Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: _____ B. WING _____	Stoddard Baptist 08/07/2015

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WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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L 000	Initial Comments The annual licensure survey was conducted on August 3, through August 7, 2015. The deficiencies are based on observations, record review and staff interviews for 44 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia D/C - discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary Team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set	L 000	Global Care at Washington Center for Aging Services (SBGC), is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the Deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

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L 000	Continued From page 1 Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - Physician ' s Order Sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- responsible party RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance	L 000	Continued from page 1	
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: A. Based on observation, record review and staff interview for one (1) of 44 sampled residents, it	L 001	**L001 3200.1 NURSING FACILITIES**	

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L 001	Continued From page 2 was determined that pharmacy services failed to ensure that an ophthalmic medication was delivered to the facility and available to be administered to the resident. Resident #274 The findings include: A review of Resident #274 ' s record revealed a physician ' s order signed July 28, 2015 at 8:55 AM directed: " Atropine Sulfate Ophthalmic Solution USP 1%- eye drop right eye (four times a day) [for] Glaucoma. " A review of the Medication Administration Record for July 2015 and August 2015 revealed that the facility identified that the Atropine Sulfate Ophthalmic Solution was to be administered at 6AM, 10AM, 2PM and 6PM. Review of the July 2015 and August 2015 Medication Administration Records (MAR) revealed that Resident #274 was not administered the medication from July 28, 2015 through August 4, 2015. The reason written on the reverse side of the July 2015 MAR was " Not available. Not given. " A total of 30 doses were not administered to Resident #274. A face-to-face interview was conducted with Employees # 3, #4, #13 and #31 on August 4, 2015 at approximately 11:00 AM regarding the aforementioned findings. After review of the clinical record all acknowledged the findings. A telephone interview was conducted with Employee #32 on August 4, 2015 at approximately 11:06 AM regarding the aforementioned findings. He/she stated the physician orders for the resident ' s admission medications were faxed and received by the	L 001	Continued from page 2 1) Resident #274 was not affected by this deficiency. The Physician was notified and a STAT order for the ophthalmic solution was immediately faxed to the pharmacy. The medication was received on August 4, 2015 and administration began at 2 pm. 2) All residents' orders for ophthalmic solutions were reviewed. No other residents were affected by this deficient practice. 3) Pharmacy will reinforce procedure to manually check off each written order as they are processed and reviewed. Pharmacy will reinforce process for communication to the facility and documentation of reasons for new orders not being processed and dispensed such as needed clarification and non-availability as well as follow up required for nursing staff. 4) Pharmacy consultant will monitor medication delivery processes. Nursing management will report findings to the monthly QI Committee quarterly.	8/31/15 8/31/15 10/16/15

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L 001	Continued From page 3 pharmacy at 10:56 PM on July 28, 2015. Further stated, " The medications should have been dispensed and delivered to the facility in accordance to the delivery schedule agreed upon by the facility and pharmacy. There was no documentation in the system as to why the medication was not sent. So, it was overlooked or missed. I will refer this incident to the Quality Department. " There was no evidence that the pharmacy ensured that an ophthalmic medication was delivered to the facility and available to be administered to the resident. The clinical record was reviewed on August 4, 2015. B. Based on record review, staff and resident interview for one (1) of 44 sampled residents, it was determined that the facility failed to ensure that Resident #161 was administered eight (8) ounces of Ensure Plus at each meal in accordance with the physician's order. The findings include: A physician's order dated July 14, 2015 directed, "D/C [discontinue] Med Pass [fortified nutritional shakes] and sugar free med pass orders (secondary) to resident's request for Ensure Plus [nutritional supplement] " Contact family to bring Ensure Plus from home..." The Interim Physician's Order dated July 16, 2015, directed: "Supplement clarification 1. Administer Ensure Plus 8 ozs (ounces) po at each meal (per resident's request) rather than	L 001	Continued from page 3	

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L 001	Continued From page 4 between meals. 2. Family responsible for bringing product" A review of the Medication Administration Record from July 14, 2015 to August 5, 2015 revealed that Ensure Plus had not been administered to Resident #161. A face-to-face interview was conducted on August 4, 2015 at approximately 4:00 PM with Employee #28. He/she was asked about the above orders and whether the resident's family member had been contacted [to bring the Ensure plus]. Employee #28 revealed that the resident contacted the [family member] a while ago [date and or time not specified] and [family member] would bring the Ensure Plus to the facility. A face-to-face interview was conducted on August 5, 2015 at approximately 3:30 P.M. with Resident #161. He/she stated, "My [family member] said [he/she] was going to bring the Ensure but I haven't seen [he/she]." A face-to-face interview was conducted with Employee #2 and Employee #28 on August 5, 2015 at approximately 4:00 PM. Employee #2 stated, "The resident has a right to refuse the Med Pass and the facility will make sure that [he/she] gets the Ensure Plus." Employee #28 said the [he/she] would personally go to the drugstore to purchase the Ensure Plus. There was no evidence that the resident	L 001	Continued from page 4 1) The Physician order for Ensure Plus for resident #161 was corrected immediately and the supplements were purchased the same day. Ensure Plus is being served with meals as ordered began on August 5, 2015 The resident was assessed and was not affected by the deficient practice. 2) A review of all residents with orders for nutritional supplements was conducted. No other residents were affected by this deficient practice. 3) All licensed staff and nutritionists were educated on transcriptions of orders for nutritional supplements. Orders will be reviewed daily by Clinical Care Coordinators. 4) The nursing management team will monitor documentation of orders for nutritional supplements. Findings will be reported to the monthly QI Committee meetings quarterly.	9/21/15 10/7/15 10/16/15

