| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| L 000 | Initial Comments<br><br>An unannounced Licensure Survey was conducted at Carroll Manor Nursing and Rehab Center from August 30, 2018 through September 11, 2018. Survey activities consisted of a review of 60 sampled residents. The following deficiencies are based on observation, record review, resident and staff interviews.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>Abbreviations<br><br>AMS - Altered Mental Status<br>ARD - assessment reference date<br>BID - Twice- a-day<br>B/P - Blood Pressure<br>cm - Centimeters<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CFU Colony Forming Unit<br>CRF - Community Residential Facility<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C Discontinue<br>Dl - deciliter<br>DMH - Department of Mental Health<br>EKG - 12 lead Electrocardiogram<br>EMS - Emergency Medical Services (911)<br>G-tube Gastrostomy tube<br>HSC Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - Interdisciplinary team<br>L - Liter | L 000 | Carroll Manor Nursing & Rehabilitation Center makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws. | 11/11/18 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Latisha C. Jones | Executive Director | 11/11/2018 |

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

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| L 051 | Continued From page 2<br>required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:<br><br>A. Based on observations, medical record review and staff interview, four (4) of 60 sampled residents, the charge nurse failed to develop an individualized person-centered care plan to address respiratory needs for one (1) resident, to address falls for two (2) residents, and to address communication for one (1) resident. Residents' #24, #85, #114 and #218.<br><br>Findings included...<br><br>1. The charge nurse failed to develop an individualized person-centered care plan to address falls (Residents #24 and #85).<br><br>a. Resident #24 was admitted on March 16, 2017, with diagnoses to include Alzheimer's Disease, | L 051 | | |

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| L 051 | Continued From page 3<br><br>Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 was coded as extensive assistance (staff provides weight-bearing assistance) of one (1) staff member for bed mobility, transfers, walk-in room, and locomotion on unit.<br><br>On September 4, 2018, Resident #24 was observed wandering independently up and down the hallways, looking in rooms, and out the exit door glass. The resident was wearing brown slipper socks. At the time, the resident's pace was rapid and unsteady.<br><br>On September 5, 2018, Resident #24 was observed wandering constantly up and down the hallways on the unit seeking a way off the nursing unit.<br><br>The "Falls" care plan was initiated on July 3, 2018, with approaches to include PT/OT [physical therapy/occupational therapy] screen for fall, complete falls assessment quarterly, evaluate falls risks factors, and keep needed items in reach.<br><br>The falls care plan failed to include person-centered approaches address associated identified risks such as wandering, elopement, and dementia.<br><br>During a face to face interview on September 7, 2018, at 3:45 PM, Employee #20 acknowledged the findings.<br><br>b. Resident #85 was admitted on June 21, 2018, with diagnoses to include Alzheimer's Dementia, | L 051 | L051<br><br>1. Resident # 24's careplan was updated with person-centered approaches to include falls. Resident # 85's careplan was updated with person-centered approaches to include falls, wandering elopement, toileting, and dementia. Resident # 114's careplan was updated with person-centered approaches to include communication. Resident # 218's careplan was updated with person-centered approaches to include respiratory needs.<br><br>2. An audit of current residents' care plans was conducted to ensure that residents' careplans included person-centered approaches.<br><br>3. Staff was educated on providing person-centered approaches to care plans.<br><br>4. The Unit Manager or Designee will audit 5 percent of care plans on a weekly basis times 3 | 11/11/18 |

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| L 051 | Continued From page 4<br><br>Hypertension, anemia, Degenerative Joint Disease, and Osteoarthritis.<br><br>Review of Admission Minimum Data Set dated June 28, 2018, showed Resident #85 is severely cognitively impaired with a Brief Interview for Mental Status Summary Score (Section C0500) coded as "3." Also, the resident rejects care and wanders one to three days, as documented in sections E0800 and E0900; respectively.<br><br>Fall risk assessments showed Resident #85 is "high" for falls as evidenced by assessments completed on June 21, 2018, with score of "14" and September 4, 2018, with score of "19".<br><br>Review of the care plans failed to reveal individualized person-centered approaches (i.e. assist with toileting, non-skid footwear, offer rest periods with wandering episodes) to minimize risk for or prevent falls.<br><br>During a face to face interview on September 10, 2018, at 1:59 PM, Employee #20 reviewed the care plans and acknowledged the finding.<br><br>The "Falls" care plan was initiated on July 3, 2018, with approaches to include PT/OT [physical therapy/occupational therapy] screen for fall, complete falls assessment quarterly, evaluate falls risks factors, and keep needed items in reach.<br><br>The falls care plan failed to include person-centered approaches address associated identified risks such as wandering, elopement, and dementia.<br><br>During a face to face interview on September 7, 2018, at 3:45 PM, Employee #20 acknowledged | L 051 | L 051 (Continued)<br><br>4. months to ensure that care plans include person-centered approaches. The results of the audit will also be reported at the monthly QAPI committee meeting for review. | |

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| L 051 | Continued From page 5<br>the findings.<br><br>2. The charge nurse failed to develop a communication care plan with individualized person-centered approaches to address a non-English speaking (Resident #114).<br><br>Resident #114 was admitted on June 15, 2015, with diagnoses to include Osteoarthritis, Cataracts, Dementia, Sensorineural Hearing Loss, and Peripheral Vascular Disease.<br><br>During observations on August 30, 2018, at 10:30 AM, Resident #114 noted wandering on the nursing unit with wet pants. The housekeeping staff in the hallway called the resident "Poppy" while trying to offer re-direction. When queried about the resident's name, the employee provided the resident's name.<br><br>Review of the "Communication" care plan showed approaches to include ask simple questions; direct eye contact, provide positive feedback, give clear, directions, use interpreter services, use written communication and communication board.<br><br>Observations in Resident #114's room on September 7, 2018, at 9:00 AM failed to reveal the presence of a communication board.<br><br>The charge nurse failed to develop and implement a communication care plan with individualized person-centered approaches to address a non-English speaking Resident to ensure communication needs are met.<br><br>During a face to face interview on September 7, 2018, at 10:27 AM, Employee #20 stated that | L 051 | | |

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| L 051 | Continued From page 6<br><br>Resident #114 understands most gestures and has used the interpreter services however, past usage of the interpretative services was unsuccessful because his speech is unintelligible. When asked directly about the asking simple questions and written communication, the employee was unable to provide further insight. Employee #20 acknowledged the findings.<br><br>3. The charge nurse failed to develop an individualized person-centered care plan with goals and approaches to meet respiratory needs for Resident #218.<br><br>Resident #218 was initially admitted to the facility on December 19, 2012, with the most recent readmission on May 7, 2018. The readmission diagnoses included Urinary Tract Infection Alzheimer's Disease, Failure to Thrive and Osteoporosis.<br><br>Review of medical record on September 18, 2018, at 11:00 AM showed a Significant Change of Status Assessment Minimum Data Set dated May 15, 2015, Section O (Special Treatment Procedures and Programs) indicated Resident #218 received oxygen therapy while in the facility with the last 14 days and six (6) days of respiratory therapy services.<br><br>Review of the physician's orders showed an order dated May 7, 2018, which stipulated "2 liters per minute via nasal cannula for wheezing and check pulse oximeter every shift on room air three (3) times per day during day, evening, and night, document pulse oximetry reading, keep oxygen in place if pulse oximetry is less than 93 % on room and remove if more than 93%." | L 051 | | |

