A review of the care plan for Foley Catheter due to Urinary Retention showed it was initiated on 1/23/2019. Goal: resident will have catheter care managed appropriately ...not exhibiting signs of urinary tract infection or urethral trauma. Approach: ...report signs of UTI ...manipulate tubing as little as possible during care ...provide catheter care ...use catheter strap ...use leg bag as needed ..." | L 052 | | |

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| L 052 | Continued From page 30<br><br>A review of Medical Record Revealed:<br><br>A physician's order dated 12/7/2018, "Insert Foley for UR [urinary retention]." "Urology consult for UR" 12/10/2018."<br><br>"Urology Consult-1/3/2019, Diagnosis; Urinary Retention with chronic indwelling Foley catheter and urethral erosion."<br><br>A review of NP (Nurse Practitioner) progress note dated 5/31/2019, revealed, "...10:36 PM Pt with UR, observed during day, unable to pee, Foley reinserted able to drain urine. Penis lacerated from previous Foley catheter with ulcer at glans Pt states pain burning at penis. Purulent drainage from penis ... Foley inserted attached to right leg to avoid further laceration at left side avoid diaper when patient has Foley (to lacerate penis)."<br><br>5/31/2019 - Interim Order, "Please avoid diaper when pt. has a Foley (cause Laceration of penis) Foley inserted routine Foley care q shift."<br><br>A review of NP Progress note dated 6/4/2019, "...Pt with Foley catheter with ulcer of glans purulent drainage from penis ..."<br><br>6/5/2019- Interim Order, "D/C order to avoid diaper when pt. has a Foley Use diaper to make it loose to prevent laceration."<br><br>"Urology Consult for possible Suprapubic catheter (6/20/2019) ...Progress note Urinary retention UTI [Urinary ...Penile erosion ...plan for SP [Suprapubic] tube placement under local ..." | L 052 | | |

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| L 052 | Continued From page 31<br><br>"Urology consultation for urinary retention at [Hospital Name] at 1:30 PM with [Physician name] (07/03/19). Change Foley catheter q 6 weeks obtain medical records or other history to determine if there are reasonable alternative to indwelling Foley catheter ..."<br><br>7/5/2019- Urology Consult findings: S/P tube inserted under u/s (ultrasound) guidance New diagnosis: Urinary Retention managed with SP tube ...urethral erosion.<br><br>7/9/ 2019- Interim Order" urology F/U [follow up] for Suprapubic Cath ..."<br><br>Upon review of the nursing progress notes dated April 1, 2019 through July 30, 2019 showed no evidence the facility staff assessed the resident's genitourinary status for complications (irritation and trauma to the penis or urethra) regarding indwelling Foley catheter prior to or after the penile laceration and erosion occurred and was documented by Nurse Practitioner resulting in the surgical insertion of the suprapubic catheter directly in to the Residents bladder for further care.<br><br>Through record review, it was noted the resident was diagnosed with penial erosion on 1/3/19. There was no evidence that facility staff conducted an initial and ongoing genitourinary assessment (size, discoloration of skin, odor, swelling, pain, drainage) and treatment plan to promote healing. On 5/31/19, the resident was noted with a laceration to his penis from previous Foley catheter with ulcer at glans, with pain burning and purulent drainage from penis. On | L 052 | | |

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| L 052 | Continued From page 32<br>7/5/19, the resident had a suprapubic catheter inserted due to urinary retention and urethral erosion.<br><br>The findings were acknowledged on July 29, 2019, at 10:00 AM during a face-to-face interview with Employee # 3 who stated she did not know what erosion was and would look it up on the internet." | L 052 | | |
| L 099 | 3219.1 Nursing Facilities<br><br>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:<br>Based on observations and staff interview, the facility failed to prepare foods under sanitary conditions as evidenced by four (4) of four (4) soiled fire sprinklers heads, one (1) of four (4) damaged sprinkler head, a water fountain with a missing cover and erroneous dish machine final rinse temperature documentation.<br>Findings included...<br><br>During a walkthrough of the facility's dietary services on July 17, 2019, at approximately 8:10 AM:<br><br>1. Four (4) of four (4) fire sprinklers located above the tilt skillet, the grill, the grease fryer and the stove were<br>soiled with a sticky, oily sludge.<br><br>2. One (1) of four fire sprinkler heads located above the tilt skillet was bent at the deflector. | L 099 | **1.**<br><br>The Sprinklers located above the tilt skillet, the grease fryer and the stove were cleaned immediately. The contractor was called and corrected the tent skillet at the defector. A safety barrier was placed around the main kitchen fountain. A new form was updated for the water temperature log, unable to retrospectively correct the dish machine temperature log.<br><br>**2.**<br><br>A review of the kitchen including the sprinklers, appliances, and other items was conducted no other area was identified to be impacted by this practice.<br><br>**3.**<br><br>The Engineering/Maintenance/Dietary staff were re-educated regarding the sanitation of the kitchen and ensuring its preventive maintenance program is in place. | 9-30-19 |

