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 ______	07/15/2016

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L 000	Initial Comments The Annual Licensure Survey was conducted at Washington Center for Aging Services from July 7, 2016 through July 15, 2016. The following deficiencies are based on observation, record review and staff interviews for 43 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass)	L 000	SBGC at WCAS, 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 MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record AM Care - morning activities of daily living	L 000	Continued From page 1	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:	L 052	L 052 3211.1 Nursing Facilities	

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L 052	Continued From page 2 (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: I. Based on observation, record review and staff interview for six (6) of 43 Stage 2 sampled residents, it was determined that facility staff	L 052	Continued From page 2	

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failed to ensure that each resident received and the facility provided the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by failure to follow physician ' s orders for the use of a left palm protector for one (1) resident, administer Midodrine 10 mg in accordance with physician ' s order for one (1) resident, ensure that one (1) resident had a follow up urologist consult in a timely manner, consistently monitor, assess and develop a pain management plan to treat one resident ' s pain, ensure that the protocol for central line catheter was followed for one (1) resident with a peripherally inserted central catheter (PICC) and to follow physician's orders to administer influenza vaccine to one (1) resident. Residents' #80, 66, 171, 208, 267, and 275.

The findings include:

1. Facility staff failed to follow physician ' s orders for the use of a left palm protector for Resident #80.

A review of the July 2016 Physician ' s Orders signed and dated by the physician directed: "Left hand Palm Protector with roll to be applied to hand with PROM [Passive Range of Motion] and hand hygiene wear at all times and remove for AM/PM care."

Resident #80 was observed on July 13, 2016 at approximately 10:00 AM and did not have the Palm Protector in place. Employee #33 who was present at the time of the observation, searched the resident's room and was unsuccessful in locating the device.

Provider's Plan of Correction:

1.

1. Resident #80 was assessed on 7/13/16 and the palm protector was placed on the resident's left hand as ordered by the attending physician. There were no unfavorable outcomes to the resident as a result of this practice. — 7/31/16
2. An audit was conducted on all other residents with orders for palm protectors to ensure compliance. — 8/31/16
3. Nursing staff are being in-serviced on resident protective devices. — 8/31/16
4. The Resident Care Managers and Charge Nurses will conduct monthly audits of residents with orders for protective devices and the information will be reported to the Quality Improvement Committee quarterly. The next meeting is scheduled on 9-16-16. — 8/31/16

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L 052 (Summary Statement of Deficiencies):

There was evidence that facility staff ensured that Resident #80 wore the left palm protector in accordance with the physician ' s order.

2. Facility staff failed to administer Midodrine 10 mg (used to treat low blood pressure) in accordance with physician ' s order for Resident #208.

The June and July 2016 Physician ' s Orders directed: " Midodrine 10 mg administer one (1) tablet by mouth three [3] times a day on dialysis days as needed for systolic blood pressure less than 120 [mm Hg] (millimeters of mercury) and/or diastolic blood pressure less than 65 [mm Hg] (Hypotension) "

Review of the June 2016 Dialysis Communication forms revealed that the resident ' s systolic blood pressure was less than 120 [mm Hg] on the following days:

June 1, 2016 - 118/no diastolic blood pressure measurement recorded - post dialysis
June 3, 2016 - 117/73 [mm Hg] post dialysis measurement
June 8, 2016- 108/68 [mm Hg] pre dialysis measurement
June 10, 2016- 110/74 [mm Hg] post dialysis measurement
June 15, 2016-114/70 [mm Hg] pre dialysis measurement
June 17, 2016 - 112/68 [mm Hg] pre dialysis measurement
June 22, 2016-117/72 [mm Hg] pre dialysis measurement; 103/71 [mm Hg] post dialysis measurement

L 052 (Provider's Plan of Correction):

2.

1. Resident #208 was assessed on 7/14/16 and the medication Midodrine 10 mg. was administered in accordance with the physician order. The order for Midodrine was discontinued. — 7/14/16

2. All physician medication orders and the medication administration records were checked to validate the medication was being given as ordered. — 8/31/16

3. Licensed Nurses are being re-educated on the medication administration of Midodrine in accordance with the physician orders. — 8/31/16

4. Physician orders and medication administration records will be audited monthly and reported to the Quality Improvement Committee quarterly. The next meeting is scheduled on 9/16/16. — 8/31/16

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L 052	Continued From page 5 A review of the June 2016 Medication Administration Record revealed that Midodrine 10 mg was administered on the following dates: June 1, 2016 at 5:00 PM; Reason for administration, systolic BP (blood pressure) less than 120 [mm Hg] June 10, 2016 at 3:00 PM; Reason for administration, SBP (systolic blood pressure) 110/74 mm Hg June 22, 2016 at 5:00 PM; Reason for administration, SBP 103/71 [mm Hg] On the aforementioned dates, the results of taking the medication were documented as " effective " however, there were no blood pressure measurements recorded on the MAR or in the nursing progress notes. There was no evidence that facility staff administered Midodrine 10 mg to the resident on four (4) occasions (June 3, 8, 15 and 17, 2016) when the systolic blood pressure was less than 120 mm Hg in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on July 14, 2016 at approximately 9:46 AM. He/she acknowledged the findings. The record was reviewed on July 14, 2016. 3.The facility staff failed to ensure that Resident #171 had a follow up consultation for a neurogenic bladder. A review of the facility's Consultation form dated May 23, 2016 directed... "(3) Follow up w [with] /	L 052	Continued From Page 5 3. 1. Resident #171 was assessed on 7/13/16. The assigned nurse/employee #23 documented a physician order for an urology consultation with Dr. Michael H. Phillips on 7/27/16 for medical evaluation of neurogenic bladder. There were no unfavorable outcomes to the resident as a result of this practice. 2. All resident medical records were checked for urology follow-up on consultation 8-31-16 orders and correction was made if required. 3. Licensed Nurses are being re-educated 8-31-16on physician orders for medical consultations. 4. The Resident Care Managers are 8-31-16 responsible for ensuring that audits are being conducted monthly to monitor physician orders for medical consultations and reported to the Quality Improvement Committee quarterly.	7-27-16 8-31-16 8-31-16 8/31/16

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[doctors name] for neurogenic bladder.."

A face-to-face interview was conducted on July 13, 2016 at approximately at 4:00PM with Employee #23. He /she was queried regarding the follow up physician ' s visit for Resident #171' s for neurogenic bladder. Employee #23 stated, "I did not write an order for the resident a follow up visit [for neurogenic bladder]."

There was no evidence that facility staff ensured that Resident #171 had a follow up consultation with [name of physician] for neurogenic bladder.

4. Facility staff failed to provide care for Resident #267 who had a PICC [peripherally inserted central catheter] line in accordance with physician's orders.

A resident observation was conducted on July 15, 2016 at approximately 11:00 AM. Resident #267 was observed lying in [his/her] bed in an isolation room. The resident was observed with a PICC line on the right upper arm. The PICC line had a clear dressing that did not have a label to identify the name, date or time that the dressing was applied.

A review of the Admission Physician Order Sheet and Plan of Care dated June 23, 2016 revealed that Resident #267 came to the facility on this date from acute care setting with medication order to give Ertapenem 1G [Gram] IV [intravenous] Daily to be given 6 weeks for ESBL [Extended-Spectrum Beta-Lactamase] in urine.

A review of the Physician order sheet dated June 23, 2016 directed, "Ertapenem (Invanz) [antibiotic] 1GM IV [intravenous] daily for 6 weeks ESBL [Extended-Spectrum

Provider's Plan of Correction (L 052):

4.