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L 001	Continued From page 5 sustained untoward affects (e.g. weight loss) as a result of not receiving the supplement. The record was reviewed on August 5, 2015.	L 001	Continued from page 5	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 44 sampled residents, it was determined that the charge nurse failed to revise the comprehensive care plan to manage connectivity concerns affecting the delivery of enteral feeding for Resident #203.	L 051	**L 051 3210.4 NURSING FACILITIES** 1) Resident #203's care plan was updated with interventions to manage Gastrostomy tube. The resident was not affected by this practice. 2) A review of all residents with gastrostomy feeding care plans was conducted. None required updates. 3) All nursing staff will be in-serviced on updating care plans. Clinical Care Coordinators will monitor care plans for residents on feeding tubes. 4) Unit Manager will audit care plans and report findings to QI Committee monthly.	9/18/15 10/7/15 10/16/15

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L 051	Continued From page 6 The findings include: The charge nurse failed to update Resident #203 ' s care plan to include interventions to manage repeated episodes of the enteral formula line separating from the Gastrostomy [feeding; g-tube] tube, affecting the delivery of enteral nutrition. An observation of Resident #203 was conducted on August 7, 2015 at approximately 1:45 PM. The resident was observed lying in bed with the bed linens soiled with enteral formula. The enteral feeding tubing was observed connected to a delivery pump, however disconnected from the resident ' s Gastrostomy site. A face-to-face interview was conducted with Employee #13 immediately after the observation of the binder and the spilled tube feeding liquid. The employee acknowledged that the Gastrostomy tube had become disconnected/separated and caused the feeding to spill into the resident ' s bed on several occasions. The employee also acknowledged that the spillage was often reported by family member(s). A review of the clinical record revealed previous connectivity concerns related to the Gastrostomy and enteral feeding lines as follows: According to a nurse ' s note dated July 19, 2015 at 3:58 PM, " RP [responsible party] called writer about G-tube [leaking] on the floor. Writer went	L 051	Continued from page 6	

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L 051	Continued From page 7 inside the room and found g-tube popped out and feeding on the floor. Writer changed y-connector and told [responsible party] that I need caregiver to help change resident. Writer left resident room to call the care giver and before writer returned the g-tube popped out again and [responsible party] said, ' I heard the [pop] and know it was [the] g-tube but I didn ' t touch it. Writer fixed the g-tube and "y-connector" [a device that provides a connection between a feeding tube] and it popped again while [responsible party] was still in the resident room. [Responsible party] voiced again that [he/she] heard the [pop]. G-tube intact and patent and flushed. No popping or draining noted. [Responsible Party] said, thank you. " A review of the comprehensive care plan last updated May 12, 2015 lacked evidence of goals and approaches to manage the connectivity concerns identified with Resident #203 ' s Gastrostomy feeding. A telephone interview was conducted with Employee #2 who verbalized that interventions such as hourly enteral feeding monitoring and device modification was implemented to manage the connectivity concerns. However; s/he acknowledged that the care plan was not amended to include the measures.	L 051	Continued from page 7	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;	L 052	**L 052 3211.1 NURSING FACILITIES**	

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L 052	Continued From page 8 (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. This Statute is not met as evidenced by:	L 052	Continued from page 8 1) Resident #91 was not affected by this deficient practice. The order for TSH was faxed to Dialysis Center on August 6, 2015. The TSH was done. 2) All other dialysis-dependent residents' orders were reviewed. None were affected by this deficient practice. — 9/18/15 3) All licensed nurses will be in-serviced on proper lab request completion. Clinical Care Coordinator will monitor all requests for labs at dialysis. — 10/7/15 4) Unit Managers will audit monthly and report findings to QI Committee monthly. — 10/16/15	