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| L 051 | Continued From page 7<br><br>Review of the care plans failed to show the charge nurse developed an individualized person-centered care plan with goals and approaches to meet respiratory needs (i.e. specific risks for complications such as increased or decreased CO2 (carbon dioxide) levels, and development of oral or ocular ulcers) for Resident #218.<br><br>During a face to face interview on September 5, 2018, at approximately 4:00 PM Employee #20 stated that the daughter requested the oxygen continuously. The further stated that the oxygen was "supposed to be as needed." When queried about the order for continuous oxygen and pulse oximetry monitoring to ensure the resident's care needs are met, Employee #20 could not provide any further insight. Employee #20 confirmed and acknowledged the findings.<br><br>B. Based on observation, medical record review and staff interview for three (3) of 60 sampled residents, the charge nurse failed to accurately code the Minimum Data Set [MDS] to reflect the use of a mobility device, behaviors and diagnosis/resident's status. Residents' #19, #24 and #147.<br><br>Findings included ...<br><br>1. Resident #19 was admitted on February 2, 2018, with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, and Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder. | L 051 | | |

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| L 051 | Continued From page 8<br><br>Review of the Minimum Data Set (MDS) dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands. Resident requires extensive assistance of two person with bed mobility, transfers, locomotion on unit, toilet use and personal hygiene as coded in "Section G0110-Functional Status." However, in Section G0600- Mobility Devices, the MDS was coded as "none of the above were used", referring to a cane, walker, wheelchair, or limb prosthesis.<br><br>Review of the Physician's Progress notes dated June 21, 2018, stated resident having "trouble walking", however, resident was able to lift legs when wheelchair is pushed from the back.<br><br>Review of Nursing Note dated June 28, 2018, stated "Resident out of bed to wheelchair with two staff assistance."<br><br>On July 8, 2018, at 10:25 PM the Nursing Note stated "mobile with wheelchair on the unit."<br><br>The charge nurse failed to accurately code the Minimum Data Set to include the use of a wheelchair as a mobility device for Resident #19.<br><br>During a face to face interview September 10, 2018, Employee #21 explained that Resident #19 has used the wheelchair for a couple of months secondary to advancing dementia and falls. When asked about the coding of the MDS, the employee was unable to provide further insight. | L 051 | | |

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| L 051 | Continued From page 9<br><br>During a face to face interview September 10, 2018, Employee #13, MDS Coordinator reviewed the MDS and acknowledged the findings.<br><br>2. Resident #24 was admitted on March 16, 2017, with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.<br><br>On September 4, 2018, at 3:00 PM, while making observations on the Memory Care Unit (first floor) Resident #24 was wandering into an unlocked utility room which had the door propped open with wet floor sign.<br><br>On September 5, 2018 Resident #24 was observed wandering constantly up and down the hallways on the unit seeking a way off of the unit. In addition, the resident was observed rummaging through the linen, in another resident's room and took a towel.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 was coded in Section E (Behavior) as rejecting care one (1) to three (3) days, and wandering four (4) to six (6) days, but less than daily.<br><br>The MDS failed to show that Resident #24 was assessed in Sections E1000 and E1100 if the "wandering placed the resident at significant risk of getting to potentially dangerous place or intrudes on the privacy of activities of others, and how the resident's current behavior status, care rejection or wandering compare to prior assessment, respectively.<br><br>During a face to face interview on September 11, | L 051 | | |

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| L 051 | Continued From page 10<br><br>2018 at 12:15 PM, Employee #23 reviewed the information and stated that each member of the interdisciplinary team is responsible for completing the various sections of the MDS. Employee #23 role is to verify the completion of the document. Employee #23 acknowledged the findings.<br><br>3. Review of the medical record on 9/10/18, at 9:00 AM showed Resident #147 was admitted to the facility on 5/19/09, and a Quarterly Minimum Data Set [MDS] dated 7/17/18, showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) of "15" which indicates "cognition intact". Section I [Active Diagnoses] Coronary Artery Disease, Dementia, Arthritis, and Hyperlipidemia, Dementia (e.g. Non-Alzheimer's Dementia such as Vascular or Multi-Infarct Dementia, Mixed Dementia, Frontotemporal Dementia) in the designated box is an "X" which indicates resident has an Active Diagnosis of Dementia.<br><br>Review of the medical record showed an Admission and Annual Physical Exam Form dated 4/6/18 with diagnoses which include Atherosclerotic Cardiovascular Disease, Chronic Venous Insufficiency, Seborrheic Dermatitis, Ileostomy Status, Diabetes Mellitus, Chronic Kidney Disease without Heart Failure.<br><br>A review of the Admission & Annual Physical Exam form dated 4/6/18 did not show an active diagnosis of Dementia.<br><br>A further review of the medical record showed a Psychiatric Progress noted dated 6/7/18, "Active Problem List Mild Memory Disturbances not mounting to Dementia." | L 051 | | |

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| L 051 | Continued From page 11<br><br>Charge nurse failed to accurately code the MDS to accurately reflect the resident's status.<br><br>During a face-to-face interview on 9/10/18 at 10:00 AM, Employee #13 acknowledged the code as incorrect and acknowledged the finding.<br><br>C. Based on medical record review and staff interview for one (1) of 60 sampled residents, the charge nurse failed to provide the resident and or the resident representative with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility. Resident #188.<br><br>Findings included....<br><br>Review of the medical record on 9/6/18, at 9:00 AM showed Resident #188 was admitted to the facility on 1/30/18.<br>Review of Resident #188's Face Sheet showed that the Primary Contact listed as the Resident's Power of Attorney (POA)/Responsible Party.<br><br>A further review of the medical record showed an unsigned baseline care plan 2/1/18, the signature line for the patient and or the patient representative was blank (the signature indicates the POA or resident was made aware of the initial goals and approaches to address the residents care needs and services.)<br><br>During an interview on 9/6/18, at 10:15 AM, with Employee #14 stated the resident has a POA, the baseline care plan is in the medical record but it's not signed; and was unable to provide insight if the resident or the resident representative was informed of the initial plan for delivery of care and | L 051 | | |

