Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0015	A. BUILDING _____ B. WING _____	07/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURT HOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

(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 000	Initial Comments An annual licensure survey was conducted on July 19, 20 and 23, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 15 residents based on a census of 60 on the first day of survey. There were four (4) supplemental records.	L 000	**L051 (1) Notification of Changes** **1. Immediate Response:** Resident #1's physician was informed of resident's change in depressive symptoms and behaviors. Resident evaluated. **2. Risk Identification:** All resident records were reviewed for documentation of significant change in depressive symptoms and behaviors and subsequent physician notification for the last quarter. **3. Systemic Changes:** Social Service and licensed nurses were in-serviced on physician notification when observing and documenting significant change in resident's symptoms of depression and/or behaviors. **4. Monitoring:** The Director of Social Services or her designee will perform a sample audit of records to assure the physician was notified of residents with significant change in depressive symptoms and/or behaviors. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	7/23/10 9/3/10 9/3/10 9/15/10
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interviews for three (3) of 15 sampled residents, it was determined that the charge nurse failed to notify	L 051	**L051 (2&3) Develop Comprehensive Care Plans** **1. Immediate Response:** Care Plan for resident #3 was completed for the use of 9 or more medications. Care plan for resident #5 was completed for self administration.	7/23//10

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Susan McHugh — LNHA

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 9/3/10

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L 051	Continued From page 1 the physician of Resident #1's depressive symptoms and behaviors for one (1) resident failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Residents # 1, 3 and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors Resident #1 was admitted to the facility on January 6, 2010. According to an admission Minimum Data Sets [MDS] completed January 15, 2010, his/her diagnoses included: Cerebrovascular accident, Emphysema, Glaucoma, Cervical Stenosis, Ataxia, BPH, and peripheral neuropathy. A review of the resident's clinical records revealed a "Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO [By mouth] before dinner 4 PM special instructions ..." "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM ..." "Ensure plus oral liquid 1 cans PO 3 times a day ..." "Ensure plus oral liquid 1 cans PO 3 times a day ...for a total of 6cans per day ..." "Flomax oral capsule extended release 24 hour 0.4 mg 1 capsule PO 8:00 PM ..." "Lasix ...oral tablet 20mg 1 tablet PO 1 time a	L 051	**(L051 2&3 Develop Comprehensive Care Plans Continued)** **2. Risk Management:** An audit was completed of the care plans for all residents (a) using 9 or more medications (b) self administering medication. Care plans in place. **3. Systemic Changes:** Staff were in-serviced on the need to care plan for residents on 9 or residents who self medicate. **4. Monitoring:** A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more meds and self administering medications. Findings will be reported at QA meeting. **L052 (1)Allergy** **1. Immediate Response:** Family contacted for clarification of fish allergy. Order written that states resident is allergic to fish, not shellfish. **2. Risk Identification:** Residents with food allergies reviewed. There were no other residents affected. **3. Systemic Changes:** Staff will be in-serviced on correctly documenting food allergies, and need to have allergies stated on POS. **4. Monitoring:** DON/designees to audit records and report findings to QA committee.	9/15/10 9/2/10 9/15/10 7/27/10 9/1/10 9/15/10 9/15/10

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L 051	Continued From page 2 day ..." "Loratadine oral tablet 1 tablet PO ..." "Multi-minerals oral tablet 1 tablet PO ..." "Potassium chloride crys CR oral table extended release 10 meq 1 tablet ..." "Acetaminophen Extra strength 500mg 2 tablets PO PRN every 6 hours-PRN for temperature >100 ..." A further review of the resident's clinical record revealed the following: Social Service Progress Notes: " April 20, 2010 " ...Resident demonstrates some symptoms of depression including irritable mood, feelings of hopelessness and uselessness, and a decline in socialization in the past 6 week ...Resident also can become verbally aggressive, swearing at nurses providing care and making sexually inappropriate comments. These behaviors are also easily redirected ..." The resident's clinical record lacked documented evidence that the physician was notified of the aforementioned resident's presentations. A further review of the physician's progress notes in the resident's clinical record lacked documented evidence that the physician addressed Resident #1's depressive symptoms and behaviors. A face-to-face interview was conducted on July 23, 2010, at approximately 9:00 AM with Employees #1 and 11. After reviewing the resident's clinical record, they both acknowledged that the resident's clinical record lacked documented evidence that the physician was notified of Resident #1's depressive symptoms and behaviors. According to Employees #1 and	L 051	**L052 (2)Labs** **1. Immediate Response:** Labs obtained. **2. Risk Identification:** Audit of physician's progress notes completed for past 90 days. Charge Nurse/DON to review physician's charts after visits to assure orders are correctly entered. **3. Systemic Changes:** Physician in-served on procedure of flagging orders when written. **4. Monitoring:** Audit of 10% of physician charts by DON or designee done monthly and reported at quarterly QA meeting. **L052 (3)Physician Order** **1. Immediate Response:** Order for self administration of eye drops obtained. **2. Risk Identification:** Records checked to make sure that any resident self-administering medications has orders in place. **3. Systemic Changes:** Licensed nursing staff in-serviced on need to obtain physicians order for all self-administered medications. **4. Monitoring:** DON/designee will audit the medical record for all residents who self administer medication to assure physician order in place. Results of audit will be reported at Quarterly Meetings.	**7/13/10** **9/10/10** **8/31/10** **9/15/10** **7/22/10** **7/23/10** **9/15/10** **9/15/10**