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| L 099 | Continued From page 33<br>3. The water fountain located in the main kitchen lacked an enclosure to protect its internal parts and provide a safety barrier.<br><br>4. Dish Machine Temperature logs from January 2019 through June 2019 were inaccurately recorded. Final Rinse temperatures were consistently documented at less than 180 degrees Fahrenheit (F) on 19 occasions in January 2019, 76 times in February 2019, 81 times in March 2019, 80 times in April 2019, and 79 times in May 2019, and twice in June 2019.<br><br>During a face to face interview with Employee #8 on July 26, 2019, at approximately 11:00 AM and Employee #9 on July 26, 2019, at approximately 12:15 PM, they both acknowledged there were no mechanical breakdowns with the dish machine when the above final rinse temperatures were recorded at less than 180 degrees Fahrenheit (F).<br><br>Dish Machine temperatures are recorded two (2) to three (3) times daily according to the Dish Machine Temperature logs.<br><br>Employee #8 acknowledged the above findings during a face-to-face interview on July 26, 2019, at approximately 11:00 AM. | L 099 | **4.**<br><br>As a component of the Quality Assurance/Improvement Program the checking of Sprinklers, Appliances and pots and pans will be added to Engineering and Dietary Quality tool. It will be conducted monthly and it will be presented to the QAPI committee quarterly. | |
| L 128 | 3224.3 Nursing Facilities | L 128 | | |

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| L 128 | Continued From page 34<br>The supervising pharmacist shall do the following:<br><br>(a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;<br><br>(b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;<br><br>(c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;<br><br>(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and<br><br>(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.<br>This Statute is not met as evidenced by:<br><br>Based on record review and staff interviews for two (2) of nine (9) nursing units, the facility staff failed to ensure that the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed.<br><br>Findings included...<br><br>A review of the Shift count Narcotic records on Unit 1 Green was completed on July 19, 2019, at | L 128 | **1.**<br><br>The Narcotic shift count for Units 1 Orange and 1 Green were immediately reconciled. No residents on units 1 Orange and 1 Green were impacted by this practice.<br><br>**2.**<br><br>All other Unit Narcotic Books were checked. No other units and no other residents were impacted by this practice.<br><br>**3.**<br><br>All licensed staff were re-educated regarding the Standard of Practice to account for the receipt, usage, disposition and reconciliation of controlled substances.<br><br>**4.**<br><br>The Nurse Managers will conduct audits of their Narcotic Records monthly. This information will be presented to the DON and/or ADON monthly and presented to the QAPI committee quarterly. | 9-30-19 |

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| L 128 | Continued From page 35<br><br>approximately 9:00 AM. The review showed that on June 5, 2019, the Shift count Narcotic was missing a nurse signature (indicating it was not done) in the space allotted the nurse going off duty to reconcile the Narcotics for the 7:30 AM to 3:30 PM shift.<br><br>A review of the Shift count Narcotic records on Unit 1 Orange was completed on July 19, 2019, at approximately 9:10 AM. On July 12, 2019, the Narcotic count sheet, showed the spaces allotted for nurse signature going off duty to reconcile the Narcotics for the 11:00 PM to 7:30 AM shift was left blank indicating "Not Done".<br><br>A review of the Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count [Reconciliation Controlled Drug Count Verification Form] directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift"<br><br>The evidence showed that the system's use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed.<br><br>A face-to-face interview was conducted with Employee #5 on July 26, 2019, at approximately 11:10 AM. After a review of the documentation, she acknowledged the findings. | L 128 | | |
| L 191 | 3231.2 Nursing Facilities<br><br>A designated employee of the facility shall be assigned the responsibility for implementing and | L 191 | | |