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L 052	Continued From page 9 Based on observation, record review, staff interview and the review of a complaint for three (3) of 44 sampled residents, it was determined that sufficient nursing time was given to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being in accordance with the comprehensive assessment and plan of care as evidenced by failure to: obtain diagnostic laboratory tests and ensure Hemodialysis treatment was performed as scheduled for one (1) resident; consistently maintain a Gastrostomy tube to ensure effective delivery of enteral feeding and comprehensively assess one (1) resident with Hypotension [low blood pressure]; and administer ophthalmic solution in accordance with physician ' s orders for one (1) resident with a diagnosis of Glaucoma. Residents' #91, #203 and #274. The findings include: 1A. Facility staff failed to ensure sufficient nursing time was given to follow through on a physician ' s order to obtain laboratory tests for Resident #91. According to a Physician ' s Interim Order dated June 13, 2015 at 8:00PM, [obtain] " TSH, Free T4 on 6/16/15 [June 16, 2015] @ [at] dialysis center-Dx [diagnosis] wt. [weight] gain ... " A review of the clinical record on August 6, 2015 lacked evidence of the results of the TSH and T4 lab results.	L 052	Continued from page 9 1) Resident #91 was assessed by Nurse Practitioner on May 2, 2015. Resident did not exhibit adverse signs related to need for dialysis. She received dialysis 5/4/2015 and 5/5/2015. 2) A review of all dialysis-dependent residents was conducted. No other resident was affected by this deficiency. Nursing supervisor will closely monitor residents' dialysis scheduled appointments. 3) All nursing staff to be in-serviced in proper notification of missed appointments. 4) Audits will be presented at the monthly QI Committee meetings quarterly.	9/18/15 10/7/15 10/16/15

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L 052	Continued From page 10 A face-to-face interview was conducted with Employee #15 on August 6, 2015 at approximately 2:00 PM. The employee reviewed the clinical record and acknowledged that the results were not available. A follow-up interview was conducted on August 7, 2015 at approximately 11:00 AM with Employee # 15 regarding the labs ordered for Resident #91. He/she stated that the labs were obtained on August 6, 2015. Facility staff failed to follow a physician ' s order to obtain diagnostic lab tests for Resident #91. The order was not acted upon until the surveyor inquired regarding the results on August 6, 2015. The record was reviewed on August 6, 2015. 1B. Facility staff failed to ensure that Resident #91 received Hemodialysis treatments in accordance with the established schedule [Tuesdays/Thursdays and Saturdays] as prescribed. A review of a History and Physical signed and dated July 22, 2015 revealed Resident #91 's active diagnosis included ESRD -HD (End Stage Renal Disease - Hemodialysis) [three] 3 times a week. A review of the plan of care dated June 6, 2015 revealed that the Resident #91 was scheduled to attend dialysis 3 days per week (Tuesdays, Thursdays and Saturdays).	L 052	Continued from page 10 1) Resident #203's soiled abdominal binder and bed linens were removed immediately. The Y-connector was also changed at this time. 2) A review of all residents with feeding tubes was conducted. No other resident was affected by this practice. — 9/18/15 3) All staff will be in-serviced on Trouble-Shooting Gastrostomy Tubes. Unit Managers will monitor feeding tubes for spillage. — 10/7/15 4) Unit Managers will report findings to the QI Committee monthly. — 10/16/15	

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L 052	Continued From page 11 A review of the Nurses Progress Notes revealed the following: May 2, 2015 [Saturday] at 3:23 PM - "Resident missed dialysis this morning, transportation did not come, supervisor made aware. " May 2, 2015 at 10:37 PM - "Resident remains alert and responsive. Denies pain or distress, Rt [right] arm access site intact, thrill and bruit present... At 6 PM NP (nurse practitioner) and supervisor on unit to assess resident, at 8:20 PM supervisor on unit and informed RP [name] of resident not going to dialysis this AM. Orders noted from NP to monitor condition and call MD/NP (medical doctor/ nurse practitioner) if there are any changes in status." A review of [Name of Dialysis Center] log sheet for the month of May 2015 revealed that on Saturday, May 2, 2015 Resident #91 was coded as " M (NS) " (Missed treatment due to -no show). There was no indication recorded as to why the resident did not show up for his/her appointment. A telephone interview was conducted on August 7, 2015 at approximately 11:00 AM with a representative from the dialysis center. He/she acknowledged that the resident did not show for his/her dialysis appointment. The resident ' s scheduled appointment time is 11:00 AM on Tuesday, Thursdays and Saturdays.	L 052	Continued from page 11 1) Resident #203 was transferred to the hospital on July 20. 2015 for evaluation of hypotension. She returned on the same day. Retrospectively no corrective action can be done for the action cited. 2) A review of all residents was conducted. No other resident was affected by this practice. 3) All licensed nurses were in-serviced on proper assessment of residents with hypotension. Clinical care coordinators will monitor assessments for any residents with a diagnosis of hypotension. 4) Nursing management will audit assessments of all residents with hypotension and report findings to the QI Committee quarterly.	9/21/15 10/7/15 10/16/15