1. Resident #267 was assessed on 7/15/16.The residents PICC line central catheter dressing was changed per physician orders and labeled to identify the name, date and time of the registered nurse on 7/15/16. There were no unfavorable outcomes to the resident as a result of this practice. — 7/15/16
2. There were no other residents affected by this practice. — 7/3116
3. Registered Nurses are being re-educated on 08/28/16 the management of PICC line central catheters. — 8/28/16
4. Monthly audits of PICC line catheters are 8/19/16 being conducted and reported to the Quality improvement Committee quarterly. — 819/16

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L 052	Continued From page 7 Beta-Lactamase] [in] urine Stop date 7/18/16." NS [normal saline] Administer 1 GM [Gram] (100 ml) IV over 30 minutes at a rate of 200ML[milliliters]/HR [hour] once every 24 hours via PICC line and Flogard pump until 8/4/16 [August 4. 2016] A review of the Central - Line Catheter Protocol revealed that the facility staff failed to follow the protocol as evidence by: Under section " device type " the allotted boxes were left blank Under section " type of infusion " , the allotted boxes were left blank Under section " On admission " the allotted boxes were left blank Under section Flushing Protocol: " 5ml NSS [normal saline] before meds, 5ml NSS after meds, 5ml 10units/ml Heparin flush " was checked but the facility reported they do not flush with heparin. Under treatment Protocols " label with name date and time was left blank on PICC line dressing Under change dressing the allotted boxes were left blank indicating not performed or not done. In addition, facility staff failed to measure the upper right arm circumference inches above insertion site and prn every seven (7) days with the dressing change; and failed to measure the external catheter length on admission with each dressing change and prn.	L 052	Continued From Page 7	

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	A review of Pharmacy Protocol " Appendix 8.3 Central - Line Catheter Protocol form " policy: last reviewed October 1, 2010 that reads, " Purpose: Documentation shall be in accordance with facility policies and procedures and on facility approved forms. Guidelines for use of the form: Each field on the form must be completed in full " ... Facility nursing staff and prescribers are responsible for checking off or writing in orders that are consistent with the current, acceptable standard of care."		5. **Resident #66** The flu vaccine was unable to be given to Resident #66 at the time of observation due to the flu season (September 1, 2015-March 31, 2016).	8/28/16
	There was no evidence that facility staff ensured that the protocol for central line catheter was followed as evidence by the allotted boxes for the catheter protocol was left blank indicating not performed or not done.		All resident immunization records were audited and no deficits were identified.	8/20/16
	A face-to-face Interview was conducted on July 15, 2016 at approximately at 4:00PM with Employees #4 and #7. After review of the aforementioned, both acknowledged the findings.		Education was provided to licensed nursing Staff on documentation of immunization records.	
	5. Facility staff failed to follow physician order to administer influenza vaccine to one resident. Resident #66		Immunization records will be audited monthly which will be reported to the Quality Assurance and Performance Improvement Committee on a monthly basis for three months, if there are no compliance issues the reporting frequency will be changed to quarterly.	8/19/16
	A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #66 was admitted to the facility on February 18, 2016 with an order that directed " Flu vaccine annually. "			
	A review of the Immunization record revealed that the space allotted for documenting administration of the flu vaccine was left " Blank " indicating the vaccine was not administered.			
	A Face-to-Face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee			

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L 052	Continued From page 9 # 7. He /she acknowledged the findings. The record was reviewed on July 15, 2016. 6. Facility staff failed to administer PPD [Purified Protein Derivative] for Resident #275 in a timely manner. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #275 was admitted to the facility on March 9, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR [chest radiograph] if positive. " A review of the Medication Administration record revealed that PPD 1- step TST [tuberculin skin test] was administered on March 24, 2016 and read March 26, 2016. This was documented on the immunization record as given and negative 15 days post physician order. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 15, 2016. II. Based on observation, record review, and interview for three (3) of 43 Stage 2 sampled residents, it was determined that facility staff failed to ensure that a resident who is unable to carry out activities of daily living [ADL] received the necessary services to maintain good grooming, personal and oral hygiene as evidenced by failure to: consistently provide personal care and grooming for one (1) resident who was observed with unkempt hair and eyelids stuck together with drainage; one (1) resident in need of oral hygiene and one (1) resident	L 052	Continued From Page 9 6. 1.Resident #275 was assessed on 7/15/16. The resident was admitted on 3/9/16 and received PPD 1-Step (tuberculin skin test on 3/24/16). There were no unfavorable outcomes to the resident as a result of this practice. 2.All new resident admissions were checked to validated that residents received PPD 2-Step (tuberculin skin test) in a timely manner. 3. All licensed nurses are being educated on 8-28-16 requirement for 2-Step PPD (tuberculin skin test) with focus on timely administration. 4. New resident admissions are being audited monthly to ensure 2-Step PPD (tuberculin skin test) are being administered in a timely manner and reported to the Quality Assurance and Performance Improvement Committee quarterly.	7/15/16 8/28/16 8/28/16 8/19/16

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L 052	Continued From page 10 observed with excessive facial hair. Residents #80, 9, and 126. The findings include: 1. Facility staff failed to ensure that Resident #80, who was unable to carry out activities of daily living, received the necessary services to maintain grooming and personal hygiene as evidenced by an observation wherein it was determined the resident ' s eyelids were stuck together with excessive eye drainage and his/her hair was unkempt. According to Resident #80 ' s annual and quarterly Minimum Data Sets (MDS) dated February 16, 2016 and May 18, 2016 respectively, revealed: Resident #80 was totally dependent on one (1) staff for hygiene and bathing according to Section G, Functional Status. The resident was coded as severely impaired for daily decision making under Section C, Cognition and under Section B, Hearing Speech and Vision, Resident #80 was coded as rarely/never understands and no speech (absence of spoken words). According to the history and physical examination signed by the physician on February 27, 2016, Resident #80 ' s diagnoses included Advanced Dementia, Generalized Debility, Hypertension and Dysphagia. A. On July 13, 2016 at approximately 10:00 AM, following the completion of AM care (confirmed by the assigned certified nurse assistant), Resident #80 was observed in his/her room lying in bed. The resident's eyes were closed and his/her eyelids were observed to be soiled with drainage.	L 052	Continued From Page 10 1. Resident #80 was assessed on 7/13/16 by the physician and charge nurse. The resident's eyes were immediately cleaned and the physician, who was present onsite prescribed treatment which was ordered and administered to the resident's eyes on 7/13/16. The resident's hair was washed and styled in the beauty shop on 7/14/16. 2. All residents that are totally dependent on staff for ADL care were assessed or checked by the Charge Nurse/Resident Care Manager and appropriate care was provided as required. Resident's in need of hair care services have received the appropriate hair care services by the Cosmetologist/ Barber/facility staff. 3. All nursing staff have been re-educated regarding providing ADL care, **including** hair care/grooming services for all residents and are conducting daily rounds on all residents to assure that all ADLs have been provided.	7-13-16 8-28-16 8-28-16

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L 052	Continued From page 11 Immediately following the observation, a query was made to Employee #35 [physician] who was present on the unit. Employee #35attempted to examine the resident's eyes, however, he/she was unable to open the resident ' s eyes due to buildup of a yellow crusted substance. Employee #35 stated [he/she] would prescribe an antibiotic treatment for the resident ' s eyes. A review of physician ' s orders revealed Employee #35 wrote the following order: " July 13, 2016 at 11:20 AM, Clean eyelids with Ocusoft [pre-moistened pad to clean eyelids] every shift, then apply Erythromycin Ophthalmic ointment x [times] 10 days for Blepharitis. " A review of the resident's care plan revealed: "ADL Functional /Rehabilitation" [Activities of Daily Living]: care plan, initiated on February 24, 2016, last updated May 25, 2016 revealed that the resident was identified with a "potential for decline in functional [status] and mobility ADLs due to Dementia, Approaches: Assist resident with ADL's...Evaluation: Resident depends on staff for all aspect of ADLs ... " A review of the Medication Administration Record [MAR] for July 13, 2016 revealed the licensed nurse signed the MAR to reflect that 9:00 AM medications were administered as follows: two (2) medications and one (1) supplement administered via gastrostomy tube (GT); one (1) transdermal patch administered topically and blood pressure assessed. Facility staff failed to provide eye care and personal hygiene consistent with the resident's needs. The resident's eyelids were stuck together with drainage. Facility staff completed AM care and medications were administered; however,	L 052	Continued From Page 11 4. Resident care managers are conducting daily audits on ADL care and will be providing a report to the QAPI Committee on a monthly basis to assure compliance. If compliance is consistent and determined appropriate by the QAPI Committee the reporting will be reported on a quarterly basis.	8-19-16

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there was no evidence that clinical staff assessed the buildup of drainage and/or crusting around the resident ' s eyes prior to the surveyor ' s observation. Subsequently, the resident was diagnosed with Blepharitis and prescribed antibiotic medication for the eyes.

A face-to-face interview was conducted with Employee #33 on July 13, 2016 at approximately 1:30 PM. He/she acknowledged that Resident #80 ' s eyes were stuck together with drainage and that licensed staff acted on the physician ' s orders to cleanse the resident ' s eyes and obtain the prescribed treatment.

A face-to-face interview was conducted with Employees # 1, 2, and 3 on July 13, 2016 at approximately 4:00 PM regarding the aforementioned observation. The clinical record was reviewed on July 13, 2016.

B. Facility staff failed to maintain grooming for Resident #80 who was observed with his/her hair unkempt (untidy/disheveled).

A resident observation was conducted on July 13, 2016 at approximately 12:00 PM with Employee #33. The employee repositioned the resident on his/her left side. At this time, Resident #80's hair [towards the back of the head] was observed uncombed, matted and unclean.