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| L 051 | Continued From page 12<br>services.<br><br>There was no evidence that charge nurse provided the resident and/or his POA with a written summary of the baseline care plan within 48 hours after the resident's admission to the facility.<br><br>During a face-to-face interview on 9/6/18 at 10:00 AM Employee# 14 acknowledged the findings.<br><br>D. Based on medical record review and staff interview, for two (2) of 60 sampled residents, the charge nurse failed to revise the care plan with person-centered goals and approaches related to falls for one (1) resident and to revise the care plan to reflect one (1) resident's use of a mobility device. Residents' #19 and #147.<br><br>Findings included ...<br><br>Charge nurse failed to revise Resident #19's fall care plan with individualized, person-centered approaches.<br><br>1. Resident #19 was admitted on February 2, 2018, with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder.<br><br>Review of the Minimum Data Set dated August 14, 2018, showed Resident #19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor. | L 051 | | |

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| L 051 | Continued From page 13<br><br>Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 experienced a fall from wheelchair during transfer.<br><br>Review of the falls care plan initiated on June 5, 2018, showed approaches to include physical therapy and occupational therapy screen, complete fall assessment quarterly, evaluate use of psychotropic medications. However, on September 5, 2018, the revision to the resident's care plan showed the approach as "PT/OT screen ...Transfer to ER ...Ensure that resident is properly seated in w/c [wheelchair] prior to transfer."<br><br>The charge nurse failed to revise the falls care plan after the September 4, 2018, with individualized person-centered approaches to prevent falls reoccurrence.<br><br>During a face to face interview on September 10, 2018, Employee #21 reviewed the care plan and acknowledged the findings.<br><br>2. Charge nurse failed to revise a care plan to address Resident #147's use of a mobility device.<br><br>Review of the medical record on 9/7/18 at 11:00 AM showed Resident # 147wsa admitted to the facility on 5/19/09. The Quarterly Minimum Data Set [MDS] dated 7/17/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) of "15" which indicates "Cognitively Intact".<br><br>Under Section I [Active Diagnoses] the resident was coded for Hypertension, Diabetes Mellitus, | L 051 | | |

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| L 051 | Continued From page 14<br><br>Hyperlipidemia, Chronic Venous Insufficiency, and Ileostomy.<br><br>Section G0300 (Balance During Transitions and Walking Resident) is coded as "1" (which indicates not steady, but able to stabilize without human assistance) for moving from seated to standing position, walking (with assistive device if used) turning around and facing the opposite direction while walking, moving on and off toilet and surface to surface wheel chair).<br>G0600. Mobility Devices (check all that were normally used) there is an X in the box for (B.) Walker, which indicates a walker is normally used.<br><br>Review of the resident's care plan showed "Category Behavioral Symptoms, Problem: Ambulating without assistive devices, Approach: allow resident to express feelings, approach in calm, direct manner, continue to educate and encourage resident on safety practices."<br><br>Charge nurse failed to revise the care plan problems and approaches to reflect resident current status as using an assistive device (walker) for ambulation.<br><br>During an interview on 9/7/18, at 1:00 PM with Employee #3, she stated the resident is independent with care and uses a walker for ambulation; this care plan needs to be changed and acknowledged the finding. | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident | L 052 | | |

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| L 052 | Continued From page 15<br>receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;<br><br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities;<br><br>(f)Encouragement and assistance to:<br><br>(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, | L 052 | | |

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| L 052 | Continued From page 16<br>including oral acre; and<br><br>j)Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br>Based on record review and staff interview for one (1) of 60 sampled residents, facility staff failed to provide sufficient nursing time to ensure adequate supervision was provided to Resident #147 to prevent the resident from sustain a fall with injury.<br><br>Findings included ...<br><br>1. Facility staff failed to provide adequate supervision to prevent an accident (fall) which resulted in harm (injury) to Resident #147.<br><br>Review of the medical record on 9/7/18, at 10:00 AM showed Resident #147 admitted to the facility on 5/19/09, with diagnoses which include Renal Insufficiency, Peripheral Cardiac Disease, Ileostomy, History of Falls, Type II Diabetes Mellitus (without complications).<br><br>Review of the Quarterly Minimum Data Set [MDS] dated 7/17/18, showed Brief Interview for Mental Status (BIMS) score of "15" which indicate "cognitively intact." Under Section G [Functional Status] Resident is coded as "1" for balance during transitions and walking. Code of "1" indicates resident is not steady, but able to stabilize without human assistance. G0600 [Mobility Devices] check all that were normally used walker is selected.<br><br>A further review of the MDS showed Section B [Hearing, Speech and Vision] B1000. Vision: | L 052 | 1. Resident #147 was assessed and transferred to the hospital for evaluation and returned to the facility on the same day. Resident has been educated to notify staff prior to going to the front of the facility. Resident verbalized understanding. Resident #19 was transferred to the hospital, evaluated and returned to the facility.<br><br>2. Supervision is provided for other residents, who were determined to need supervision.<br><br>3. Staff has been educated on providing supervision for residents while in front of the facility. Staff has been educated on providing supervision during transfer.<br><br>4. The Unit Manager or designee will conduct random observations and discuss findings during the monthly QAPI meeting. | 11/11/18 |

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| L 052 | Continued From page 17<br><br>Ability to see in adequate light (with glasses or other visual appliances) is coded as "1"; impaired-sees large print but not regular print in newspapers. B1200. Corrective Lenses (contacts, glasses, or magnifying glass) used in completing vision is coded as "1" which indicates yes.<br><br>Review of physical therapy notes dated 5/24/17, " at discharge from therapy to end reporting patient is independent with ambulation with rollator (rolling walker)."<br><br>Review of the progress note dates 7/11/18, showed "resident went out doors to take her walk and she came back complaining that she could not see, she (resident) was seen by eye doctor and she (resident) has an appointment scheduled for 7/12/18."<br><br>Review of the Consultation Record dated 7/12/18, "follow-up on blurred vision O/S (left eye); recommendation: needs YAG Lased Capsulotomy O/S (eye procedure to correct blurry vision of the left eye) YAG Laser surgery scheduled for 7/19/18 at 8:30 AM."<br><br>During an resident interview on 9/7/18, at 10:30 AM, "I would wake up with my eyes blood shot I could not see the numbers on that wall clock it was hard to see so I told them (staff), I usually go for my walk out of the building around the circle and I would tell them (staff) when I am leaving the floor, I go by myself but not any more since I had the fall."<br><br>Review of care plan showed "At risk for falls r/t (related to) history of falls (start date 8/12/17). Approach: assist resident with all transfer and mobility as needed, encourage resident to use call light for assistance, keep frequently used | L 052 | | |