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L 052	Continued From page 12 A face-to-face interview was conducted with Employee #15 on August 7, 2015 at approximately 12:30 PM. He/she acknowledged the findings and stated, " The resident leaves [the unit] at 9:30AM for transportation to pick him/her up to go dialysis appointments. The resident returns to facility around 4:00 PM. " There was no evidence that Resident #91 received his/her Hemodialysis treatment on Saturday, May 2, 2015 [the scheduled day]. A face-to-face interview was conducted with Employee #15 on August 7, 2015 at approximately 12:30 PM. He/she acknowledged the findings. 2. Facility staff failed to consistently assess and manage Resident #203's Gastrostomy tube [G-tube] to ensure that the connectivity was maintained in order to deliver enteral feeding effectively. Additionally, licensed nursing staff failed to conduct comprehensive nursing assessments when Resident #203 was assessed with repeated episodes of hypotension [low blood pressure]. A. Facility staff failed to consistently assess and manage Resident #203 ' s G-tube. The Physician ' s Order signed and dated [unable to read], directed, " ...Tube feeding with Jevity 1.5 [enteral formula] 70 ml via g [Gastrostomy] tube via pump for 18 hours per day or until total nutrient delivered. Downtime: 12 AM - 6AM... "	L 052	Continued from page 12 1) Resident #274 physician was notified and the order was given to continue the eye drops. The medication was delivered STAT. Administration began on August 4, 2015 at 2 pm. 2) A review of all residents with eye drops was conducted. No other resident was affected by this deficiency. 3) All nursing staff will be in-serviced on Physician order transcription and administration of eye drops. 4) The Unit Manager will audit administration of eye drops and report findings to QI Committee quarterly.	9/18/15 10/7/15 10/16/15

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L 052	Continued From page 13 " Apply Abdominal binder for g-tube protection. Remove abdominal binder every shift and monitor for any irregularities and re-apply every shift ... " change feeding (Spike Cap Set/bag) every day " The nurse ' s note dated July 19, 2015 at 3:58 PM reads, " RP [responsible party] called writer about G-tube [leaking] on the floor. Writer went inside the room and found g-tube popped out and feeding on the floor. Writer changed y-connector and told [responsible party] that I need caregiver to help change resident. Writer left resident room to call the care giver and before writer returned the g-tube popped out again and [responsible party] said, ' I heard the [pop] and know it was [the] g-tube but I didn ' t touch it. Writer fixed the g-tube and "y-connector" [a device that provides a connection between a feeding tube] and it popped again while [responsible party] was still in the resident room. [Responsible party] voiced again that [he/she] heard the [pop]. G-tube intact and patent and flushed. No popping or draining noted. [Responsible Party] said, thank you. " An observation of the resident ' s abdominal binder was conducted on August 7, 2015 at approximately 1:45 PM. At the time the tubing [that connects the feeding to the resident] was noted to be disconnected at the connector site and the enteral feeding had spilled onto the resident ' s bed linens [sheets and draw sheet]. A face-to-face interview was conducted with Employee #13 immediately after the observation of the binder and the spilled tube feeding liquid. The employee acknowledged that the Gastrostomy tube had become	L 052	Continued from page 13	

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L 052	Continued From page 14 disconnected/separated and caused the feeding to spill into the resident ' s bed on several occasions. The employee also acknowledged that the spillage was often reported by family member(s). There was no documented evidence that facility staff assessed the resident ' s GI status [gastrointestional] after occurrences of the Gastrostomy tube separating from the " Y-connector. " In addition there was no documented evidence that facility staff had taken steps to determine why the tubing repeatedly became disconnected. B. Licensed nursing staff failed to conduct comprehensive assessments when Resident #203 was assessed with repeated episodes of " Hypotension " - defined by the American Heart Association as " a blood pressure lower than 90/60 mm/Hg [millimeters of mercury] which may be accompanied with dizziness, lightheadedness, rapid/shallow breathing, fatigue ... " www.heart.org <http://www.heart.org> A review of the clinical record for Resident #203 revealed that he/she sustained approximately three (3) episodes of hypotension between the period of July 14 thru 20, 2015. The resident required transport to a local emergency department to evaluate hypotension. The record included the following documentation relative to episodes of Hypotension:	L 052	Continued from page 14	

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L 052	Continued From page 15 Nurse ' s notes: July 14, 2015 at 4:12 PM " V/S [vital signs] 87/60 [blood pressure], 79 [pulse]; 16 [respirations]; 97.9 [temperature]. Seen by the NP [nurse practitioner named] for low blood pressure ...lab done. Result shows no infection as per NP. New order for extra water flush to 200 ml every 2 hours x [times] one day for hypotension and Sodium chloride 1 g [gram] per g-tube [Gastrostomy-tube] bid [twice daily] x2 doses for low blood pressure. RP [responsible party named] was on the unit and NP updated [him/her] about resident low blood pressure and labs result and new order. " SIC July 22, 2015 at 4:02 PM " Resident is stable. G-tube intact and patent. Feeding and medication well tolerated. Low blood pressure at 84/55. NP was notified. No distress or agitation noted this shift. " July 20, 2015 at 4:19 PM " Resident is stable. G-tube is intact and patent. Medication administered as ordered. No agitation noted this shift. Resident has low blood pressure [blood pressure recorded on medication administration record 85/60]. NP was notified. " Physician ' s interim order Physician ' s order dated July 20, 2015 at 5:01 PM read: " Send pt [patient] to ER [emergency room] [hospital name] for eval [evaluation] of hypotension. "	L 052	Continued from page 15	