The clinical record lacked evidence of documentation related to the resident ' s most recent shampoo and/or hair styling.

The resident was unable to communicate his/her needs and the staff was required to anticipate the resident ' s needs. According to the care plan "ADL Functional /Rehabilitation " [Activities of

Provider's Plan of Correction:

1. Resident #80 was assessed on 7/13/16 by the physician and charge nurse. The resident's eyes were immediately cleaned and the physician, who was present onsite prescribed treatment which was ordered and administered to the resident's eyes on 7/13/16. The resident's hair was washed and styled in the beauty shop on 7/14/16. — 7-13-16

2. All residents that are totally dependent on staff for ADL care were assessed or checked by the Charge Nurse/Resident Care Manager and appropriate care was provided as required. Resident's in need of hair care services have received the appropriate hair care services by the Cosmetologist/ Barber/facility staff. — 8-28-16

3. All nursing staff have been re-educated regarding providing ADL care, including hair care/grooming services for all residents and are conducting daily rounds on all residents to assure that all ADLs have been provided. — 8-28-16

4. Resident care managers are conducting daily audits on ADL care and will be providing a report to the QAPI Committee on a monthly basis to assure compliance. If compliance is consistent and determined appropriate by the QAPI Committee the reporting will be reported on a quarterly basis. — 8-19-16

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L 052	Continued From page 13 Daily Living] dated May 25, 2016, " Resident depends on staff for all aspect of ADLs ... " On July 14, 2016, subsequent to the surveyor ' s observation, Resident #80 was observed in the beauty shop having a shampoo. A face-to-face interview was conducted with Employees' #1, #2, #3, #4, #33, and #36 at the time of the observations. After review of the aforementioned, all acknowledged the findings. 2. Facility staff failed to consistently provide routine oral care for Resident #9 who was totally dependent and was observed with large amounts of food particles around his/her gums and between the teeth. A family interview was conducted on July 8, 2016 at approximately 12:40 PM. In response to the question; " Does the resident receive the help he/she needs in cleaning his/her teeth, the family member responded, " No. [His/her] teeth always have food particles. " The family member then said to the resident, " Show me your teeth. " The resident responded by opening his/her mouth and revealed large amounts of food particles around the gums and between the teeth. " Subsequent observations prior to breakfast on July 11 and 12, 2016 also revealed the food particles caked between the resident ' s teeth and on the gums. A review of the quarterly MDS with an ARD (Assessment Reference Date) of June 10, 2016 revealed, the resident was coded as totally	L 052	Continued From page 13 2. 1. Oral care is offered on a daily basis to resident #9 who has had a history of refusals, however she received oral care for food particles in the mouth on 7/8, 7/11, and 7/12/16. 2. All totally dependent residents oral care has been checked and oral care has been provided to the residents as required if allowed. 3. Nursing staff (RNs, LPNs, CNAs) are being re-educated on oral health care to residents, which will entail instruction on the recommended oral hygiene care practices in older adults. The education will be conducted by nurse managers, Dr. Rogers (Dentist) and Dr. Lawrence (Dentist) as a part of an intervention to improve oral health outcomes among residents residing in long term care facilities	7/12/16 8/28/16 8/31/16

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dependent for dressing, toilet use and personal hygiene. According to Section I (Diagnoses) the resident was admitted to the facility with diagnoses which included Alzheimer ' s Disease, Non-Alzheimer ' s Dementia and Depression.

A face-to-face interview was conducted with Employee #47 at approximately 2:30PM on July 14, 2016. The employee was queried whether he/she usually brushed the resident ' s teeth when providing daily oral care. He/she responded, " No. When I tried to brush [his/her] teeth they bled and I was told not to brush them. I wipe them but [he/she] does not always open his/her mouth. "

A face-to-face interview was also conducted with Employee #9 at approximately 3:00PM on July14, 2016. The employee was informed of the family member ' s statement, the surveyor ' s observations and the staff ' s interview. In response the employee stated, " it is true that [he/she] does not always open [his/her] mouth and allow the teeth to be cleaned. That ' s why we use the sponges. Employee #9 acknowledged the finding.

3. Facility staff failed to provide necessary services to maintain grooming for Resident #126 who requires extensive assistance to maintain his/her grooming was observed with excessive facial hair.

On July 8, 2016 at approximately 12:16 PM and July 13, 2016 at approximately 10:00 AM, Resident #126 was observed with gray colored hair covering [his/her] upper lip and chin.

Provider's Plan of Correction (L 052):

Corrective action	Complete date
1. Resident #126 facial hair was removed on 7/13/16. There were no unfavorable outcomes to the resident as a result of this practice.	7/13/16
2. All residents were checked for facial hair and groomed accordingly.	8/28/16
3. Nursing assistants are being re-educated on ADL care with focus on removal of facial hair on residents.	8/28/16
4. Audits are being conducted monthly to monitor the residents with facial hair and information is reported to the Quality Improvement Committee monthly.	8/31/16

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According to the Certified Nursing Aide charting, the resident received AM and PM care (personal hygiene/grooming) on July1-13, 2016, however there was no evidence that facility staff shaved the resident while providing AM care.

A face-to-face interview was conducted with Resident #126 on July 13, 2016 at approximately 3:30 PM. He/she stated, " Someone use to shave me, I don't know who. I tried to find someone who is regular to remove it (the hair on his/her chin). I asked someone but they never came back. I would like it [the hair on his/her chin] removed. " This interview was conducted in the presence of Employee # 38 who acknowledged the findings.

III. Based on observation, record review and staff interview for two (2) of 43 Stage 2 sampled residents, it was determined that facility staff failed to ensure that the resident environment was as free of accident hazards as is possible; and that each resident received adequate supervision to prevent accidents as evidenced by: failure to utilize appropriate safety measures while providing AM (morning) care to one (1) resident who subsequently sustained a fall and required transport to a local emergency department for treatment of a complaint of chest pain post fall; and failure to adequately supervise one (1) resident with wandering behaviors who entered the room and engaged in an encounter with another resident who subsequently sustained an injury. Residents' #126, #154 and #279.

The findings include:

Provider's Plan of Correction (L 052):

1. (A) Resident #126 sustained an injury on 7/10/16 while (1) CNA was providing am care at the bedside, which correlated to the rehabilitation screen/evaluation during this incident. Resident#126 was assessed on 7/10/16 and orders were received to transfer the resident to the emergency room on 7/10/16. The facility is unable to correct this experience for the resident, however the careplan has been assisted for the assist of two persons.. — 8/3/16

(B) Resident #154 wandered into the room of resident #279 without supervision on 6/27/16 and an altercation caused resident #279 to fall and sustain an abrasion .2x.1 on right eyelid which healed in 24 hours. The resident was assessed and orders received to transport the resident per 911 to the emergency room for CT scan which was negative the resident returned on the same day and was seen by the in house physician on the following day. The facility is unable to correct this experience for the residents involved, however the careplan of Resident#154 has been updated to reflect additional approaches to address wandering.

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1. Facility staff failed to utilize appropriate safety measures while providing AM/ADL (morning activities of daily living) care to Resident # 126 who sustained a fall during care in the company of a CNA (certified nurse assistant), complained of chest pain at the time of the fall and subsequently required transport to the local emergency department for treatment post fall.

According to the Minimum Data Set completed June 15, 2016, Resident #126 was coded as requiring two-person physical assistance for transfers, toilet use, and bathing. The resident was coded as not steady, only able to stabilize with staff assistance and impairment to lower extremities on both sides, under Section G Functional Status. Under section H (Bladder and Bowel) the resident was coded as always incontinent of urine and bowel.

Review of the nursing progress notes revealed:

July 10, 2016 at 9:28 AM, "At 8:30 AM writer received a report from the assigned CNA that resident slid from standing position to the floor while receiving AM care. On assessment resident alert and oriented x2, verbalized chest pain, r [right] 2nd toe skin tear 0.8 x 0.4 x 0.0 cm with minimal active bleeding, pressure dressing applied to R 2nd toe, bleeding stopped, NP (nurse practitioner) called and new order received to send [the resident to the] ER (emergency room) via 911 for chest pain ... "

July 10, 2016 at 9:28 PM, "Resident return from the [Hospital Name] at 6:19 PM alert and stable ... "

Falls risk Assessment completed June 22, 2016 revealed, "Evaluation Score = 21 (Score of 10 or

Provider's Plan of Correction:

(C) Upon identified of the frayed call 8/3/16 bells (3) they were replaced immediately and the unsecured surge protector (1) located in a resident's room was identified as not belonging to the facility was immediately removed and a facility surge protector was put in place. The general cleaning chemical located in 1 of the 8 units surveyed was removed immediately upon location. It was identified as a product used on special cleaning projects.