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| L 191 | Continued From page 36<br>maintaining the medical records service.<br>This Statute is not met as evidenced by:<br>Based on record review and staff interview facility staff failed to maintain medical record with complete and accurate documentation for one (1) of 56 sampled residents in accordance with professional standards and practices. Resident #39.<br>Findings included ...<br><br>Resident #39 was admitted to the facility on 4/28/16 with diagnoses that include: Hypertension, Chronic Obstructive Pulmonary Edema, Peripheral Vascular Disease, Hyperlipidemia and Type II Diabetes Mellitus.<br><br>Review of the Comprehensive Minimum Data Set (MDS) dated 4/9/19 showed resident Brief Interview for Mental Status (BIMS) is coded as "2" to indicate severe cognitive impairment. Further review of the MDS showed Section M [Skin Conditions] resident is coded as "3" to indicate the presence of a Stage 3 pressure ulcer (present on admission).<br><br>Review of the care plan dated 4/18/19 showed resident "impaired skin integrity pressure ulcer to the sacral area."<br><br>Review of wound and skin care progress notes showed the following entries:<br><br>1/7/19: "sacral 3-deteriorated due to prolonged seating, resident goes with her family in some weekends and typically sits for over 12 hours in her wheelchair." This statement was repeated on the February- March wound and skin progress notes (twelve entries), this would indicate the resident spent 144 hours seated in her wheelchair. | L 191 | 1.<br><br>Resident # 39 wound documentation was reviewed. Facility cannot retrospectively correct the previous wound documentations on resident # 39. The wound documentation was updated to reflect an accurate and complete information about the wound.<br><br>2.<br><br>Documentation review of residents with wounds was conducted. No other resident was impacted by this deficient practice.<br><br>3.<br><br>Educational in-service was provided to the Nurse practitioner and the wound team on accurate and complete documentation on wounds .<br><br>4.<br><br>An audit tool for accurate and complete documentation on wounds initiated. This information is presented to the QAPI committee quarterly. | 9-30-19 |

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| L 191 | Continued From page 37<br><br>Review of the facilities "Sign Out Roster" showed resident was signed out of the facility on 7/27/19 at 10:56 AM and returned to the facility at 9:39 PM. There is no documented evidence of the resident signing out of the facility prior to 7/27/19 or that the resident spent 12 hours sitting in her wheelchair with family on the weekends.<br><br>Further review of the wound notes dated 7/22/19 showed "wound healing is expected but slow due to protein malnutrition ..."<br><br>During an interview with Employee #21 on 7/29/19 at 1:30 PM, the Employee stated "I did not know that she was not going out on weekends, and no I cannot verify that the resident was sitting in her wheelchair for 12 hours as documented in the notes."<br><br>Facility staff failed to maintain medical record with complete and accurate documentation.<br><br>During an interview on 7/29/19 at 1:30 PM, Employee #21 acknowledged the finding. | L 191 | | |
| L 201 | 3231.12 Nursing Facilities<br><br>Each medical record shall include the following information:<br><br>(a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion;<br><br>(b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; | L 201 | | |

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| L 201 | Continued From page 38<br>(c)Medicaid, Medicare and health insurance numbers;<br><br>(d)Social security and other entitlement numbers;<br><br>(e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;<br><br>(f)Date of discharge, and condition on discharge;<br><br>(g)Hospital discharge summaries or a transfer form from the attending physician;<br><br>(h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation;<br><br>(i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease;<br><br>(j)Current status of resident's condition;<br><br>(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;<br><br>(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; | L 201 | | |

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| L 201 | Continued From page 39<br><br>(m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service;<br><br>(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;<br><br>(o)The plan of care;<br><br>(p)Consent forms and advance directives; and<br><br>(q)A current inventory of the resident's personal clothing, belongings and valuables.<br><br>This Statute is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 56 sampled residents the charge nurse failed to ensure the resident received treatment and care in accordance with professional standards of practice as evidenced by failure to ensure that Resident #548 was seen by the orthopedic physician in a timely manner.<br><br>Findings included...<br><br>Resident #548 was admitted to the facility on 7/10/19, with diagnoses to include Pain in Ankle and Joints of Unspecified Foot, Unstable Angina, Diabetes without Complications and Hypertension. | L 201 | | |