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| L 052 | Continued From page 18<br>items in easy reach and keep room free from clutter."<br><br>A further review of the care plan (start date of 9/11/12) showed "Alteration in vision secondary to wearing glasses, Dry Eyes (S/P right eye surgery); approach: administer eye drops as needed, encourage resident to voice changes in visual acuity, monitor for changes in vision or eye pain, drainage or redness, ophthalmology appointments as ordered, provide adequate lighting and resident room and hallway clutter free."<br><br>Review of the medical record on 9/7/18 at 11:30 AM showed a Safety Checklist dated 7/18/18, a column for time and hour. At 10:00 AM and 11:00 AM a code of 1 is recorded to indicate resident in room (Resident# 147 room). At 12:00 PM a code of 4 is recorded to indicate Resident #147 was off the unit.<br><br>Review of the progress note dated 7/18/18, at 10:40 showed a nurse input transfer note: "resident transfer after a fall secondary to losing her balance while ambulating by herself via roller walker. Resident was found on the ground in front of the main entrance at the facility. Sustained laceration on the right lateral side of her right eye with small bleeding and hematoma observed. Alert and oriented x3 follows appropriately. VS (vital signs) 98-78-20 150/78. Denied pain or discomfort (resident). Positive range of motion. Resident was transferred to [hospital name]".<br><br>Review of the nurse practitioner interdisciplinary progress note dated 7/18/18 showed "Fall Code RN stat (at once) "patient stated she was walking and must have lost her step she reports hitting her head on the concrete ground, she denies | L 052 | | |

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| L 052 | Continued From page 19 | L 052 | | |

headaches, dizziness, weakness or pain to extremities; R (right) slightly deep abrasion noticed to R (right) lateral eyes, bleeding pressure applied bleeding stopped and now with ice; Fall mostly mechanical send to the emergency department to have CT (computed tomography) Scan of head done."

During an interview on 9/7/18 at 3:00 PM with Employee #3 the resident uses a walker for ambulation and at the time of the fall the resident was using her walker, but there was no staff present at the time of the fall. I arrived first and provided care to the resident and the resident was transferred to [hospital name].

Review of the hospital discharge note dated 7/18/18 showed "you were seen today for head injury, laceration of face without complication. Impression of CT Scan showed no acute fracture or dislocation."

During an interview on 9/7/18 with Employee #3, the resident wears glasses and uses a walker for ambulation, on the unit the staff do hourly safety checks, at the time of the fall there was no staff present I arrived first and provided care to the resident; There were no other interventions put in place because she is independent and can make her needs known.

Facility staff failed to provide insight into why the resident with a known eye complaint of "not being able to see" and with a scheduled eye appointment (7/19/18) to correct vision was ambulating outside of the facility without supervision.

Facility staff failed to provide appropriate and sufficient supervision to reduce the risk of

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| L 052 | Continued From page 20<br>resident fall with injury.<br><br>During a face-to-face interview on 9/7/18 at 5:00 PM Employee #3 acknowledged the finding.<br><br>Based on investigation report, medical record, and staff interview for one (1) of 60 resident records reviewed, the nursing staff failed to protected Resident #19 from an accident and injury by ensuring a mechanical lift was utilize during transfer to prevent a fall for Resident #19, who sustained a left forehead hematoma.<br><br>Findings included...<br><br>Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder.<br><br>Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor.<br><br>Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer. Resident #19 hit her head on the floor resulting in swelling to the left side of the forehead. The resident was transfer out to the hospital for evaluation<br><br>Review of Occupational Therapy Progress and | L 052 | | |

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| L 052 | Continued From page 21<br><br>Discharge Summary dated August 15, 2018, Resident #19's sit to stand transfers "Long Term Goals" were not met and rehab discontinued "due to cognition pt [patient] has reached max rehab potential and requires max A (maximum assistance) with lift for transfer."<br><br>Review of the falls care plan initiated on June 5, 2018, showed approaches to include physical therapy and occupational therapy screen, complete fall assessment quarterly, evaluate use of psychotropic medications. However, on September 5, 2018, the revision to the resident's care plan showed the approach as "PT/OT screen ...Transfer to ER[Emergency Room] ...Ensure that resident is properly seated in w/c [wheelchair] prior to transfer."<br><br>The facility failed to ensure the care plan as revised to include the use of a mechanical lift to assist with transfers after Resident #19 was discharge from Occupational Therapy on August 15, 2018.<br><br>During a face to face interview on September 10, 2018, at approximately 10:45 AM, Employee #24 stated Resident #19 has not walked in months and requires two people to help her transfer. When asked which type of lift is use for transfer, the employee stated the resident "can hold on and stand with the sit to stand lift."<br><br>During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21 stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked whether a lift was used during the transfer, Employee #21 was unable to | L 052 | | |

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| L 052 | Continued From page 22<br><br>state definitively. When asked about the investigation into the incident, the employee stated that the supervisor completes the incident investigation.<br><br>Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer and appropriate corrective actions to prevent reoccurrence.<br><br>The failure to ensure that a mechanical lift was utilized during the attempted transfer on September 4, 2018, created the potential for harm when Resident #19 fell from the wheelchair sustaining a hematoma on the forehead.<br><br>During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #19 on September 4, 2018. Employee #1 acknowledged the findings. | L 052 | | |
| L 056 | 3211.5 Nursing Facilities<br><br>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. | L 056 | | |

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| L 056 | Continued From page 23 | L 056 | | |

This Statute is not met as evidenced by:

Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per Resident per day for one of 16 (sixteen) days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.

The findings included:

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 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 3211.5.

A review of the Nurse Staffing was conducted on September 11, 2018, at approximately 1:00 PM.

Of the ten (10) days reviewed, Four of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day and sixteenths (0.6) hours of advanced practiced registered nurse as follows:

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| L 056 | Continued From page 24<br><br>Hours of Direct Care per resident per day<br>Saturday, February 17, 2018, showed that the facility provided direct nursing care per resident at a rate 4.0 hours.<br><br>Friday, May 26, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours.<br><br>Saturday, May 27, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours.<br><br>Sunday, August 19, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.7 hours.<br><br>Hours of Advanced practice Registered Nurse per resident per day<br><br>Saturday, February 17, 2018, showed that the facility provided advanced practiced registered nurse per resident at a rate 0.5 hours.<br><br>Friday, May 26, 2018, showed that the facility provided advanced practiced registered nurse per resident at a rate of 0.5 hours.<br><br>Saturday, May 27, 2018, showed that the facility provided advanced practiced registered nurse per resident at a rate of 0.5 hours.<br><br>Sunday, August 19, 2018, showed that the facility provided advanced practiced registered nurse per resident at a rate of 0.4 hours.<br><br>A face-to-face interview conducted with the Staffing Coordinator at the time of the staffing review and she acknowledged the findings. | L 056 | L056<br><br>1. Facility will make every effort to staff the facility based on the regulation.<br><br>2. Facility will make every effort to staff the facility based on the regulation.<br><br>3. Nursing Administration was inserviced on ensuring that the facility is staffed per regulation.<br><br>4. The Scheduler or designee will review daily staffing and report any deficiencies to the DON and ED. Results of the review will be discussed during the monthly QAPI. | 11/11/18 |