The general cleaning chemical container was immediately removed from the unsecured biohazard room on 8/3/16 by the Director of Environmental Services.
The janitor's closet is set up to have cleaning chemicals dispensed through a wall dispensing system located in the janitor's closet which is to be locked at all times.

(D) The Micro-kill One and Epiclenz were immediately to the SDS books located on each unit.

2. (A) All residents with the potential to be affected by this practice have been reviewed and updated if applicable to address safety measures. — 7/15/16

   (B) Hourly rounding has been 7/15/16 implemented in an effort to minimize accidents with injury.

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higher represents a high risk for falls) "

According to the "Point of Care History" Activities of Daily Living data competed by the respective Certified Nurse Assistant from July 1-10, 2016, revealed that Resident #126 was coded as having one (1) person physical assistance during transferring and toileting.

A face-to-face interview was conducted with the Employee # 39 [staff assigned to care for Resident #126 on July 10, 2016, day of the fall] on July 14, 2016 at approximately 1:30 PM Employee #39 was asked to explain how the incident occurred with the resident ending up on the floor during AM care. " He/she stated, "I washed [his/her] face. The [resident] likes to stand up on the side of the bed and stand. [He/she] holds the rails. On this morning [he/she] was standing facing the window. [He/she] was at the bottom part of the bed. I raised the rail so [he/she] could grab it. [He/she] urinated and [he/she] wanted to step out of it [urine] and [his/her] foot slipped. [His/her] right foot hit the foot pedal on the wheel chair. The wheel chair was behind the resident. [He/she] stepped to the left to get out of the urine, I was standing to the right of the [him/her]. I lowered [him/her] to the floor. I never use a Hoyer lift with [him/her] before because [he/she] can stand. Now, since the incident we use a Hoyer lift..."

A follow up interview was conducted on July 14, 2016 at approximately 3:10 PM with Employee #39. He/she stated, "Foot rest were not removed from the wheelchair. If [he/she] had fallen backward [he/she] would have fallen into the chair. No gait belt was used. I wasn't expecting [him/her] to move. [He/she] moved [his/her] leg without me knowing. I was washing [him/her] up.

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(C) A facility wide check for frayed cords, unsecured surge protectors and unsecured cleaning chemicals was conducted on 7/15/16.

3. In an effort to prevent future reoccurrences the engineering team will conduct monthly facility wide call bell inspections on all units, the unit managers/designee will conduct weekly call bell inspection audits and the nursing staff will be re-educated on the reporting of environmental concerns on a daily basis after conducting their daily shift rounds. — 8/31/16

4. A preventive maintenance program is In place to monitor and inspect: call bells, unsecured surge protectors in resident rooms on a monthly basis, which will be reported to the Safety Committee which meets bi-monthly and the QAPI Committee which meets monthly. Th next meeting is scheduled for 9/16/16. reported to the Safety Committee which meets bimonthly and the QAPI Committee, which meets monthly. The next meeting is scheduled for 9/16/16 — 8/31/16

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L 052	Continued From page 18 [He/she] can stand. When [he/she] says I want to sit down we let [him/her] sit down. [The resident] doesn't like [his/her] head to be lying flat, [he/she] would rather stand. The old manager knew, I never discussed it with the new manager. " Review of the Care plan section of the resident ' s clinical record revealed that there was no approach or intervention to address the resident ' s choice to have AM care provided while standing at the bed side. In addition, there was no evidence of a Physical or Occupational therapy screening or evaluation to ensure that it was safe for the resident to stand and for how long to have am care provided. Through interview with Employee #39, he/she stated that the resident stepped to the left, there was no evidence that the employee applied the resident ' s shoes and used a gate belt while transferring the resident from a lying position in the bed to then have the resident stand and hold on to the side rail of the bed to have AM care performed. In addition, the employee stated that the resident ' s wheel chair was directly behind the resident, however he/she failed to remove the footrest/legs of the wheelchair prior to transferring the resident. A telephone interview was conducted on July 27, 2016 at approximately 4:05 PM with Employee #27. He/she stated, "I knew [that the resident likes to stand to have AM care provided], that ' s how he/she is, that was his/her request. " In addition, Employee #27 acknowledged the findings. There was no evidence that appropriate safety measures were taken when Employee #39	L 052	Continued from page 18	

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provided AM care to Resident #126. The resident was transferred with the assistance of one (1) staff from lying in the bed to a standing position at " the bottom part of the bed. " However, the MDS was coded that the resident required the assistance of two (2) persons for transfer. Subsequently, the resident sustained a fall (lowered to the floor). During the assessment of the resident at the time of the fall, the resident verbalized chest pain and required transport to a local emergency department via emergency medical services (911). The record was reviewed on July 15, 2016.

2. Facility staff failed to provide adequate supervision for Resident #154 who had a history of wandering. On June 27, 2016 Resident #154 was placed at the nurse ' s station without supervision, he/she then wandered into Resident #279 ' s room, encountered an altercation with the resident and subsequently Resident #279 sustained an abrasion to the right eyelid.

A review of Resident #154 ' s quarterly Minimum Data Set (MDS) dated June 21, 2016 under Section I, Active Diagnoses revealed his/her diagnoses included Alzheimer ' s disease, Dementia and Schizophrenia. Section C, Cognitive Skills for daily decision making revealed the resident was coded as moderately impaired, decisions poor, cues/supervision required. Section E, Behavior was coded as having physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others ...) occurred 1 to 3 days. Section E, wandering (Presence & Frequency)- resident was coded as having behavior of this type daily.

A review of the comprehensive care plan for

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L 052	Continued From page 20 Resident #154 revealed the interdisciplinary team [IDT] identified " wanderer, " as a problem with a goal that the resident ' s safety be maintained, no injury occurs ... " The plan was initiated December 30, 2015 and updated June 25, 2016. The " wanderer" care plan included [but was not limited to] the following: "Problem Start Date: 12/30/2015- Identified wanderer, Potential for Injury r/t [related to] Dementia, Alzheimer ' s manifested by: walking back and forth toward exit. Wanders near exits. Long Term Goal Target Date: March 30, 2016- Safety maintained, no injury occurs, Resident will not leave the unit during the review period. Approach Start Date: December 30, 2015- Provide calm environment. Have photo taken for identification, Check ID (Identification) bracelet. Picture on chart, ensure resident wander guard bracelet is working properly. Staff to walk resident to the front exit door every Wednesday to ensure wander guard is working. If not to notify security for a new bracelet. Monitor resident for elopement every shift. Offer activities. " A review of Resident #154 ' s clinical record revealed the following nurses' notes: "June 19, 2016- 3:59 PM- resident wandering on the unit. Resident takes objects found on the unit (Christmas decorations, cleaning wipes, food from breakfast and lunch trays). Resident behavior unimproved. " " June 21, 2016- 8:27 AM- Resident noted several times pulling lamp and radio from wall outlet and dropping it on the floor. Also took it off again and took it to roommate ' s bed. "	L 052	Continued from page 20	

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" June 21, 2016- 3:54 PM- Resident continue wandering on the unit, touching everything [he/she] can lay [his/her] hand on. Staff continue to be redirect. "

" June 23, 2016- 9:43 PM- Resident alert and responsive. Continues to wander in the unit. Dropped keyboard in the nursing station on the floor, keyboard broken. Resident redirected by staff. Refused to be redirected. "

June 25, 2016- 10:49 PM- resident continues to wander in the unit touching and pulling everything [he/she] sees. Attempted pulling the assignment board by the nursing station. Redirected by staff. Refused to be redirected. Ate 100% of dinner. Safety precaution maintained.