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| L 201 | Continued From page 40<br><br>During a face-to-face interview with Resident #548 on 7/17/19 he stated, "I have not had a follow up appointment related to my fractured toe(s). When I spoke with the facility, they stated the hospital did not give them the appointment date. I have not seen the orthopedic surgeon since I have been here and I do not have an appointment."<br><br>Review of the discharge summary from the hospital dated 7/10/19, showed, " ...[Resident #548] should remain NWB (Non weight bearing) LLE (left lower extremity) and elevate LLE when not ambulating ...Follow up with [Doctor Name] in 7-10 days after discharge. Splint should remain in place and will get repeat x-rays in ortho clinic in 2 weeks."<br><br>The physician's order dated 7/13/19 stipulated, " ...Schedule appointment to follow up with orthopedic ..."<br><br>The facility staff failed to schedule Resident #548 for a follow up orthopedic appointment in a timely manner.<br><br>During a face-to-face interview with Employee #16 on 7/22/19, at 2:12 PM, she (nurse manager) stated the appointment has not been made. He did not come with an appointment date. Employee #16 then reviewed the discharge summary and stated, "We will make the appointment today."<br><br>The facility staff failed to ensure that Resident #548 was seen by the orthopedic physician within 7 -10 days after he was discharged from the hospital. | L 201 | 1.<br><br>Resident #548 was reassessed. An Orthopedic appointment was immediately re-scheduled. Resident #684 met his goals and was discharged home.<br><br>2.<br><br>A review of residents who have consultations with follow-up appointments and newly admitted with follow-up appointments conducted. No resident was affected by this practice.<br><br>3.<br><br>The nursing management and Unit Secretaries were re-educated regarding scheduling of follow-up appointment. A monitoring tool will be used to monitor the scheduled follow-up appointments.<br><br>4.<br><br>Monitoring follow-up appointment has been added to the quality improvement tool. This will be done monthly and submitted to the DON and/or representative. This information will be submitted quarterly to the QAPI committee. | 9-30-19 |

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| L 217 | Continued From page 41 | L 217 | | |
| L 217 | 3234.4 Nursing Facilities<br><br>The provision of space and the way in which the facility is equipped, furnished, and maintained shall provide a home- like setting for each resident while providing the staff a pleasant and functional working environment.<br><br>This Statute is not met as evidenced by:<br>Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom vents in four (4) of 65 residents' rooms and ten (10) of ten (10) containers of Boost nutritional drinks that were stored for use beyond their expiration date.<br><br>Findings included...<br><br>During an environmental tour of the facility on July 18, 2019 between 10:00 AM and 3:30 PM the following observations were made:<br><br>1. Bathroom vents in Resident rooms' #159, #160, #208 and #237 were soiled with dust, four (4) of 65 resident's<br>rooms.<br><br>2. Ten (10) of ten (10) eight-ounce carton containers of Boost nutritional supplement drinks, stored in the pantry<br>on Unit 2 Blue, were expired as of May 30, 2019.<br><br>Employee #9 acknowledged the above findings during a face-to-face interview on July 18, 2019 at approximately 3:00 PM. | L 217 | **1.**<br>The Bathroom vents in rooms #159, 160, 208 and 237 were cleaned immediately. The expired Boost in the pantry was removed and discarded on the day identified.<br><br>**2.**<br>A review of the bathroom vents in the facility was conducted, no other vents were identified. A review of the Boost was conducted; no other expired cans of Boost were noted.<br><br>**3.**<br>The Housekeeping staff were re-educated regarding the inspection and cleaning of vents. The nursing staff and central supply staff were re-educated regarding the checking of supplemental feeding and of ensuring that the First In First Out project is in place.<br><br>**4.**<br>As a component of the Quality Assurance/Improvement Program the checking of Vents will be added to Engineering Quality tool. The monitoring of supplemental feeding i,e Boost will be added to the monitoring of the nursing environment, including the pantry. This information will be presented to the QA/QI quaterly | 9-30-19 |

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| L 306 | Continued From page 42 | L 306 | | |
| L 306 | 3245.10 Nursing Facilities<br><br>A call system that meets the following requirements shall be provided:<br><br>(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;<br><br>(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;<br><br>(c)Be of a quality which is, at the time of installation, consistent with current technology; and<br><br>(d)Be in good working order at all times.<br><br>This Statute is not met as evidenced by:<br><br>Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in two (2) of 65 resident's rooms that failed to alarm when tested.<br><br>Findings included...<br><br>During an environmental walkthrough of the facility on July 18, 2019, between 10:00 AM and 3:30 PM, the call bell in resident rooms #155A and #309A did not alarm when activated, two (2) of 65 resident's rooms.<br><br>This breakdown could prevent or delay care to residents in an emergency. | L 306 | **1.**<br><br>The Call Bell System in rooms 155A and 309A was corrected immediately.<br><br>**2.**<br><br>A review of the call bells and its operation was conducted. No other call bell rooms were affected.<br><br>**3.**<br><br>The Engineering/Maintenance staff were re-educated regarding the call bell systems and checking of functionality.<br><br>**4.**<br><br>The Call Bell System is audited as a part of the Engineering/Maintenance program monthly. This information is presented to the QAPI committee quarterly. | 9-30-19 |