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L 052	Continued From page 16 There was no evidence that licensed nursing staff comprehensively assessed Resident #203 to determine his/her hemodynamic status once he/she was noted with Hypotension. The documentation in the nursing entries lacked evidence as to whether or not the resident demonstrated adverse signs and symptoms of Hypotension [examples listed above in Hypotension definition] and the documentation was inconsistent with acceptable standards of practice as it relates to a comprehensive assessment of hemodynamic status. The findings were acknowledged during a telephone interview with Employee #2. 3. Facility staff failed to administer an ophthalmic solution to Resident #274 in accordance with physician ' s orders. According to a history and physical progress note dated July 28, 2015 revealed Resident # 274 was admitted to the facility on July 27, 2015 and diagnoses included Glaucoma. A physician ' s order dated July 27, 2015 and signed July 28, 2015 directed; " Atropine Sulfate Ophthalmic Solution USP 1%- eye drop right eye (four times a day) [for] Glaucoma. " A review of the July and August 2015 Medication Administration Records (MAR) lacked evidence	L 052	Continued from page 16	

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L 052	Continued From page 17 of nurses initials in the allotted spaces [indicative that the medication was administered] on July 28, 29, and 30 and August 1-4, 2015. A total of 30 doses were omitted. On the reverse side of the MAR under the heading " PRN, STAT and Medications not administered, " nursing staff documented the following: " 7/31/15 -6AM- Atropine Sulfate-not available- not given. " There was no further documentation to indicate why the Atropine Ophthalmic Solution was not administered. A face-to-face interview was conducted with Employees' # 3, #4, #13 and #31 on August 4, 2015 at approximately 11:00 AM regarding the aforementioned findings. After review of the clinical record all acknowledged the findings. The clinical record was reviewed on August 4, 2015.	L 052	Continued from page 17 **L 056 3211.5 NURSING FACILITIES** 1) On August 7, 2015, the overall nursing care coverage requirement of 4.1 hours was not met at 3.9 hours. This observation is unable to be corrected.	
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the facility failed to provide 4.1 [four and one tenth] hours for Direct	L 056	2) All residents have the potential to be affected when the overall nursing care coverage hours is not met, however there were no negative outcomes found to the facility's residents. 3) Recruitment plans are in place to hire required staffing levels with focus on hiring LPNs and CNAs. Wage salary scale based on years-of-experience has been implemented.	9/18/15 9/18/15

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L 056	Continued From page 18 Nursing Care on one (1) of the seven (7) days reviewed, in accordance with Title 22 DCMR Section 3211. Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 7, 2015 at approximately 2:30 PM. According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. Of the seven (7) days reviewed, one (1) of the days failed to meet the Direct Nursing Care Hours 4.1 [four and one tenth] as follows: On August 7, 2015 it was determined that the facility provided direct nursing care at a rate of 3.9 hours. The findings were determined on August 7, 2015 at approximately 3:30 PM during a concurrent review of records with Employee #2 who acknowledged the findings.	L 056	Continued on page 18 4) Human Resources and the Director of Nursing will continue to monitor vacancies and the facility's retention plan and findings will be reported to the monthly QI Committee quarterly.	10/16/15
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set	L 099		

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L 099	Continued From page 19 forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on August 3, 2015 at approximately 9:30 AM and on August 6, 2015 at approximately 11:05 AM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by the lack of food temperature monitoring from steam tables located in the dining room of units 1 Green and 2 Green, a soiled ice machine on unit 2 Orange and dented hotel pans in the main kitchen. The findings include: 1. Food temperatures from newly installed steam tables located in the dining room of units 1 Green and 2 Green are not monitored and have never been monitored. 2. One (1) of one (1) ice machine on unit 2 Orange was soiled. 3. Three (3) of nine (9) six-inch hotel pans, one (1) of nine (9) four-inch hotel pans and two (2) of eight (8) eight-inch hotel pans in the main kitchen were dented. These observations were made in the presence of Employee #23 who acknowledged the findings.	L 099	Continued from page 19 **L 099 3219.1 NURSING FACILITIES** 1. Food temperatures from newly installed steam tables located in the dining room of units 1 Green and 2 Green are not monitored and have never been monitored. The temperature of the food for the newly installed steam tables was taken prior to leaving the kitchen area. As of 8/4/05 food temperature logs for steam tables was implemented. 2. One (1) of one (1) ice machine on unit 2 Orange was soiled and upon observation 3. Three (3) of nine (9) six-inch hotel pans, one (1) of nine (9) four-inch hotel pans and two (2) of eight (8) eight-inch hotel pans in the main kitchen were dented. An order was placed on 9/10/15 to replace the identified dented hotel pans. The expected delivery date for the replacement hotel pans is 9/15/15. 2) 1. Food temperature logs for the delivery of all resident food is in place. Food 09/28/15 temperatures are reviewed by the Director of Food and Nutritional Services on a daily basis. 2. Ice machines on all units have been inspected by the Director of Engineering/ Designee on 9/21/15.	9/15/15 9/28/15
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in	L 168	3. The condition of all hotel pans/ kitchen equipment will be inspected for replacement/repair.	