June 27, 2016- 4:16PM- Resident is alert and verbal with intermittent confusion, resident wandered into another resident room and [tried] to take the other resident [Bible] and they started dragging the [Bible] and both residents fell, resident [#154] thoroughly assessed with no apparent injury noted. Resident remain stable at this time. RP (Responsible Party) and MD (Medical Doctor) made aware of resident's fall. V/S (Vital Signs)- 130/70 [blood pressure], 60 [pulse], 18 [respirations] ... "

A review of the facility ' s incident report titled, "Incident Report" , documented by nursing staff, dated June 27, 2016, [time of incident: 8:30 AM]. Read as follows: " [Exact Location of Incident: [location recorded], Patient ' s Condition Before Incident: Alert and confused; Was Resident Attended: No; ... Describe Exactly What Happened (What you Saw-Who Reported the Incident-What The Resident Said)- [Resident # 154] went into another resident [room] and was

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trying to pick up the resident ' s Bible and the resident try to stop [his/her] and they both ended up on the floor. Resident has no apparent injury ... Supervisor Comments and Recommendations: Indicate what contributes to the incident: Resident will be closely monitored for wandering. What action is recommended to prevent similar incidents: When the CNA ' s (Certified Nursing Assistants) are busy doing AM (morning) care, the charge nurse will make sure [Resident # 154] is in sight at all times ... "

According to the "24 Hour Nursing Report, " Unit dated June 26, 2016 revealed the following:

" Name: [Resident #154], Room - [Diagnosis]: Dementia. Day Remarks: Resident found on the floor in Room 106. No visible bruising or hematomas/lacerations. " Name: [Resident #279], , [Diagnosis]: Dementia. Day Remarks: Resident has a hematoma to the right side of [his/her] head as a result of fall as a result of fall as stated by resident. Resident transported to hospital [hospital named] at 12 noon .... "

The "Day Shift Assignment Sheet" dated June 26, 2016 for unit (7:30 AM-4:00 PM) revealed: the on the morning of the incident there was one License Practical Nurse (LPN) and two Certified Nurse Assistants (CNA). The assessments were as follows:

Charge Nurse: (assigned LPN), Resident Group I- (assignment split between CNA assigned to Group II and Group III), Group II (assigned CNA), Group III (assigned CNA), Solarium Monitoring: 8:00- I (split); 8:30- II (assigned CNA)

A face-to-face interview was conducted with the night CNA assigned to Resident #154 on July26,

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2016 at approximately 10:00 AM. He/she stated after Resident #154 was given him/her AM care, he/she escorted the resident to sit at the nurse ' s station. Also, stated, he/she was sitting beside the resident. When her tour of duty ended; he/she left; however, it was a charge nurse at the nurse ' s station.

Employee #32 was asked about the staffing for the day shift, and what was the unit ' s process for monitoring residents in the solarium. He/she stated, that he/she was re-assigned to another unit to assist with medication administration when the incident happened. There was one charge nurse for days after he/she was re-assigned. Further stated; there is usually three CNA's assigned on day shift.

A follow up face-to-face interview was conducted with Employee #9 on July 12, 2016 at approximately 3:00 PM. He/she stated there were only two (2) CNA ' s assigned to the unit. Group I residents had to be split between the two CNA ' s. At the time of the incident, the CNA were doing am in care to other residents. The day charge nurse was at the nurse ' s station and was doing drug reconciliation with the off going night charge nurse. Further stated, there was no one in the solarium monitoring residents.

Through record review and staff interview it was determined that facility staff assessed and identified Resident #154 as a wanderer. On June 27, 2016 at approximately 8:30 AM, Resident #154 was placed at the nurse ' s station without supervision. He/she then wandered into the room of Resident #279, and tried to take his/her Bible. This initiated a resident-to-resident altercation that caused Resident #279 to fall and sustain a hematoma to the right side of his/her head.

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L 052	Continued From page 24 Resident #279 was sent to the emergency room for treatment. There is no evidence that facility staff took reasonable precautions to maintain adequate supervision for Resident #154 who wandered into Resident #279 ' s room encountered a resident-to-resident altercation and subsequently Resident #279 sustained an abrasion to the right eyelid. The record was reviewed on July 12, 2016.	L 052	Continued from page 24 **L056** 3211.5 Nursing Facilities 1. The facility is unable to correct the days that staffing was not met during the observation.	
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 staffing review [direct care per resident day hours], it was determined that the facility failed to meet 0.6 [six tenth] hour for Registered Nurses/APRN [Advanced Practice Registered Nurse] hours on one (1) of the nineteen days and four and one tenth (4.1) hours of direct nursing care per resident per day for twelve of nineteen days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.	L 056	2. All residents have the potential to be affected when the overall nursing care coverage hours are not met. The facility has been improved in meeting the and surpassing the staffing requirement for clinical staff from July 15, 2016 – August 31, 2016 (present). 3. A robust and enhanced recruitment plan including biweekly orientations; participation in community events and collaboration with local nursing programs, welcoming of staff input, in addition to adjustments in salary and incentives in place for on-call status and scheduled weekends has been implemented to increase the staffing pool. HR department has implemented a standard open house on Wednesdays to attract candidates with on-site interviewing with contingent job offers based on references, drug and criminal background checks. To date an additional 16 certified nursing assistants, 6 registered nurses and 1 licensed practical nurse has been hired since July, 2016 – August, 2016	08/31/16 08/31/16

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L 056	Continued From page 25 The findings include: A review of Nurse Staffing was conducted on July 8, 2016 at approximately 2:00PM. Nineteen days were reviewed; June 19, 2016 through July 7, 2016. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for one (1) of nineteen days reviewed as outlined below. On Sunday, June 19, 2016 it was determined that the facility provided RN coverage at a rate of 0.50 hours of direct nursing care per resident day . The facility failed to meet four and one tenth (4.1) hours of direct nursing care per resident per day for twelve of nineteen days reviewed as outlined below. On Sunday, June 19, 2016 it was determined that	L 056	Continued from page25 4. The staffing is being monitored via daily reviews and the recruitment plan is being updated as applicable to be competitive in an ffort to address the staffing requirement, which is being reported on a monthly basis to the Quality Assurance and Improvement meeting until the committee determines that this area has sustained and maintained consistent compliance.	08/19/16

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L 056	Continued From page 26 the facility provided direct nursing care coverage at a rate of 3.37 hours. On Monday, June 20, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.05 hours. On Thursday, June 23, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.08 hours. On Friday, June 24, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.94 hours. On Saturday, June 25, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.69 hours. On Sunday, June 26, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.29 hours. On Monday, June 27, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.05 hours. On Tuesday, June 28, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.05 hours. On Saturday, July 2, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.77 hours. On Sunday, July 3, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.55 hours. On Wednesday, July 6, 2016 it was determined	L 056	Continued from page 26	

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L 056	Continued From page 27 that the facility provided direct nursing care coverage at a rate of 4.06 hours. On Thursday, July 7, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.03 hours. The review was done in the presence of Employee #22. He/she acknowledged the findings.	L 056	Continued on Page 27 1) SBGC has revised their Infection Control Program which entails CDC and 9/2/16 APIC guidelines for LTC to enhance the effectiveness of our infection control program in an effort to prevent the spread of infection.	9/2/16
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff failed to maintain an Infection Control Program that tracked and trends infections in the facility; to ensure that two (2) of 11 residents' received the purified protein derivative (PPD) using the two-step tuberculin skin test (TST), to administer the PPD for one (1) resident in a timely manner, and to ensure that one (1) resident on isolation had his/her own dedicated medical devices in his/her room. Residents' #40, #267, #272, #275 The findings include: 1. Facility staff failed to maintain an Infection Control Program that tracked and trends infections in the facility.	L 091	A) The tracking and trending of infections as evidenced in the line listing has been revised to reflect corrections to the April, May and June 2016 data that correlates to the monthly summary report and entails the proper data under the categories on the listing as follows; Signs and Symptoms – McGreer criteria is being utilized; Chext Xray results section includes the actual chest xray results; Culture date and results includes the actual cuture results; Treatment end date, which a column has been added to entail the date for resolution or follow up diagnostic ests/cultures. Root cause analysis for facility infections Has been initiated for UTIs for residents as evidenced via the initiation of the use of brainstorming and fishbone diagrams.	

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L 091	Continued From page 28 On July 13, 2016 at approximately 11:24 AM, during an interview with the Infection Control Nurse, the surveillance lists were reviewed. Review of the facility's infection control surveillance list from April to June 2016 revealed the following: The line listing for April 2016 categorized the 32 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility included nine (9) facility acquired urinary tract infections, two (2) respiratory infections, three (3) skin infections, four (4) wound infections and one (1) eye infection. The line listing for May 2016 categorized the 25 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility included five (5) facility urinary tract infections, two (2) Clostridium difficile, four (4) respiratory infections, two (2) skin infections, three (3) wound infections and one (1) eye infection. The line listing for June 2016 categorized the 14 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility recorded that 14 infections listed were in facility acquired infections. The listing included five (5) urinary tract infections, two (2) of which were identified with ESBL (Extended-spectrum beta-lactamases), one (1) respiratory infection, four (4) skin infections. In addition, the surveillance sheets for April, May,	L 091	Continued from Page 28 B).The facility is unable to correct the initial lack of administering the 2 step TST for Resident #40 and Resident #272. C) The facility is unable to correct the time period that the PPD was given to Resident #275, however a policy was developed and training has been provided to address the administration of TB for residents on admission and annually. D) The facility upon identification of the isolated observation of no hand towels and dedicated medical devices being in Resident #267's room was immediately corrected. The process that has been implemented to prevent recurrences of this nature entails that the stocking of the room being checked during rounds conducted by the off going and incoming shift. 2). A review of all resident's PPD chest xrays/ 2 step TST have been provided/administered. Newly admitted residents effective 8/24/16 have been given the 2 step TST.	8/24/16