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| L 099 | 3219.1 Nursing Facilities<br><br>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:<br><br>Based on observations and interview, the facility failed to store, serve and distribute foods under sanitary conditions as evidenced by foods such as one (1) of one (1) roasted turkey breast, one (1) of one open pack of turkey cold cuts, 21 of 21 turkey sandwiches and three (3) of three (3) ham sandwiches that were not labeled or dated, sixteen (16) of sixteen (16) peanut butter and jelly sandwiches in the walk-in refrigerator that were stored beyond their 'use by' date of August 29, 2018, soiled cooking equipment and utensils such as two (2) of two (2) convection ovens, one (1) of one (1) four-inch frying pan, one (1) of four (4) six-inch frying pan, and 13 of 13 six-inch full pans, six (6) of six (6) soiled fire sprinkler heads, three (3) of three (3) soiled air curtains from the dishwashing machine, one (1) of one (1) soiled dishwashing machine, dented cooking pans and frying pans such as five (5) of five (5) half-inch sixth pans, nine (9) of nine (9)<br>half-inch third pans, two (2) of two (2) six-inch third pans, one (1) of one (1) four-inch pan, four (4) of four (4) six-inch pans and one (1) of one (1) twelve-inch pan and five (5) of five (5) CAMBRO food transport carts with broken latches and cracks.<br><br>Findings included...<br><br>During a walk-through inspection of Dietary Services on August 30, 2018, at approximately 8:55 AM, the following were observed: | L 099 | | |

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| L 099 | Continued From page 26<br><br>1. Food items such as one (1) of one (1) roasted turkey breast, one (1) of one open pack of turkey cold cuts,<br>21 of 21 turkey sandwiches and three (3) of three (3) ham sandwiches were not labeled or dated.<br><br>2. Sixteen (16) of sixteen (16) peanut butter and jelly sandwiches in the walk-in refrigerator had a 'use by' date of<br>August 29, 2018.<br><br>3. Cooking equipment and utensils were soiled with grease and/or burnt food including: two (2) of two (2)<br>convection ovens, one (1) of one (1) four-inch frying pan, one (1) of four (4) six-inch frying pan, and 13 of 13<br>six-inch full pans.<br><br>4. Six (6) of six (6) fire sprinkler heads located above the grease fryer, the stove, the grill and the tilt skillet were<br>soiled with dust and grease.<br><br>5. Three (3) of three (3) air curtains from the dishwashing machine were soiled.<br><br>6. The dishwashing machine was soiled throughout with food stains and residue.<br><br>7. Final Rinse dishwashing machine temperatures were documented at less than 180 degrees Fahrenheit on six (6)<br>occasions in June, three (3) occasions in July and 18 occasions in August 2018, with no documented corrective<br>actions initiated. | L 099 | L 099<br><br>1. The unlabeled food items were discarded. Items with expired use- by dates were also discarded. The soiled cooking equipment and utensils were cleaned. The sprinkler heads in the kitchen were cleaned. The dishwashing machine was cleaned. The final rinse meets acceptable temperatures. The dented pans and dented frying pans were discarded. The Cambro carts were repaired.<br><br>2. The Dining services manager made rounds to ensure that food items were labeled, cooking equipment and utensils were clean, kitchen sprinkler heads were free from dust and grease, the dishwasher was cleaned and met acceptable rinse temperatures, dented or damaged pans were discarded, and Cambro carts were in good repair. | 11/11/18 |

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| L 099 | Continued From page 27<br>8. Cooking pans such as five (5) of five (5) half-inch sixth pans, nine (9) of nine (9) half-inch third pans and two (2) of two (2) six-inch third pans were dented in several areas.<br><br>9. Frying pans were dented in several areas including one (1) of one (1) four-inch pan, four (4) of four (4) six-inch pans and one (1) of one (1) twelve-inch pan.<br><br>10. Five (5) of five (5) CAMBRO food transport carts were damaged with broken latches and cracks:<br><br>The blue cart and the red cart had a broken latch at the top compartment<br><br>The teal colored cart had a broken latch at the bottom compartment<br><br>The green cart had broken latches at the top and the bottom compartments<br><br>The brown cart was cracked at the top compartment.<br><br>During a face-to-face interview on August 30, 2018, at approximately 12:30 PM, Employee #4 confirmed the findings. | L 099 | L 099 (Continued)<br><br>3. Dining services staff was educated on food labeling, kitchen cleanliness including the dishwasher, acceptable dishwasher temperatures, dented or damaged pans, keeping sprinkler heads free from dust and grease, and maintenance requests for equipment.<br><br>4. The dining services manager will audit food labeling, kitchen cleanliness including the dishwasher, acceptable dishwasher temperatures, dented or damaged pans, keeping sprinkler heads free from dust and grease, and maintenance requests for equipment on a weekly basis times 3 months. The results of the audit will be shared at the monthly QAPI meeting. | |
| L 137 | 3225.4 Nursing Facilities<br><br>Each medication order shall state:<br><br>(a)The name and strength of the medication;<br><br>(b)The dosage; | L 137 | | |

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| L 137 | Continued From page 28<br><br>(c)The duration;<br><br>(d)The form of the drug;<br><br>(e)The frequency and time of administration; and<br><br>(f)The route of administration<br>This Statute is not met as evidenced by:<br>Based on policy review, medical record review and staff interview for two (2) of 60 resident records, the facility failed to ensure that nutritional supplement order include the dosage for administration, in accordance with professional standards of practice (Residents' #198 and #388).<br><br>Findings included ...<br><br>According to the facility's "Guidelines for Charting and Documentation" policy last revised January 2018, dietary supplement orders must specify the type, amount, frequency (i.e. Ensure 3 ounces three times a day between meals).<br><br>1. Resident #198 was admitted on February 11, 2018, with diagnoses to include Atrial Fibrillation, Dementia, Heart Failure, edema, Hypokalemia, and Cerebral Infract.<br><br>Review of the medical record showed a physician order for "Ensure Plus one (1) time per day at 1400, Special Instructions: Daily at breakfast at 7:30 AM."<br><br>Review of the Dietary Progress Notes dated August 7, 2018, showed Resident #198 continues to receive "Ensure Plus 1x/day [opne times per day]-PM." | L 137 | L 137<br><br>1. Resident # 198 and 388's nutritional supplement orders were updated to include the dosage for administration.<br><br>2. The Dietician reviewed current resident nutritional supplement orders to ensure that they include the dosage for administration.<br><br>3. Licensed nurses and Dieticians were educated on ensuring that nutritional supplement orders include the dosage for administration.<br><br>4. The Dietician or designee will conduct monthly audit of nutritional supplement orders to ensure that they include dosage for administration. Results of the audits will be submitted to QAPI for review. | 11/11/18 |