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L 051	Continued From page 3 11 after the face-to-face interview [July 23, 2010], the resident was seen by a psychiatrist and was prescribed medication for depression. The record was reviewed July 23, 2010. The findings include: 2. The Charge Nurse failed to initiate a care for the potential adverse interaction of the use of nine (9) or more medications for Resident #3. A review of the Physician Order Record for Resident #3 for July 2010, signed by the physician on July 2, 2010, revealed the following medication orders: Aricept, Aspirin, Colace, Ensure, Miralax, Sinemet, Vitamin D3, Zyprexa, Ativan, and Tylenol. A review of the care plan that were last updated on July 14, 2010, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #4 on July 19, 2010 at approximately 11:30 AM. After review of the care plans he/she acknowledged that the record lacked a problem identified or a care plan for the potential adverse interaction of the use of nine (9) or more medications. The record was reviewed on July 19, 2010 3. The charge nurse failed to initiate a care plan with appropriate goals and approaches for self	L 051	**L052 (4) Free of Accident Hazards/Supervision/Devices** **1. Immediate Response:** Resident #12 was immediately assessed to insure that safety measures and assisted devices were in place to protect against accidents. Safety measures include extensive assistance of two (2) persons for bed mobility and transfer. Assisted devices include two half side rails on a specially ordered bariatric bed. All assisted devices and safety measures were found to be in place and in compliance with physician orders and assessments. **2. Risk Identification:** The DON's RN designee went room by room to inspect each resident bed and its side rails to assure compliance with physician orders. The DON's RN designee reviewed each resident's MDS to assure all residents are provided with the necessary assistance for bed mobility and transfer. **3. Systemic Changes:** Rehab manager in-serviced staff on resident #12's safe bed mobility techniques, need for extensive assistance during transfer, and placement on bed pan. DON spoke with licensed nurses about supervision of C.N.A. staff to follow amount of assistance requirement to minimize potential for accidents	**7/20/10** **7/22/10** **9/15/10** **7/22/10**

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L 051	Continued From page 4 administration of medication for Resident #5. According to an "Interim Order Form" dated and signed March 23, 2010, it directed "resident may self administer eye drop with nurse supervision." A review of the plan of care for Resident #5 lacked problem identification, objectives and approaches for self administration of eye drops. A face-to-face interview was conducted with Employee #4 on July 20, 2010 at approximately 3:00 PM. He/she acknowledged that the record lacked a care plan for self administration of eye drops. The record was reviewed on July 20, 2010.	L 051	**(L052 (4) Free of Accident Hazards/Supervision/Devices Continued)** Rehab manager in-serviced nursing staff on safe bed mobility techniques for all residents. DON in-serviced nursing staff on the necessity of providing extensive assistance for bed mobility or transfer as indicated. **4. Monitoring:** Rehab manager will report any changes to side rail orders at safety committee weekly. DON/ or RN designee will conduct an audit of all beds and side rails with corresponding physician orders. The findings will be reported at the Quarterly QA meetings. Each resident will be reviewed on admission, quarterly and as needed for level of assistance to maximize safety. The findings will be reported at weekly safety committee meetings. RN managers will perform random observations of resident care every shift, every month to monitor appropriate level of assistance provided for bed mobility and transfer. The DON or her designee will review RN Manager audits and report findings at quarterly QA.	**8/30/10** **9/15/10**
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; (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	L 052		