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L 091	Continued From page 29 and June 2016 revealed: Under the section - Signs & Symptoms diagnoses were listed instead of signs and symptoms. Under the section " CXR (chest x-ray) and results " the information record was N/A (not applicable), however two (2) residents were identified with Pneumonia, one (1) upper respiratory infection and one (1) Bronchiectasis. Under the section " Culture date and results " the information recorded was N/A or dates. However, the facility identified infections that included, urinary tract infections, wound infections, and Clostridium difficile. Under the section " Treatment end date " the information recorded was dates that the treatment ended, however there was no date for the resolution the infection or follow up diagnostic tests or cultures. The surveillance forms lacked consistent documentation to determine whether the infections were acquired in-house or in the community; if a culture, a diagnostic test or laboratory test was ordered, the results and name of the identified organism; if signs and symptoms were assessed and observed; and was there any follow-up cultures. There was no evidence that the facility trends/tracks/ and performs root cause analysis for the list of the facility's infections. In addition, there was no evidence that facility staff were	L 091	Continued From Page 29 3. The systemic changes that have been initiated and implemented include, however are not limited to: 1). Establishment of TB policy which entails 2 step TST administration upon admission for all new residents; Education on this policy and for the licensed staff on the administration of the 2 step TST. Also, an Infection Control Preventionist with an Infection Preventionist (IP) certification has been hired with an anticipated start date of 09/6/16. The facility's TB program has been re-engineered to entail: District of Columbia Department of Health Chest Clinic; APIC and CDC standards and best practices. 4). The Infection Control Committee will begin meeting monthly effective 9/2/16 for 3 months to ensure the following, however not limited to are in place: 1). Infection Control Program is in place with tracking and trending of infections; 2). root cause analysis; 3). monitoring of the 2 step PPD administration will be conducted by the Resident Care Manager/Assistant Resident	9/2/16 8/19/16

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L 091	Continued From page 30 re-educated/trained on areas of improvement from the surveillance data consistently. A face-to-face interview was conducted with Employee #7 and 4 on July 15, 2016 at approximately 4:30 PM. They acknowledged that findings. 2. Facility staff failed to ensure that two (2) of 11 resident ' s PPD were administered using the 2 - steps TST baseline. Residents' #40 and #272 2A. A review of Residents #40 immunization records revealed there was no indication that the 2 - steps TST baseline was administered. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #40 was admitted to the facility on January 28, 2016 with an order that directed " PPD 2 step 0.1ml 5tu Intradermal, administer one week apart, obtain CXR if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on February 1, 2016 and read February 2, 2016. This was documented on the immunization record as given and negative. There was no indication on the record that PPD 2 - step was administered. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 18, 2016. 2B. A review of Resident #272 immunization records revealed there were no indication that the	L 091	Continued from Page 30 4). ***Cont.*** Care Manager/Nurse Supervisor within the 24 hour period upon admission, which will be reviewed by the Infection Control Nurse within a 24-72 hour period to ensure compliance; 4). the stocking of the isolation carts and rooms for proper medical devices and hand towels will being inspected by the Resident Care Manager /Nurse Supervisor/ Infection Control Nurse. If there is consistent compliance found the meeting frequency will change to meeting quarterly. The Infection Control Committee will report to the Quality Assurance Performance Improvement meeting on a monthly basis monthly for 3 months if compliance is consistent the reporting frequency to the QAPI Committee will change to quarterly	

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L 091	Continued From page 31 2 - steps TST baseline was administered. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #272 was admitted to the facility on March 3, 2016 with an order that directed " PPD 2 step 0.1ml 5tu Intradermal, administer one week apart, obtain CXR if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on March 4, 2016 and read March 6, 2016. This was documented on the immunization record as given and negative. There was no indication on the record that PPD 2 - step was administered. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employees #4 and # 7. They acknowledged the findings. The record was reviewed on July 18, 2016. 3. Facility staff failed to administer PPD for Resident #275 in a timely manner. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #275 was admitted to the facility on March 9, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR [chest xray] if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on March 24, 2016 and read March 26, 2016. This was documented on the immunization record as given and negative 15 days ' post physician order. A face-to-face Interview was conducted on July	L 091	Continued From Page 31	

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L 091	Continued From page 32 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 15, 2016. 4. Facility staff failed to ensure that one resident on isolation had his/her own dedicated medical devices in his/her room. Resident #267. A review of Resident #267 record revealed him/her was on contact isolation for ESBL in urine. On July 15, 2016 at approximately 3:00 PM an observation of Resident #267's room, (who was in isolation) was conducted. At this time it was observed that there were no dedicated medical devices such as, blood pressure cuff and stetescope stored in the isolation room. In addition, there were no hand paper towels at the sink that was located in the isolation room. At the time of the observation Employee #49 was queried concerning the resident's lack of dedicated medical devices and disposable paper towels in the isolation room. After this query dedicated medical devices were placed in the isolation room. A face-to-face Interview was conducted on July 15, 2016 at approximately at 3:00PM with Employee #49. He/she acknowledged the findings.	L 091	Continued From Page 32	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal	L 099		

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L 099	Continued From page 33 Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on July 7, 2016 at approximately 9:00 AM and on July 13, 2016 between 1:00 PM and 2:00 PM, it was determined that the facility failed to prepare foods under sanitary conditions as evidenced by two (2) of two (2) grease fryers that were soiled with leftover food residue, two (2) of four (4) convection ovens that were soiled with burnt food residue, one (1) of one (1) gas stove that was soiled with spilled food stains, a staff member serving foods without a hair net and a beard net and sporadic, inconsistent food temperatures from the steam table service on 1 Green, 2 Green and 3 Green. The findings include: 1. Two (2) of two (2) grease fryers soiled with lefover food residue. 2. Two (2) of four (4) convection ovens were soiled with burnt food residue. 3. One (1) of (1) gas stove was soiled with spilled food stains. 4. Staff failed to wear a hair net and a beard net while serving food for lunch in the solarium on 2 Green on July 13, 2016 at approximately 1:10 PM. 5. Food temperatures from steam tables on units 1 Green, 2 Green and 3 Green were not tested daily during the months of May, June and July 2016. According to the steam table food temperature logs from units 1 Green, 2 Green and 3 Green, that were presented by Employee #24 for the	L 099	Continued From Page 33 1. The facility is unable to correct the findings for the time of observation. Howeever the Food & Nutritional Director/Designee will monitor the uise of the soiled kitchen equipment (grease fryers, convection oven and gas stove). Education and ongoing inservice training will be provided by the Director of Food and Nutritional Services/Designee on a monthly basis to discuss the importance of wearing appropriate head and hair covering(s) to in an effort to protect food item(s) from hair while preparing and distributing/serving. 2. Random checking of the facilities cooking equipment will be conducted to be sure that it is clean and free of debris Appropriate head/hair covering will be assigned on the units for steam tables in use prior to serving as part of the daily uniform. The steam table temperature log will be audited by the Director of Food and Nutritional Services/Designee.	7/18/16 7/18/16

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L 099	Continued From page 34 months of May, June and July 2016, the following issues were noted: a. Food temperatures on unit 1 Green were completed a total of 12 times in May 2016, and were not done at all in June and July 2016. b. Food temperatures on unit 2 Green were documented once in May 2016, 24 times in June 2016 and three (3) times in July 2016. c. Food temperatures on unit 3 Green were recorded on seven (7) occasions in May 2016 and on six (6) occasions in June 2016. They were not recorded at all in July 2016. d. Food temperature logs were not clearly identified for breakfast, lunch or dinner meals. These observations were made in the presence of Employee #24, Employee #25 and /or Employee #26 who acknowledged the findings.	L 099	Continued From Page 32 3. Education of Food Service staff on LTag-099 has been conducted. 4. The findings of random checks/audits/observations will be reported to the QAPI Committee on a monthly basis until determined by the committee to change the frequency of reporting.	7/18/16 8/19/16
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations made on July 13, 2016 at approximately 1:10 PM and on July 13, 2016 at approximately 1: 40 PM, it was determined that the facility failed to serve foods to residents at the proper temperature as evidenced by food temperatures that tested at less than 140	L 108		