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L 168	Continued From page 20 accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: During a medication storage tour on August 3, 2015 at approximately 10:55 AM, it was determined that the facility failed to label two (2) of two (2) opened bottles of alcoholic beverages, that were stored in the medication room in an unlocked storage cabinet on one (1) of eight (8) residential care units. The finding include: The facility ' s policy , " Resident Alcohol Beverages " Policy No: NSD04-164, stipulates, " ... 2. All alcohol beverages will be labeled with the resident ' s first and last name and room number and stored in the medication room or the refrigerator on the nursing units. " On August 3, 2015 at approximately 10:55 AM an observation of the medication room was conducted. At this time two (2) of two (2) unlabeled and opened 3 liters and 1.5 liters bottles of Livingston Cellars Burgundy Wine was observed on the 3rd shelf of an unlocked cabinet located in the medication room on Unit 2 Blue. The observation was made in the presence of Employee #2, Employee #29 and Employee # 30. All acknowledged the findings.	L 168	Continued from page 20 3) An in-service will be provided to the Food and Nutritional services and Engineering staff on the relevance of food sanitary conditions and the regulatory requirements. This training will be initiated on 9/21/15 . 4) A quality assurance program to monitor Food procurement, storage, preparation, serving and sanitary requirements was implemented under the supervision of the Director of Food and Nutritional Services and Director of Engineering which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor effective 10/16/15. **L 168 3227.19 NURSING FACILITIES** 1) The alcoholic beverage bottles were immediately labeled with the resident's name and room number and safely stored upon observation. 2) All residents' orders were reviewed. No resident was affected by this practice. 3) The nursing staff has been re-educated on proper labeling and storage of ordered alcoholic beverages.	9/28/15 10/16/15 9/18/15 10/7/15
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records.	L 190		

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L 190	Continued From page 21 This Statute is not met as evidenced by: Based on record review and staff interview for one (1) for 44 sampled residents, it was determined that facility failed to ensure that facility staff accurately documented the amount of water administered to Resident #203. The findings include: The Physician ' s Interim Order dated July 14, 2015 at 3:00 PM, directed, " Extra water flush to 200 ml every 2 hours x [times] one day for hypotension... " A review of July 2015 Medication Administration Record revealed, " Extra water for one day may increase water flush to 200 ml 2qh [every two hours] x [times] one day for hypotension " . The hours recorded for the administration times were 11-7 [shift]; 7-3 [shift] and 3-11 [shift]. On July 14 and 15 nurses ' initials were observed allotted spaces indicating that water flushes were administered every shift. There was no documented evidence that the facility administered water flushes every two hours [twelve times in 24 hours] as ordered by the physician. On September 3, 2015 at approximately 11:00 AM, a telephone interview was conducted with Employee #3. He/she stated that the resident received the fluids every two hours and acknowledged the findings.	L 190	Continued from page 21 4) Nursing management will monitor labeling and storage of alcoholic beverages and report the findings to the monthly QI Committee quarterly. **L 190 3231.1 NURSING FACILITIES** 1) Resident #203's feeding pump was set to deliver the extra water as ordered. The fluid was given to the resident through the feeding tube. 2) A review of all residents with feeding tubes was conducted. No other residents were affected by the deficient practice. 3) All nursing staff will be re-educated on correct documentation of extra amounts of water ordered for residents with feeding tubes. The clinical care coordinators will monitor orders for extra water for residents. 4) The nursing management team will report findings to the monthly QI committee quarterly.	9/18/15 10/7/15 10/16/15

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L 212	Continued From page 22	L 212	Continued from page 22	
L 212	3233.5 Nursing Facilities Each facility shall use its best efforts to resolve each grievance as soon as practicable, and shall report to the resident and the Resident's Representative on the status of the resolution of the grievance at least thirty (30) days. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 44 sampled residents, it was determined that facility staff failed to resolved one (1) resident's complaint of lost dentures in a timely manner. Resident #108 The findings include: A face-to-face interview was conducted with Resident #108 on August 5, 2015 at approximately 10:00 AM. At this time resident stated, " I have no teeth. My dentures were stolen from inside the cabinet. Everyone is aware that my dentures were stolen. I saw the dentist few months and am waiting for dentures. As we finished the interview resident restated, " I still need my dentures. " A review of the Physician's Order Sheet for the month of April 2015 directed, " Dental consult as needed. " A "Consult for Dental Appointment" dated April 8, 2015 revealed, "Complete oral exam/oral concerns ... "Pt [patient] informs of lost dentures and request more, Nurse informed ... need denture start, if facility cannot find, Condition of teeth, Pt [patient] edentulous. "	L 212	**L 212 3233.5 NURSING FACILITIES** 1) Resident #108 was not adversely affected by the deficiency. The Dentist was notified immediately and invoice for resident's denture has been processed. Dental impressions were done. Resident will receive dentures within 2-3 weeks. 2) All other residents with pending orders for dentures were reviewed with the dentist for timely follow up. 3) Unit managers will report Weekly on follow up from dentist for processing of dentures requests. 4) Unit managers will report findings to the QI committee monthly.	10/7/15 9/18/15 10/7/15 10/16/15