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L 052	Continued From page 5 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. A. Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff to provide sufficient nursing time to clarify allergy to shell fish for one (1) resident, to follow through with physician's plan to obtain labs for one (1) resident and to obtain a physician's order for self administration of eye drops for one (1) resident. Residents # 2, 3, and 5. The findings include: 1. Facility staff failed to clarify allergy to shellfish	L 052	**L091 Infection Control** **(1) Storage of Waste Boxes** **1. Immediate Response:** 7/23/10 The two infectious waste boxes were immediately removed from the floor. **2. Risk Identification:** 7/23/10 All areas of storage of waste boxes were checked, no other boxes were observed on the floor. **3. Systemic Changes:** 9/15/10 All nursing, environmental and housekeeping staff in-serviced on the proper storage of medical waste boxes. **4. Monitoring:** 9/15/10 ADON or designee will perform random audits and report findings at the Quarterly Quality Assurance Meeting. **L091 Infection Control** **(2) Hand Washing during Meal Serving** **1. Immediate Response:** 7/20/10 Identified employee and in-serviced on infectious control practices and hand washing technique. Employee was reassessed for hand washing between residents while providing care. Employee was observed to wash her hands between residents care. **2. Risk Identification:** 7/24/10 All nursing staff was observed/ reassessed on hand washing practice while providing care. **3. Systemic Changes:** 7/24/10 Staff in-serviced on infectious control practices and hand washing between residents while providing care.	

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L 052	Continued From page 6 for Resident #2. History and Physical dated and signed November 3, 2009, directed " See H&P [History and Physical] Sibley [October 25, 2009] and [May 29, 2009]. The [hospital] H&P dated October 25, 2009 and May 29, 2009, revealed "Allergies: Shellfish." The "Initial Nutritional Assessment "completed November 8, 2009, revealed " *no baked, fried fish* tuna [and] shellfish OK." According to the "Nutritional Risk Care Plan" dated November 23, 2009, revealed "Other: Allergy/intolerance to fish (tuna OK and shellfish OK)" According to the "Nutrition Risk Care Plan" dated February 17, 2010, revealed "Intolerance to fish (shellfish and tuna OK)." The "Quarterly Nutrition Review " dated and signed May 24, 2020, revealed " no baked or fried fish, tuna/shellfish OK. " A face-to-face interview was conducted with Employees #4 and Employee #17, both stated, "Resident #2 is not allergic to shellfish, she has eaten shrimp with no problem, she prefers not to have baked and fried fish." After reviewing the resident's clinical record both acknowledged the record lacked evidence of clarifying resident ' s allergy to shellfish. The record was reviewed July 19, 2010. 2 Facility staff failed to follow through with physician's plan to obtain labs on Resident #3. A review of the physician's progress note dated	L 052	**(L091 Infection Control (2) Hand Washing during Meal Serving Continued)** **4. Monitoring:** ADON or designee will perform a monthly staff observation for hand washing practices while providing care during mealtime and report findings at the Quarterly QA Meeting. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(1) Soiled Toaster Oven and Convection Oven** **1. Immediate Response:** Convection oven, toaster and stove were cleaned. **2. Risk Management:** All cooking equipment was checked for cleanliness. **3. Systemic Changes:** All Dietary staff was in-serviced on cleaning cooking equipment. Every Cook will be responsible for cleaning equipment after every meal. **4. Monitoring:** Cooks will sign daily "Opening Procedures" and "Closing Procedures" checklist. Heavy cleaning will be added to Tuesday cleaning schedule and signed off by cleaning personnel. Supervisor on Duty will check cleanliness and monitor aforementioned checklists. Director or designee will audit and report findings at Quarterly QA.	9/15/10 7/19/10 7/19/10 7/27/10 9/15/10