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L 108	Continued From page 35 degrees Fahrenheit (F) from two (2) test trays and food temperatures that tested at less than 140 degrees Fahrenheit (F) from the steam table service on 2 Green. The findings include: 1. Staff served hot foods such as spaghetti noodles (130 degrees F) and sliced turkey (115 degrees F) that tested at less than 140 degrees Fahrenheit on 2 Green on July 13, 2016 at approximately 1:10 PM. Food temperature logs were reviewed during lunch on unit 2 Geen on July 13, 2016 at approximately 1:10 PM. Spaghetti noodles were documented at 130 degrees F and sliced turkey at 115 degrees F. Employee #26 was asked if he/she had informed the dietary supervisor (s) that the aforementioned foods had tested below the recommended temperatures of 140 degrees Fahrenheit (F). Employee #26 answered "no". A review of the food temperature logs from the main kitchen on July 13, 2016 at approximately 3:30 PM revealed that the spaghetti noodles and the sliced turkey were both tested at 180 degrees Fahrenheit before the food carts were delivered to unit 2 Green on July 13, 2016 at approximately 12:45 PM. 2. Hot food temperatures tested at less than 140 degrees Fahrenheit (F) from two (2) test trays on July 13, 2016 at approximately 1:35 PM. From the puree test tray, spaghetti noodles tested at 137.2 degrees F and the puree vegetables tested at 134.9 degrees F and from the regular diet test tray, the cauliflower	L 108	Continued From page 35 1 and 2. 1.This practice is unable to be corrected for the residents that may have received their meal at these temperatures. There were no unfavorable outcomes to the residents. 2. The kitchen staff will continue the procedure of taking tray line temperatures 7/18/16 prior to food tray distribution service, inaddition to conducting random test temperature trays. The kitchen staff serving on units where steam tables are in use will document on the form when the steam table service does not occur vs. leaving the space blank. The temperature of the food will be taken and documented: 1. in the kitchen prior to the assembled food items are transported; upon transfer to the steam table and 3). prior to the last meal being served from the steam table. If temperatures are not maintained the food will be returned to the kitchen for warming at the appropriate temperature.	7/18/16

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L 108	Continued From page 36 tested at 136.3 degress F. The first observation was made during a review of the food temperature log on July 13, 2016 at approximately 1:10 PM with employee #26 who acknowledged the findings. The second observation was made in the presence of Employee #24 who acknowledged the findings.	L 108	Continued From page 36 3. To address others having the potential to be affected by this practice the Dir. Of Food and Nutritional Services (Dir. Of FNS) has instructed the kitchen staff on a protocol that that has been established which entails that if hot food temperatures are not in compliance the food will be reheated to a temperature of 180 degrees prior to leaving the kitchen, and will maintain a holding temperature of 140 degrees during tray distribution.. 4. The Food and Nutritional Services Supervisor/Designee will be responsible for going to the assignedunit and taking the temperatures. If temperatures are inadequate, the food item(s) will be removed, heated up and served. The Director of FNS will submit a report on the status of to the Quality Assurance and Performance Improvement Committee on a monthly basis for an initial period of three months, if complian ce issustained for this time period, the QAPI will determine if the reporting time frame can be changed to quarterly.	7/18/16 8/19/16
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 43 Stage 2 sampled residents, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized as evidenced by failure to: The physican failed to doucment in that one (1) resident had a Pacemaker, to ensure that the status of one (1) resident's oral treatment plan was included in the clinical record, failed to document the rationale for the administration of Normal Saline intravenously for one (1) resident, and for one (1) resident failed to document the administration of a PPD on the immunization record sheet. Residents' # 98, 154, 281 and 254. The findings include:	L 199		

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L 199	Continued From page 37 1. The physican failed to doucment in that Resident #98 had a Pacemaker on the History and Physical form. A review of the clinical record revealed that Resident #98 had a Pacemaker device implanted on March 27, 2015. A review of the Physician ' s Notes: Physical Examination dated March 3, 2016 and April 27, 2016 respectively revealed under: Cardiovascular that the resident had a " pacemaker. " A review of Resident #98 ' s Physician ' s Order signed by the physician [date June [unreadable] directed the following, " Pacemaker F/U [Follow up] in Six months on June 1, 2016. The Original order date December 2, 2015". A review of the resident ' s History and Physical form dated December 2, 2015 lacked evidence that the physician documented that the resident had a pacemaker device. A face-to-face interview was conducted with Employee #27 on July 12, 2016 at approximately 11:00 AM. After review of the clinical record, Employee #27 acknowledged the findings. 2. The dentist failed to ensure that the status of Resident #154 ' s oral treatment plan was included in the clinical record. A physician interim order dated May 4, 2016 at	L 199	Continued from page 37 1. A). The pacemaker was unable to be added to the physician history and physical, however on 8/17/16 an updated History and Physical was completed to reflect the pacemaker on this form. B). Resident #154 was seen by Dentist as evidenced in the dentist Progress note that was obtained on July 12, 2016 from the dentist to add to the resident's clinical record. Per the dentist there were no mouth lesions present at the time of her visit(s). This practice is unable to be corrected for Resident #154. C). The Nurse Practitioner's progress notes entailed the rationale for the normal saline order for Resident #281,however because the medical order has been discontinued the practice cannot be corrected timely for Resident #281. However, an addendum to the medical order for Resident # 281 is in place as of 8/31/16. D) Resident Care Manager/Designee will conduct an audit of residents' immunization records. There were no unfavorable outcomes	8/31/16

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L 199	Continued From page 38 4:00 PM directed; "... Dentist consult for mouth lesion ... " A review of the dental treatment notes in the clinical record revealed the most recent dental examination was December 9, 2015. The clinical record lacked evidence of a dental evaluation subsequent to December 9, 2015. There was no additional documentation related to the status of oral examination/treatment for the resident. Employee #32 was queried regarding the status of the aforementioned order for the dentist to evaluate Resident #154 ' s mouth lesion. He/she responded that the dentist had evaluated the resident. A telephone interview was conducted with the Dentist on July 12, 2016 at approximately 3:30 PM regarding the aforementioned finding. He/she stated ...stated he/she saw the resident in May [2016] and no mouth lesion(s) were seen. The dentist failed to document the status of the oral treatment plan for Resident #154, particularly as it relates to the status of any mouth lesions. On July 12, 2016 at approximately 4:00 PM, Employee #3 obtained an updated dental note and included it in the clinical record. The clinical record was reviewed on July 12, 2016. 3. Facility staff failed to document the rationale for the administration of Normal Saline intravenously for Resident # 281. A review of the " Interim Order Form " dated [May 25, 2016] at 4:10 PM, " 1) IV (intravenous) NS (normal saline) at 100 ml/h (hour) x [times] 1	L 199	Continued From page 38 2.A).The RCMs have conducted monthly pacemaker audits to ensure that the physician History and Physical entails documentation to reflect these applicable residents have a pacemaker device. B). The unit clerks have conducted monthly dental consults to ensure that no other 8/31/16 residents have been affected by this practice. C). All medical orders written for IVs will be reviewed by both the NP and RCM to ensure that rationales for normal saline are appropriately documented . D) Facility is unable to correct the missing PPD on the immunization record for resident #254. 3. A). The Medical Director has communicated with the medical team their expectations as medical staff and a review of Ltag-199 was reviewed with the specific medical team members involved in the practice identified in this citation. 4. The following reports will be reported to the Quality Assurance Performance Improvement Committee	8/3116 8/3116 8/3116

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L 199	Continued From page 39 (one) L (liter), then NS at 80 ml/h x 1 (one) L ... " A review of the Infusion Medication Record for May 2016 revealed, " NS IV at 100 ml/hr x 1 L." After review of physician ' s order and the Infusion Medication record, there was no evidence that an indication for treatment was documented for the use of normal saline. A face-to-face interview was conducted with Employee # 23 on July 14, 2016 at approximately 3:44 PM. After reviewing the record, he/she acknowledged the findings. The record was reviewed on July 14, 2016. 4. Facility staff failed to document the administration of a PPD [Purified Protein Derivative] on the immunization record sheet for Resident #254. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #254 was admitted to the facility on February 23, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR (Chest X-ray) if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on February 24, 2016 and read March 27, 2016. A review of Resident #254 immunization record revealed that the space allotted for the documentation of the PPD was left " Blank. A face-to-face Interview was conducted on July 15, 2016 at approximately at 3:00PM with Employee # 4 and #7. They acknowledged the findings.	L 199	Continued From page 39 A). The Resident Care Managers will include in their monthly report the findings of the audits conducted which entails that the rationale is in place for pacemaker devices; B). Dentist will send a weekly summary to the facility's Director of Nursing (Interim) that entails: all consult requests, residents seen by the dentist and scheduled appointments in an effort to reconcile/verify that no resident consults/requests have been missed	