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L 212	Continued From page 23 A face-to-face interview was conducted with Employee #17 on August 6, 2015 at approximately 11:17AM regarding the resident lost dentures. Employee #17 presented the writer with an invoice dated June 17, 2015 from the dental office that revealed a request for payment for new dentures. There was no evidence that the facility staff made prompt efforts to resolve Resident#108 ' s complaint of lost dentures in a timely manner. Another face-to-face interview was conducted on August 6, 2015 at approximately 1:17 PM with Employee #17. He/she acknowledged the findings. The record was reviewed on August 6, 2015.	L 212	Continued from page 23 **L 214 3234.1 NURSING FACILITIES** 1) The flat aluminum-like pan and the trash receptacle upon observation was filled with sand on 8/6/15. There were no unfavorable outcomes as a result of this finding. 2) An order for two safe smoker receptacles was placed on 8/10/15 and upon arrival these receptacles will be put into use and the existing receptacles will be removed.	8/6/15 10/5/15
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 and staff interview, it was determined that the facility failed to ensure that the facility was free of potential accident hazards as evidenced by failure to ensure the safe disposal of smoking materials in adequate receptacles in the designated smoking area for residents' that reside in the facility. The findings include: According to National Fire Protection Association	L 214	3) The order for safe smoker receptacles was placed on 8/10/15, however until the safe smoker receptacles arrive this solution will ensure that the identified practice does not recur. 4) A quality assurance program to monitor accident hazards/supervision/devices requirements has been implemented under the supervision of the Director of Engineering/Designee which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. A report will be provided at the next Quality Improvement meeting effective 10/16/15	10/5/15 10/16/15

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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 214	Continued From page 24 (NFPA) 2000 Edition,19.7.4..."3) Ashtrays on noncombustible material and safe design shall be provided in all areas were smoking is permitted. 4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking in permitted." On August 6, 2015 at approximately 4:25 PM in the presence of Employee #24 the facility ' s designated smoking area was observed. At this time one (1) of one (1) flat aluminum-like pan was observed on the metal outdoor table in the designated smoking area. There were no residents observed smoking at the time of the observation; and there were no cigarette wastes (i.e. butts) observed in the flat aluminum-like pan. One (1) of one (1) open top trash receptacle with a clear plastic liner was also observed in the designated smoking area. Employee #24 acknowledged that the flat aluminum-like pan and the trash receptacle were not adequate for safe disposal of cigarette waste. He/she stated, " Security is always present when the residents are smoking. I will order one [an approved cigarette receptacle] it will be here tomorrow. " The facility failed to ensure that the designated smoking area was equipped with adequate receptacles for the safe disposal of cigarette waste. The receptacles (aluminum pan and the open top trash can with a plastic liner) utilized for the disposal of cigarette waste failed to meet safe disposal requirements.	L 214	Continued from page 24	

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	HFD02-0007	A. BUILDING: _____ B. WING _____	08/07/2015

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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 August 6, 2015 at approximately 2:15 PM, it was determined that the facility failed to maintain call bells in good working condition as evidenced by call bells that failed to alarm when tested in two (2) of 48 resident's rooms and call bells that were wrapped around the grab bar in two (2) of 48 resident's rooms. The finding include: 1. Call bells in resident room #105 and #112 did not activate when tested. 2. Call bells located in the bathroom of resident room #311 and #313 were wrapped around the	L 306	**L 306 3245.10 NURSING FACILITIES** 1) Call bells for residents in rooms #105 and #112 were immediately replaced. 2) A review was conducted of call bells in all other residents' rooms. None were found to be inactive. — 9/18/15 3) All staff were re-educated on checking call bells for proper functioning. Unit clerks will conduct testing of call lights weekly. — 10/7/15 4) Nursing management team will report findings to the monthly QI Committee quarterly. — 10/16/15	