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L 052	Continued From page 7 and signed April 13, 2010 indicated ... no recent labs; check CBC (complete blood count)... A review of the physician's orders for April 2010 lacked evidence of a CBC order. A review of the nurse's notes for April 2010 lacked documented evidence that a CBC was ordered. A review of the laboratory sheets lacked evidence that a CBC was ordered or drawn. A face-to-face interview was conducted on July 23, 2010 at approximately 10:30 AM with Employees #1, 2, and 13. After review of the clinical record he/she acknowledged that the clinical record lacked documented evidence that the CBC was ordered. Facility staff failed to follow through with the physician's plan to obtain labs on Resident #3. The record was reviewed on July 23, 2010. 3. Facility staff failed to obtain physician order for self administration of eye drops for Resident #5. A review of an Interim Order dated and signed June 22, 2010 directed, "Patanolol eye drops, ii gtts [two drops] ou [both eyes] twice a day [bid]." According to "Physician Order Record "dated July 16, 2010, directed, "Patanol Ophthalmic Solution 0.1% [two] drops both eyes [two] times a day". According to the Medication Administration Record [MAR] for July 2010, the resident	L 052	**L099 Food Procure, Store/ Prepare/ Serve – Sanitary** **(2) Rinse water in 3 compartment sink was not holding water** **1. Immediate Response:** Maintenance repaired mechanical stopper. **2. Risk Management:** All stoppers on sinks throughout the kitchen were checked. **3. Systemic Changes:** Dietary Staff was in-serviced on importance or reporting malfunctioning equipment to a supervisor immediately. **4. Monitoring:** Dietary Personnel will check stoppers daily and report any malfunction immediately. Work orders will be submitted to Maintenance. Director will report work orders submitted at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(3) Temperature of pot wash sink 104** **1. Immediate Response:** Water was emptied and refilled with 110 degree water. **2. Risk Management:** sink water temperatures were checked throughout kitchen. **3. Systemic Changes:** Food Service Staff was in-serviced and temperature of water will be over 110 degrees.	**7/19/10** **7/19/10** **7/27/10** **9/15/10** **7/19/10** **7/19/10** **7/27/10**

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L 052	Continued From page 8 received Patanol Ophthalmic Solution at 9 AM and 5 PM every day. A face-to-face interview was conducted with Resident #5. He/she stated, "Yes, I put my own eye drops in my eyes, and it is for dry eyes." A face-to-face interview was conducted on July 20, 2010 at approximately 3:00 PM with Employees # 4 and Employee #17. Both stated, "[Resident #5] self administers his/her eye drops." The record was reviewed July 20, 2010. B. Based on observation, interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to implement safety measures and assistance devices to ensure safety from accidents for one (1) Resident who sustained a fall with injury while being turned in bed for Resident #12. The findings include: According to the annual and quarterly Minimum Data Sets [MDS] dated February 1, 2010 and May 3, 2010 respectively, Section I, Disease Diagnoses included Diabetes, Hypertension, Arthritis, Osteoporosis, Allergies, Cardiovascular Disease, and Cancer. Section G, Physical Functioning revealed the resident required extensive assistance of two (2) persons for bed mobility and transfer. Bed rails were coded for bed mobility and transfer and a mechanical lift was required for transfer. The resident had limited range of motion and partial loss of voluntary movement of the arm and leg on one side. Section K, Nutritional Status revealed Resident #12's height was 60 inches and weight	L 052	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(3) Temperature of pot wash sink 104 Continued)** **4. Monitoring:** Temperature log implemented and temperature will be taken and recorded three times per day. Director and supervisor on duty will monitor. Director will report findings at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve – Sanitary** **(4) Rug in front of freezer stained and soiled** **1. Immediate Response:** Rug was thrown away. **2. Risk Management:** All floors were checked throughout kitchen. **3. Systemic Changes:** Rubber safety mat was purchased to replace rug. **4. Monitoring:** Rubber safety mat was added to the Tuesday heavy cleaning list to check for rips and soil. Director will report any finding at Quarterly QA.	**9/15/10** **7/19/10** **7/19/10** **7/28/10** **9/15/10**

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L 052	Continued From page 9 225 pounds. Physician's orders signed June 2, 2010 prescribed the use of two ½ side rails for safe bed mobility. According to the "Nursing Monthly Summary" report for May and June 2010, " Ambulation/Rehab: Requires total transfer by staff 2 [two] persons." Resident #12 sustained a fall with injury as evidenced by the following nurse's notes: June 19, 2010, 4:30 AM, "At 2:50 AM resident fell out of left side of bed while [staff] was trying to put [resident] on the bedpan. Resident observed lying prone [face down] on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. [Staff] reported that resident's head hit walker as [resident] fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial, 4cm [long] x 0.2 cm wide. " June 19, 2010, 3:00 PM "...continues to complain of headache ...left eye swollen and dark colored ...new order to transfer to [hospital] emergency room at 10:50 AM." According to the emergency department discharge summary dated June 19, 2010, the resident sustained the following injuries: closed head injury, forehead laceration, facial contusion, cervical strain and multiple contusions. A face-to-face interview was conducted with	L 052	**L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(5) Apple juice and Pineapple/carrot/raisin salad were 48 degrees** **1. Immediate Response:** Juice and pineapple/carrot/raisin salad were thrown away. **2. Risk Management:** Cold temperatures were checked on other trays. **3. Systemic Changes:** Food Service staff was in-serviced on proper point of service temperatures. Juices will be poured from Vitality Juice Dispenser immediately after each meal and put into refrigerator to chill before the next meal. All cold items will be chilled and served in an insulated Alladin cup. **4. Monitoring:** Test Tray temperatures will be taken every week by Catering Associate. Director will report any finding at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(6) Staff was not specific on how to properly test or verify the concentration of the sanitizing solution for the dishwasher.** **1. Immediate Response:** Test strips were replaced with Chlorine Test Paper that was easier to identify color.	**7/19/10** **7/19/10** **7/27/10** **9/15/10** **7/19/10**