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L 214	Continued From page 40	L 214		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on July 12, 2016 between 9:50 AM and 12:30 PM, it was determined that the facility failed to maintain resident's environment free of accident hazards as evidenced by frayed call bells in three (3) of 44 resident's rooms, an accessible container of cleaning chemical in one (1) of eight (8) resident units surveyed, and an unsecured surge protector in one (1) of 44 resident's rooms surveyed. The findings include: 1. Call bell cords were frayed in three (3) of 44 resident's rooms surveyed including rooms #200, #240A and #337C. 2. A container of General Purpose (GP) cleaning chemical was observed in an unsecured, easily accessible biohazard room on resident unit 3 Blue, one (1) of eight (8) resident units surveyed. 3. A surge protector was observed unsecured, on the floor of resident room #215, one (1) of 44 resident's rooms surveyed. These observations were made in the presence of Employee #5 and Employee #6 who acknowledged the findings.	L 214	1. Upon identified of the frayed call bells (3) they were replaced immediately and the unsecured surge protector (1) located in a resident's room was identified as not belonging to the facility was immediately removed and a facility surge rotector was put in place. The general cleaning chemical located in 1 of the 8 units surveyed was removed immediately upon location. It was identified as a product used on special cleaning projects. 2. The general cleaning chemical container was immediately removed from the unsecured biohazard room on 8/3/16 by the Director of Environmental Services. The janitor's closet is set up to have cleaning chemicals dispensed through a wall dispensing system located in the janitor's closet which is to be locked at all times. 3. In an effort to prevent future reoccurrences the engineering team will conduct monthly facility wide call bell inspections on all units, staff will be re-educated on the reporting of environmental concerns on a daily basis after conducting their daily shift rounds.	8/3/16 7/15/16 8/3/16

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L 306	Continued From page 41	L 306	Continued From page 41	
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 July 12, 2016 between 9:50 AM and 12:30 PM, it was determined that the facility failed to maintain resident's call bells in good working condition as evidenced by a non functioning call bell in one (1) of 44 resident's rooms surveyed. The findings include: The call bell in resident room #219 failed to initiate an alarm when tested, one (1) of 44 resident's rooms surveyed. This observation was made in the presence of Employee #5 and Employee #6 who acknowledged the finding.	L 306	4. A preventive maintenance program is In place to monitor and inspect: call bells, unsecured surge protectors in resident rooms on a monthly basis, which will be reported to the Safety Committee which meets bimonthly and the QAPI Committee, which meets monthly. The next meeting is scheduled for 9/16/16. 1. The call bell in resident room #219 7/12/16 that failed to initiate when tested was immediatelyreplaced. 2. Facility wide the call bell system all resident's rooms, bathrooms, nursing units and solariums have been inspected to confirm that they are functioning properly. 3. A preventative maintenance program is now in place to monitor and inspect the call bell system on a monthly basis. 4. The Dir. Of Engineering will provide the QAPI 7/31/16 committee with a monthly 8/19/16 inspection report on the call bell system's operation, it will be reported on a monthly basis for 3 months, if there are no compliance issues after the 3 month period, the reporting period will be changed to quarterly.	8/3/16 7/12/16 7/18/16 8/19/16 8/19/16

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L 410	Continued From page 42	L 410	Continued From page 42	
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on July 12, 2016 between 9:50 AM and 12:30 PM, it was determined that the facility failed to provide housekeeping services necessary to maintain a sanitary environment as evidenced by soiled bathroom vents in two (2) of 44 resident's bathrooms, soiled bathroom floors in two (2) of 44 resident's bathrooms, five (5) of 17 stained chairs located in the solarium of one (1) of eight (8) resident care units surveyed, five (5) of 72 cans of Glucerna nutritional supplements that were expired as of June 2016 on one (1) of eight (8) resident care units surveyed, and two (2) of two (2) eight-ounce cans of Jevity high protein cans of nutritional supplement that were expired as of March 2016 on one (1) of eight (8) resident care units surveyed. The findings include: 1. Bathroom vents in two (2) of 44 resident's rooms (#272 and #316) surveyed were soiled with dust. 2. The floor in the bathroom of resident room #337 and #339 were soiled with dark spots throughout, two (2) of 44 resident's rooms surveyed. 3. Five (5) of 17 chairs in the solarium on unit 1 Green were stained, one (1) of eight (8)	L 410	1. (A) Dust has been removed and cleaning has been completed for the 2 out of 44 identified resident bathroom vents identified in rooms #272 and #316 on 8/3/16. (B) The 2 out of 44 soiled bathroom floors identified in rooms #337 and #339 with dark spots were corrected with cleaning/stain removal on 8/3/16. (C) The 5 out of 17 stained chairs located in the solarium on 2 Green were immediately removed and cleaned on 8/3/16. (D) The 5 out of 72 cans of Glucerna nutritional supplements that expired as of June 2016; 2 out of 2 cans of eight ounce Jevity high protein cans of nutritional supplement that were expired as of March 2016 on the 1 of 8 units surveyed all were immediately removed. 2. (A) The Dir. Of Environmental Services/Environmental Services Supervisors/Team Leaders conducted rounds to ensure that the all bathroom vents have been cleaned and dust removed if applicable. They will continue to make daily rounds and random checks will be conducted by the Regional Dir. Of Environmental Services. (Need rounds checklist).	88/3/16 8/3/16

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L 410	Continued From page 43 resident care units surveyed. 4. Five (5) of 72 eight-ounce cans of Glucerna, 1.2 cal, nutritional supplement located in the storage room on unit 3 Green were expired as of June 2016, one (1) of eight (8) resident care units surveyed. 5. Two (2) of two (2) eight-ounce cans of Jevity, 1.5 cal high protein cans of nutritional supplement with fiber located in the storage room on unit 3 Green were expired as of March 2016, one (1) of eight (8) resident care units surveyed. These observations were made in the presence of Employee #5 and Employee #6 who acknowledged the findings.	L 410	Continued From page 43 (B) The Dir. Of Environmental Services/Environmental Services Supervisors/Team Leaders conducted rounds to ensure that all bathroom floors are free of stains. C) The Dir. Of Environmental Services/Environmental Services Supervisors/Team Leaders reviewed all solarium chairs and had them cleaned as applicable. (D)The Materials Management Manag conducted a facility wide check of all o nutritional supplement areas to ensure that there were no oth nutritional supplements. 3 A) The Dir. Of Environmental Services Regional Director of Environmental Services re-educated the environmental services employees on the daily checklist and proper cleaning of vents, in addition to the regulation, F253 and the importance of ensuring compliance.	
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 July 13, 2016 at approximately 12:10 PM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by a broken pressure gauge from the dishwashing machine. The findings include: The booster heater pressure gauge to the dishwashing machine was broken and the incoming water pressure could not be	L 442	(B) The Dir. Of Environmental Services/ Regional Director of Environmental Services re-educated the environmental services employees on the cleaning of floors, which entailed stain/spot removal and their expectations F253 and the importance of ensuring compliance. (D	8/3/16

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 ______	07/15/2016

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	Continued From page 44 determined. This observation was made in the presence of Employee #25 who acknowledged the finding.	L 442	Continued From page 44 C) Dir. Of Environmental Services/ Regional Director of Environmental Services re-educated the environmental services employees on the expectations LTag-442 and the importance of ensuring compliance. (D)The Materials Management Manager changed the nutritional supplement stocking and storage process from the Vendor conducting to being conducting by in house staff on a weekly basis. D) The Materials Management Manager changed the nutritional supplement stocking and storage process from the Vendor conducting to being conducting by in house staff on a weekly basis. 4. (A) The Dir. Of Environmental Services/ Designee will provide the QAPI committee with a monthly report on the status of cleanliness (dust free) of: (A) bathroom vents; (B) bathroom floors; (C) soiled chairs/furnishings. The Materials Management Manager/Designee will report on the nutritional supplement storage (assuring compliance with no expired cans In circulation). All of these areas will be reported on for a minimal of 3 months, if found to consistently be in compliance for	8/19/16

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NURSING FACILITIES

1. The booster heater pressure gauge to the Dishwashing machine was replaced upon observation by the Engineering team. — 7/13/16

2. A service contractor came out to check the booster heater on 8/24/16 and a final rinse solenoid valve remaining open was identified to be leaking water. The vacuum scaler was leaking. This part was ordered on 8/24/16 and upon delivery the vendor will install. — 8/24/16

3. A preventative maintenance program will entail the monitoring of kitchen equipment. — 8/19/16

4. The preventative maintenance findings of concern will be reported to the Quality Assurance Performance Improvement meeting on a monthly basis. — 8/19/16