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| L 137 | Continued From page 29<br><br>The order for Ensure Plus failed to contain the amount to be administered to the resident at the specified time. The failure to include the dose for administration is inconsistent with standards of practice to ensure Resident 198's calorie and nutritional needs are met.<br><br>During a face to face interview on September 6, 2018, Employees' #20 and 21 were asked about the dose to be administered and the conflicting times in the order. Employee #21 stated that conflicting time was an error which should have been corrected. However, neither employee could provide further insight into the omission of the dose to be given.<br><br>During a face to face interview on September 6, 2018, at approximately 4:05 PM, Employee #22, Dietician, stated that it is not customary practice in the facility to include the amount of nutritional supplement to be administered. The findings were acknowledged. | L 137 | | |
| L 204 | 3232.2 Nursing Facilities<br><br>A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:<br><br>(a)The date, time, and description of the incident;<br><br>(b)The name of the witnesses;<br><br>(c)The statement of the victim;<br><br>(d)A statement indicating whether there is a | L 204 | | |

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| L 204 | Continued From page 30<br>pattern of occurrence; and<br><br>(e)A description of the corrective action taken.<br><br>This Statute is not met as evidenced by:<br>Based on investigation documents, medical record review, and staff interview three (3) of 60 resident records, the facility failed to conduct a thorough investigation of incident involving injuries of unknown source. The failed practice affected the facility's ability to implement appropriate corrective actions to prevent reoccurrence. (Resident #15, 19, and 24)<br><br>Findings include ...<br><br>1. Resident #15 was admitted on January 4, 2016 with diagnoses to include Anemia, Arthritis, Dementia, and Hypertension.<br><br>Medical record review conducted on September 10, 2018, at 3:30 PM, showed Resident #15 is severely cognitively impaired as evidence by the quarterly Minimum Data Set (MDS) dated August 14, 2018, Section C1000. Cognitive Skills for Daily Decision Making was coded as "3" severely impaired- never/rarely made decisions. According to Section G0110 Activities of Daily Living (ADL) Assistance, Resident #15 requires extensive assistance from two plus persons physical assistance for bed mobility and transfers, and uses a walker as a mobility device.<br><br>Review of the Nursing Notes dated June 17, 2018 at 6:00 PM showed that Resident #15 was observed moaning guarding her left foot. Upon assessment, the nurse observed swelling to the left mid-shin area extending to the ankle. The physician was notified and the resident transferred to the hospital for evaluation. | L 204 | | |

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| L 204 | Continued From page 31<br><br>Resident #15 returned from hospital on June 18, 2018, at 6:35 AM, with diagnoses of Fracture of Distal Tibia and Fibula. On June 19, 201, Resident #15 was seen in follow-up by orthopedic and received a diagnosis of fragility fracture secondary to severe osteoporosis.<br><br>On September 7, 2018, at approximately 1:17 PM, Employee #2 was asked to provide a copy of the incident investigation. Upon receipt and review of the incident investigation, it was noted that the investigation only contain copies of handwritten statements from the staff. All of the statements indicated that staff was unaware of how the injury occurred. However, one employee indicated the use of a lift to place the resident back to bed. When asked about the facility's inquiry into the employee's statement and other questions that were asked, Employee #2 was unable to provide insight.<br><br>The facility failed to provide evidence a thorough investigation was conducted of the injury of unknown origin regarding Resident #15 on June 17, 2018.<br><br>During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conducted a thorough investigation. Employee #1 acknowledged the findings. | L 204 | | |

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| L 204 | Continued From page 32<br><br>2. Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder.<br><br>Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor.<br><br>Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer.<br><br>During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21 stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked about the investigation into the incident, the employee stated that the supervisor completes the incident investigation.<br><br>Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer.<br><br>The facility failed to provide evidence a thorough investigation was conducted of the fall regarding | L 204 | L 204<br><br>1. The Facility reviewed resident #15, #19 and #24's injury information and initiated education for staff regarding injuries of unknown origin.<br><br>2. Injuries of unknown origin and falls for current residents during the month of September 2018 were reviewed to ensure thorough investigation of injuries of unknown origin and falls.<br><br>3. Staff was educated on ensuring thorough investigation of injuries of unknown origin and falls.<br><br>4. The Unit Manager or designee will review injuries of unknown origin and falls on a weekly basis times 3 months to ensure thorough investigation of injuries of unknown origin. The results of the audit will also be reported at the monthly QAPI committee meeting for review. | 11/11/18 |

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| L 204 | Continued From page 33<br>Resident #19 on September 4, 2018.<br><br>During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings.<br><br>3. Resident #24 was admitted on March 16, 2017 with diagnoses to include Alzheimer's Disease, Psychotic Disorder, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated August 21, 2018, showed Resident #24 has severe cognitively impaired as coded in Section C0600 Brief Interview for Mental Status Summary Score of "00." The staff was unable to complete the Resident Mood Interview in Section D resulting in a "Total Severity Score of 99." However, Section E0200 Behavioral Symptoms was coded for "other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging) 1 to 3 days" during the assessment reference period.<br><br>Review of nursing notes dated July 18, 2018, at 10:11 PM, showed that Resident #24 was found with an injury of unknown origin during PM care. | L 204 | | |

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| L 204 | Continued From page 34<br><br>A laceration on the middle chin measuring 1.5 centimeters by 1.5 centimeters with no active bleeding was observed. Due to Resident #24's history of Dementia, the resident was unable to give an account of the cause of the injury. The resident vital signs were documented as blood pressure 70/45, pulse-98 on the right arm; and left arm manual blood pressure measured 76/37 while lying down and pulse-99. Consequently, Resident #24 was transferred to the hospital for evaluation.<br><br>Review of the Physician Progress Notes dated July19, 2018 (no time documented), does not mention the laceration or probable cause for the injury.<br><br>During a face to face interview on September 7, 2018 at approximately 12:15 PM, Employee #2 was asked for the incident investigation related to the injury of unknown origin for Resident #24. Upon receipt and review of the incident investigation, it was noted that the investigation only contain copies of handwritten statements from the staff. All of the statements indicated that staff was unaware of how the injury occurred.<br><br>Further review of the investigation documents revealed the "Statement of Witness" forms completed by the staff included the following instructions "Document responses to questions below; review written responses with witness prior to signing. Attach additional page(s) if needed.) Each of the "Statement of Witness" forms attached to the incident report for Resident #24 provided by Employee #2 did not contain a set of question to which the employee was responding.<br><br>On September 7, 2018, at approximately 3:30 PM, during a face to face meeting with | L 204 | | |