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L 052	Continued From page 10 Resident #12 on July 20, 2010 at approximately 3:45 PM. Resident stated, "I fell out of the bed 2-3 weeks ago. The nurse was trying to put me on the bedpan, when I turned [an] there was no side rail for me to hold onto. So, I tried grabbing the wall, and I fell and hit my head. My eyeglasses broke. I had to get another pair. I had a cut over my eye and I was bleeding into my eye and my head was hurting. " A face-to-face interview was conducted with Employee #1 on July 23, 2010 at approximately 11:30 AM. He/she stated, "[Resident] had been complaining about the bed...the third replacement had one long side rail... the fall occurred while being assisted onto the bedpan." According to the clinical record, Resident #12 was prescribed ½ side rails for bed mobility and extensive assistance of two (2) persons for bed mobility and transfer in accordance with the quarterly MDS completed May 3, 2010. The record lacked evidence that two (2) side rails were implemented in accordance with physician ' s orders to assist the resident with bed mobilization. Additionally, there was no evidence that staff utilized the number of individuals to assist the resident with bed mobility. Facility staff failed to implement safety measures and assistance devices to ensure the resident's safety from accidents. The resident sustained a fall out of bed with subsequent injuries. The record was reviewed on July 20, 2010.	L 052	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(6) Staff was not specific on how to properly test or verify the concentration of the sanitizing solution for the dishwasher.** **Continued)** **2. Risk Management:** Ecolab was called immediately to check PPM. PPM was correct. **3. Systemic Changes:** All Dietary Personnel were in-serviced on how to use new Chlorine Test Paper. **4. Monitoring:** Supervisor will continue to monitor logs. Director will report any findings at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink** **1. Immediate Response:** Dietary Director informed the Dietary Personnel that the correct temperature is 110 degrees or higher. Sink was emptied and refilled. **2. Risk Management:** Water was emptied from sink and refilled with water and temperature was tested with thermometer.	**7/19/10** **7/27/10** **9/15/10** **7/19/10** **7/19/10**
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are	L 091		

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L 091	Continued From page 11 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: A. Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidenced by the improper storage of medical waste boxes in the soiled utility room. The findings include: Two (2) of four (4) infectious waste boxes were stored upright and directly on the floor in the soiled utility room. These observations were made in the presence of Employees #8 and #9 who acknowledged these findings during the survey. B. Based on observations and staff interview for two (2) of 15 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to wash hands after direct resident contact during dinner meal. Residents #3, 4, A1, A2, A3, and A4. The findings include: Residents #3, 4, A1, A2, A3 and A4 were observed during dinner in the special care unit's dayroom on July 19, 2010 at approximately 4:05 PM... Resident #3 was observed seated on a chair by himself/herself. Resident # 4 was observed seated on by a table	L 091	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink Continued)** **3. Systemic Changes:** Dietary Personnel was in-serviced on correct temperatures. Temperature will be taken three times per day and recorded on log. **4. Monitoring:** Supervisor will check log daily. Director will report findings at Quarterly QA. **L161 Expired Drugs** **1. Immediate Response:** Identified expired and discontinued medications and removed from medication carts. **2. Risk Management:** Medications were checked in all storage areas to make sure there were no expired or discontinued medication. **3. Systemic Changes:** Education to nursing staff was done about necessity of removing meds upon discharge or expiration. **4. Monitoring:** Supervisor to monitor carts for expired/discharge medications. Findings will be reported by DON or designee at QA committee.	**7/27/10** **9/15/10** **7/23/10** **9/15/10** **9/15/10** **9/15/10**