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L 306	Continued From page 26 grab bar and failed to activate when tested. These observations were made in the presence of Employee #24 and/or Employee #26 who acknowledged the findings.	L 306	Continued from page 26 **L 410 3256.1 NURSING FACILITIES** 1) Exhaust vents in resident's shower rooms located on units 3 Blue, 3 Orange, 3 Green, 2 Blue, 1 Green were soiled, five (5) of eight (8) resident care units were cleaned upon notice on 8/6/15.	8/8/15
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 6, 2015 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled exhaust vents in resident shower rooms located in five (5) of eight (8) resident care units and soiled exhaust vents in one (1) of 48 resident's rooms was missing one (1) vent cover. The findings include: 1. Exhaust vents in resident's shower rooms located on units 3 Blue, 3 Orange, 3 Green, 2 Blue, 1 Green were soiled, five (5) of eight (8) resident care units. 2. The exhaust vent located in the bathroom of resident room #202 was soiled, one of 48 resident rooms surveyed.	L 410	2) The exhaust vent located in the bathroom of resident room #202 was soiled, one (1) of 48 resident rooms surveyed, which was cleaned upon notice on 8/6/15. 3) Privacy curtains were hanging loose and off the hooks in resident's room #201, #240,#285, #382, #339, five (5) of 48 resident's rooms surveyed, which were rehung properly upon notice on 8/6 /15. 4) Privacy curtains were torn in four (4) of 48 resident's rooms including room #185, #201,#203, and #240 which were replace with untorn curtains on 8/6 /15. 5) One (1) of three (3) privacy curtains in room #209 (bed A) was missing, one (1) of 48 resident rooms surveyed which were were replaced on 8/6/15.	8/8/15 8/8/15 8/8/15

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L 410	Continued From page 27 3. Privacy curtains were hanging loose and off the hooks in resident's room #201, #240, #285, #382, #339, five (5) of 48 resident's rooms surveyed. 4. Privacy curtains were torn in four (4) of 48 resident's rooms including room #185, #201, #203, and #240. 5. One (1) of three (3) privacy curtains in room #209 (bed A) was missing, one of 48 resident rooms surveyed. 6. Shower curtains were hanging loose and off the hooks in shower rooms located on units 3 Green and 3 Orange. These observations were made in the presence of Employee #24 and/or Employee #26 who acknowledged the findings.	L 410	Continued from page 27 6) Shower curtains were hanging loose and off the hooks in shower rooms located on units 3 Green and 3 Orange which were rehung properly upon notice on 8/6 /15. 2) All exhaust vents were inspected and cleaned if required; all privacy curtains were inspected and rehung or replaced if determined necessary. Weekly inspections to include: exhaust fans, privacy and shower curtains will be conducted by the Director/Designated Manager (Lead) in an effort to provide and maintain housekeeping and maintenance services in a sanitary, orderly and comfortable interior. 3) An environmental services competency training program will be initiated on 09/23/15 for the environmental services staff on daily inspections and corrective actions.	9/28/15 9/28/15
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on August 3, 2015 at approximately 9:30 AM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by two (2) of two (2) chipped and dented blades from the buffalo chopper, one (1) of seven (7) steam table covers with a missing handle and one (1) of two (2) reach-in refrigerator with a torn door gasket. The findings include:	L 442	4) A quality assurance program to monitor environmental and engineering rounds was implemented under the supervision of the Director of Environmental Services and Director of Engineering which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. **L 442 3258.13 NURSING FACILITIES** 1) 1. Two (2) of two (2) blades from the buffalo chopper were chipped and dented and needed to be replaced. There were no negative outcomes to the	10/16/15 8/14/15

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L 442	Continued From page 28 1. Two (2) of two (2) blades from the buffalo chopper were chipped and dented and needed to be replaced. 2. One (1) of seven (7) steam table lid cover did not have a handle. 3. The door gasket from one (1) of two (2) reach-in refrigerators was torn. These observations were made in the presence of Employee #23 who acknowledged the findings.	L 442	residents as a result of this deficiency. The blades from the buffalo chopper were ordered on 8/10/15 and have been put into use as of 8/14/15. 2. One (1) of seven (7) steam table lid covers did not have a handle. There were no negative outcomes to the residents as a result of this deficiency. The replacement steam table lid was ordered as of8/17/15 and has been placed into use. 3. The door gaskets of two (2) reach in refrigerators in the kitchen were torn and replaced on 09/21/2015. There were no negative outcomes to the residents as a result of this deficiency. 2) All essential equipment in the kitchen including the buffalo chopper blades, steam table lid and refrigerator door gaskets will be checked and assessed on 09/28/2015 to determine if repairs/ replacements are required. 3) An in-service was provided for all Food and Nutritional Services and Engineering staff regarding the ongoing inspections of all Essential equipment the kitchen and specific to the Engineering staff they gained additional knowledge on the essential equipment throughout the facility. 4) A Preventative Maintenance Program will be implemented effective 09/30/15 to to monitor and inspect essential equipment, to include, however not be limited to kitchen equipment such as (buffalo chopper blades, pans and steam table lid covers, which will be inspected by the Director of Food and Nutritional Services and refrigerator gaskets will be inspected by Director Engineering. refrigerators in the facility monthly, which will be reported effective10/16/15 quarterly to the QI Committee.	9/28/15 9/30/15 10/16/15