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| L 204 | Continued From page 35<br><br>Employees #1, 2, and 19, the investigation process was discussed for falls and other incidents. Employee #2 stated that all incidents are report to the Department of Health and entered into the facilities incident reporting system. When asked about the completion of the investigation and the questions that are utilized to gain further insight into the incident, Employee #2 stated that the information is placed into the corporate system and the Quality Director decides the next steps. A "Level 1 Root Cause Analysis" form was attached to several of the incidents provided by Employee #2, when asked when the form is utilized for investigation, the employee stated the form is only completed when the Director of Quality instructs the team. When asked directly about the investigation and outcome related to Resident #24's injury of unknown origin, the employees were unable to provide further insight or provide evidence of a thorough investigation.<br><br>On September 10, 2018, at 8:36 AM, during a face to face interview, Employee #20 provide the surveyor with a copy of the "Level 1 Root Cause Analysis" form and stated that the nurses complete the form with each fall. When asked if the form is completed with other incidents, the employee stated "no."<br><br>The facility failed to provide evidence a thorough investigation was conducted of the injury of unknown origin regarding Resident #24 on July 18, 2018.<br><br>During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of | L 204 | | |

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| L 204 | Continued From page 36<br><br>"Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings.<br><br>3. Resident #19 was admitted on February 2, 2018 with diagnoses to include Hypertension, Edema, Peripheral Vascular Disease, Dementia with Behavioral Disturbance, Alzheimer's Disease, and Sleep Disorder.<br><br>Review of the Minimum Data Set dated August 14, 2018, showed Resident # 19 is cognitively impaired as evidenced by "Section B0700. Makes Self Understood coded as 3- rarely/never understood; and Section B0800. Ability to Understand Others" coded as "3- rarely /never understands." Also, the resident required extensive assistance of two-persons for transfer, bed mobility, walking in room and corridor.<br><br>Review of the nursing note dated September 4, 2018, at 8:39 PM, Resident #19 suddenly slid out of the wheelchair while the nurse was attempting to transfer.<br><br>During a face to face interview on September 10, 2018, at approximately 3:00 PM, Employee # 21 stated the resident fell forward while the nurse was attempting a transfer. When asked about the resident's transfer and mobility status, Employee #21 stated that Resident #19 uses a sit-stand lift for transfers. When asked about the investigation into the incident, the employee stated that the | L 204 | | |

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| L 204 | Continued From page 37<br>supervisor completes the incident investigation.<br><br>Upon review of the incident investigation, the document did not provide evidence that a thorough investigation was conduct to include insight into if the mechanical life device was utilized during the transfer.<br><br>The facility failed to provide evidence a thorough investigation was conducted of the fall regarding Resident #19 on September 4, 2018.<br><br>During a follow-up meeting on September 11, 2018, at approximately 10:07 AM, with Employees #1, 2, 19, and 18, Employee #18, Assistant Director of Nursing confirmed the use of "Level 1 Root Cause Analysis" form for all fall investigations. However, the employees could not provide evidence to demonstrate that a thorough investigation was conducted regarding Resident #24 on July 18, 2018. Furthermore, when the employees were asked about the process from investigating incidents other than falls, the facility could not provide evidence they conduct a thorough investigation. Employee #1 acknowledged the findings. | L 204 | | |
| L 306 | 3245.10 Nursing Facilities<br><br>A call system that meets the following requirements shall be provided:<br><br>(a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents;<br><br>(b)In new facilities or when major renovations are made to existing facilities, be of type in which the | L 306 | | |

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| L 306 | Continued From page 38<br>call bell can be terminated only in the resident's room;<br><br>(c)Be of a quality which is, at the time of installation, consistent with current technology; and<br><br>(d)Be in good working order at all times.<br><br>This Statute is not met as evidenced by:<br><br>Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 66 resident's rooms that failed to alarm when tested and two (2) of three (3) call bells in the west wing shower room with no pull cord.<br><br>Findings included ...<br><br>1. During observations on the fifth floor on August 31, 2018, at approximately 10:30 AM, call bells in resident room<br>#502 and #532 did not alarm when activated, possibly delaying residents or visitors from alerting staff in the event<br>of an emergency in two (2) of 66 observations.<br><br>2. During observations on the fourth floor on August 31, 2018, at approximately 11:00 AM, two (2) of three (3) call<br>bells located in the west wing shower room did not have a pull cord.<br><br>During a face-to-face interview on August 31, 2018, at approximately 12:30 PM, Employee #5 confirmed the findings. | L 306 | L 306<br>1. The call bells in room #'s 502 and 532 alarm when activated. Pull cords were placed in the west wing shower room.<br>2. The Facilities Manager or designee will make rounds to ensure that the room call bells are in good working condition and the shower rooms have pull cords.<br>3. Staff was educated on reporting call bell functioning issues and missing pull cords.<br>4. The Facilities Manager or designee will randomly audit 10 percent of the resident rooms on a weekly basis times 3 month to ensure the functionality of call bells. Facilities Manager or designee will also audit shower rooms on a weekly basis to ensure that they have pull cords. The results of the audit will be reported at the monthly QAPI committee meeting for review. | 11/11/18 |

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| L 410 | Continued From page 39 | L 410 | L 410 | 11/11/18 |
| L 410 | 3256.1 Nursing Facilities<br><br>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.<br>This Statute is not met as evidenced by:<br>Based on observations and staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a comfortable interior as evidenced by exhaust vents in five (5) of 66 resident's rooms that did not function as intended and soiled exhaust vents in two (2) of 66 resident's rooms<br><br>Findings included...<br><br>Facility failed to ensure resident common areas were maintained in a safe, comfortable condition .<br>During observations on the fourth, fifth and sixth floor on August 31, 2018, between 10:20 AM and 12:30 PM, resident's rooms and common areas were observed with the following:<br><br>1. Exhaust vents did not provide suction when tested in five (5) of 66 resident's rooms (#455, #550, #553, #555, #556).<br><br>2. Exhaust vents were soiled with dust in two (2) of 66 resident's rooms (#542, #545).<br><br>During a face-to-face interview on August 31, 2018, at approximately 12:30 PM, Employee #5 confirmed the findings. | L 410 | 1. The exhaust vents in room #'s 455,550,553,555, and 556 provide suction. The vents in room #'s 542 and 545 were dusted.<br><br>2. The Maintenance Manager or designee conducted rounds to ensure that the exhaust vents in resident rooms suction and are free from dust.<br><br>3. The maintenance staff was educated on ensuring that the exhaust vents suction and are free from dust.<br><br>4. The Maintenance Manager or designee will randomly audit 10 percent of the resident rooms on a weekly basis times 3 months to ensure that the exhaust vents suction and are | |