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| L 306 | Continued From page 43<br>Employee #9 acknowledged the above findings during a face-to-face interview on July 18, 2019 at approximately 3:00 PM. | L 306 | | |
| L 410 | 3256.1 Nursing Facilities<br><br>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.<br>This Statute is not met as evidenced by:<br>Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom vents in four (4) of 65 resident's rooms and ten (10) of ten (10) containers of Boost nutritional drinks that were stored for use beyond their expiration date.<br><br>During an environmental tour of the facility on July 18, 2019 between 10:00 AM and 3:30 PM the following observations were made:<br><br>1. Bathroom vents in Resident rooms' #159, #160, #208 and #237 were soiled with dust, four (4) of 65 resident's<br>rooms.<br><br>2. Ten (10) of ten (10) eight-ounce carton containers of Boost nutritional supplement drinks, stored in the pantry<br>on Unit 2 Blue, were expired as of May 30, 2019.<br><br>Employee #9 acknowledged the above findings during a face-to-face interview on July 18, 2019 at approximately 3:00 PM. | L 410 | **1.**<br>The Bathroom vents in rooms #159, 160, 208 and 237 were cleaned immediately. The expired Boost in the pantry was removed and discarded on the day identified.<br><br>**2.**<br>A review of the bathroom vents in the facility was conducted, no other vents were identified. A review of the Boost was conducted; no other expired cans of Boost were noted.<br><br>**3.**<br>The Housekeeping staff were re-educated regarding the inspection and cleaning of vents. The nursing staff and central supply staff were re-educated regarding the checking of supplemental feeding and of ensuring that the First In First Out project is in place.<br><br>**4.**<br>As a component of the Quality Assurance/Improvement Program the checking of Vents will be added to Engineering Quality tool. The monitoring of supplemental feeding i,e Boost will be added to the monitoring of the nursing environment, including the pantry. This information will be presented to the QA/QI quaterly | 9-30-19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0007 | A. BUILDING: _____ B. WING _____ | 07/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WASHINGTON CTR FOR AGING SVCS | 2601 18TH STREET NE WASHINGTON, DC 20018 |

| (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 442 | 3258.13 Nursing Facilities<br><br>The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br>This Statute is not met as evidenced by:<br>Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by four (4) of four (4) fire sprinkler heads from the Ansul fire suppression system in the main kitchen that were soiled with grease and one (1) of four (4) fire sprinklers with a bent deflector and a water fountain with a missing cover.<br><br>Findings included...<br><br>During a walkthrough of the facility's dietary services on July 17, 2019, at approximately 8:10 AM:<br><br>1. Four (4) of four (4) fire sprinklers located above the tilt skillet, the grill, the grease fryer and the stove were soiled<br>with a sticky, oily sludge.<br><br>2. One (1) of four fire sprinkler heads located above the tilt skillet was bent at the deflector.<br><br>3. The water fountain located in the main kitchen lacked an enclosure to protect its internal parts and provide a<br>safety barrier.<br><br>Employee #8 acknowledged the findings during a face-to-face interview on July 26, 2019, at approximately 11:00 AM. | L 442 | **1.**<br><br>The Sprinklers located above the tilt skillet, the grease fryer and the stove were cleaned immediately. The contractor was called and corrected the tent skillet at the defector. A safety barrier was placed around the main kitchen fountain. A new form was updated for the water temperature log, unable to retrospectively correct the dish machine temperature log.<br><br>**2.**<br><br>A review of the kitchen including the sprinklers, appliances, and other items was conducted no other area was identified to be impacted by this practice.<br><br>**3.**<br><br>The Engineering/Maintenance/Dietary staff were re-educated regarding the sanitation of the kitchen and ensuring its preventive maintenance program is in place.<br><br>**4.**<br><br>As a component of the Quality Assurance/Improvement Program the checking of Sprinklers, Appliances and pots and pans will be added to Engineering and Dietary Quality tool. It will be conducted monthly and it will be presented to the QAPI committee quarterly. | 9-30-19 |