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| L 442 | Continued From page 40 | L 442 | L 442 | 11/11/18 |
| L 442 | 3258.13 Nursing Facilities<br><br>The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br>This Statute is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to maintain essential equipment in safe condition as evidenced by exposed electrical wires from one (1) of one (1) meat slicer and one (1) of one (1) buffalo chopper.<br><br>Findings included ...<br><br>1. The power cord to one (1) of one (1) meat slicer was frayed and its internal electrical wires were visible and<br>accessible and posed a safety hazard to staff.<br><br>2. The power cord to one (1) of one (1) buffalo chopper was frayed and its internal electrical wires were visible and<br>accessible and created an unsafe environment for staff.<br><br>During a face-to-face interview on August 30, 2018, at approximately 12:30 PM, Employee #4 confirmed the findings. | L 442 | 1. The exposed electrical wires for the meat slicer and buffalo chopper were repaired.<br><br>2. The Dining Services Manager walked through the kitchen to ensure that there were no other exposed electrical wires.<br><br>3. The Dining Services Staff was educated on reporting exposed electrical wires.<br><br>4. The Dining Services Manager or designee will conduct weekly rounds times 3 months to ensure that there are no exposed wires. The results of the rounds will also be reported at the monthly QAPI committee meeting for review. | |
| L 521 | 3269.1d Nursing Facilities<br><br>(d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care;<br><br>This Statute is not met as evidenced by:<br>Based on observations and staff interview of one (1) of 60 sample residents, the facility failed to ensure Resident #114 was treated with dignity | L 521 | | |

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| L 521 | Continued From page 41<br>and respect as evidenced by facility staff calling resident "Poppy."<br><br>Findings included ...<br><br>Resident #114 was admitted on June 15, 2015, with diagnoses to include Osteoarthritis, Cataracts, Dementia, Sensorineural Hearing Loss, and Peripheral Vascular Disease.<br><br>During observations on August 30, 2018, at 10:30 AM, Resident #114 noted wandering on the unit with wet pants. Employee #28 in the hallway called the resident "Poppy" while trying to offer re-direction. When queried about the resident's name, the employee provided the resident's name.<br><br>On August 30, 2018, at 11:56 AM, Resident #14 walked pass the nursing station with a large wet area on the front of the pants in the groin area. Employee #21 called Resident #114 "Poppy" to gain attention to assist with changing pants.<br><br>A review of the medical record to include social services assessment, preferences, and care plans failed to demonstrate the resident's preference to be called "Poppy."<br><br>During a face to face interview on August 30, 2018, at approximately 12:15 PM, Employee #21 stated the resident is Japanese and apologized for speaking to the resident in that manner. The employee acknowledged the findings. | L 521 | L 521<br>1. Resident # 114 was treated with dignity and respect as evidenced by facility staff calling him by his name.<br>2. All other residents have been treated with dignity and respect.<br>3. Staff has been educated on treating residents with dignity and respect by addressing residents by their name.<br>4. The Unit Manager or designee will conduct random observations on a weekly basis times 3 months to ensure that staff treats residents with dignity and respect by addressing residents by their name. The results of the observations will be reported at the monthly QAPI committee meeting for review. | 11/11/18 |
| L 529 | 3269.1l Nursing Facilities<br><br>(l) To be free from mental or physical abuse; | L 529 | | |

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| L 529 | Continued From page 42<br><br>This Statute is not met as evidenced by:<br>Based on resident and staff interview for one (1) of 60 sampled residents, the facility failed to ensure that Resident #338 was free from verbal abuse.<br><br>Findings included...<br><br>The facility's "Abuse Prevention" policy last revised August 2018, defines mental abuse as "the use of verbal or non-verbal conduct which cause or has the potential to cause a resident to experience humiliation, intimidation, fear, shame, agitation, or degradation." In addition, the policy states "IDENTIFICATION- b. Associates or person affiliated with this community who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any criminal offense shall immediately report the suspected abuse or incidents of abuse to the administrator or designee.<br><br>During the onsite recertification survey, Resident #338 reported an allegation of verbal abuse to the surveyor, during a resident interview, stating the certified nursing assistant spoke in a harsh and rude manner which was hurtful and caused the resident to cry.<br><br>Resident #338 was admitted on August 6, 2018, with diagnoses to include Anemia, Heart failure, Hypertension, Peripheral Vascular Disease, Gastroesophageal Disease, Diabetes Mellitus, and Asthma. | L 529 | | |

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| L 529 | Continued From page 43<br><br>According to the Brief Interview for Mental Status (BIMS) Summary Score on the admission Minimum Data Set (MDS) dated August 13, 2018, the resident is cognitively intact as Section C0500 was coded "15."<br><br>During a face-to-face resident interview on August 30, 2018, at 3:15 PM, Resident #338 stated the staff providing am care spoke to in a harsh manner, which cause her to feel upset and hurt and made her cry. When asked if she reported the incident to anyone, the resident stated "no." A Rehab staff member (Employee #8) was waiting outside the room to transport the resident for a therapy session.<br><br>On August 30, 2018, at approximately 3:30 PM, Employee #7 was asked if the facility was aware of Resident #338's allegation of verbal abuse. The employee acknowledged being aware of the allegation and state the employee involved was sent home until further notice. Employee #7 stated she learned about the verbal allegation at around 12:00 PM. However, the employee did not report the incident to the State Agency until 4:53 PM on August 30, 2018.<br><br>During a telephone interview on September 4, 2018, at 10:45 AM, Employee #8 stated, on August 30, 2018, at approximately 9:50 AM, while waiting, outside of the resident's room, to take the resident to therapy, the employee overheard a lot of noise, yelling and rough talking. Employee #9, Certified Nurse Aide, and Resident #338 were in | L 529 | L 529<br><br>1. Resident #338 was assessed and provided reassurance.<br><br>2. No other residents were identified to have reported abuse.<br><br>3. Staff have been in-service to ensure that residents are free from abuse.<br><br>4. Random observations and interviews will be conducted by Nurse Manager or Designee on a weekly basis times 3 months. Results will be reviewed and addressed immediately as needed. The results of the observations will also be reported at the monthly QAPI committee meeting for review. | 11/11/18 |

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| L 529 | Continued From page 44<br>the bathroom. When the resident came out of the bathroom, she was crying and coughing. Employee #9 was overheard yelling at the resident to cover her mouth.<br><br>Employee #8 was asked whether she reported the incident to anyone prior to taking Resident #338 to therapy. Employee #8 stated she did not report the incident to because the resident wanted to get to therapy quickly. The employee decided to take the resident to therapy and report the matter to Rehab Supervisor. The employee was advised by her supervisor to report the incident to the nurses on the unit upon Resident #338's return to unit after therapy. Employee #8 stated the charge nurse was informed on August 30, 2018, at approximately 11:00 AM.<br><br>During a face-to-face interview at approximately 4:00 PM on September 4, 2018, Employee #7, Unit Manager, acknowledged the witnessed incident of verbal abuse towards Resident #338. | L 529 | | |