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L 091	Continued From page 12 by himself/herself. Resident #A1, A2, A3, and A4 were observed seated together at the same table. Employee # 10 was observed serving the residents their dinner trays. After he/she completed passing out some of the trays, he/she moved between Residents #4, A1, A2, A3, and A4 and assisted the residents with setting up their dinner trays and feeding He/she stood next to Resident #4 and fed him/her for approximately five (5) minutes. Returned Resident # 4's tray to the cart, outside the dayroom. Employee #4 returned to the dayroom with Resident A1's dinner tray. Resident A1 presented with difficulty keeping food on his/her fork. Employee # 10 stood by Resident A1 and fed him/her. Resident A2 expressed frustration opening his/her drinking straw. Employee #10 left Resident A1 to assist Resident A2. Employee #10 touched the end point of the straw that Resident A2 put in his/her mouth with his/her unwashed hands. Employee #10 left Resident A2 to assist Resident A3 back to the dayroom from the hallway. He/she gave Resident A3 a cup of ice cream and returned to Resident A1. Employee #10 assisted Resident #4 to his/her room. He/she went to the community kitchen across from the nurses 'station to collect Resident #3's dinner tray from the food warmer. He/she returned to the dayroom with Resident #3's dinner tray. He/she stood next to the resident	L 091	**L206 Documentation of Injury** **1. Immediate Response:** Corrected incident report sent to proper authorities. **2. Risk Identification:** Other incident reports involving injury were reviewed for correct documentation of injury and proper transmission. **3. Systemic Changes:** Licensed nursing staff in-serviced on proper documentation and transmission of incident reports. **4. Monitoring:** A random audit will be done monthly at safety committee meetings. The findings will be reported at the Quarterly QA meetings. **L410 Housekeeping and Maintenance Services** **(1) Privacy Curtains Stained** **1. Immediate Response:** Unable to remove ink stains from privacy curtains in room 105 and 123 therefore privacy curtains were replaced. **2. Risk Identification:** All other privacy curtains were inspected and replaced if indicated. **3. Systemic Changes:** Staff in-serviced on checking privacy curtains for cleanliness and lack of stains. **4. Monitoring:** Privacy curtains will be inspected on a monthly basis and findings will be reported at Quarterly QA meetings.	**9/2/10** **9/4/10** **9/15/10** **9/15/10** **7/20/10** **7/20/10** **9/1/10** **9/15/10**

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L 091	Continued From page 13 and fed him/her. Throughout the period of the above observations, Employee #10 failed to wash his/her hands after direct residents contact during dinner meal on July 19, 2010 at approximately 4:05 PM. He/she failed to wash his/her hands between residents 'care: He/she provided care for multiple residents at the same time without washing his/her hands. A face-to-face interview conducted at with Employee #10 on July 23, 2010 at approximately 1:20 PM. He/she acknowledged the above observation. He/she said, "I was trying to hurry-up with the feeding. All the residents required my help as you can see. I know better than that. "	L 091	**L410 Housekeeping and Maintenance Services** **(2) Ceiling Vent Dripping Water** **1. Immediate Response:** Vent closed and water dripping ceased. **2. Risk Identification:** All other ceiling vents on unit checked for water dripping and fixed if indicated. **3. Systemic Changes:** Staff in-serviced to check ceiling vents for dripping water during scheduled room checks. **4. Monitoring:** Engineering will monitor ceiling vents for dripping water on scheduled PM room checks and will report findings at Quarterly QA Meeting.	**7/20/10** **7/20/10** **9/3/10** **9/15/10**
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 Regulations (DCMR), and Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made during tours of the dietary services on July 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: one (1) of one (1) soiled toaster oven, one (1) of one (1) soiled convection oven, and one (1) of one (1) soiled gas stove; out of range temperatures on the test tray; a leak in the three-compartment sink, a stained and soiled rug in front of the freezer and on one (1) of one (1) occasion a staff member failed to correctly state the expected temperature of the washing solution	L 099	**L410 Housekeeping and Maintenance Services** **(3) Damaged AC Cover & Grill in Room 134** **1. Immediate Response:** Cover and grill removed, repaired and replaced. **2. Risk Identification:** All other grills and covers checked on unit and repaired if necessary. **3. Systemic Changes:** Engineering staff was in-serviced on need to check condition of air conditioner covers and grills. **4. Monitoring:** Air conditioner covers and grills will be monitored by engineering staff during scheduled PM room checks and finding will be reported at quarterly QA Meetings.	**8/25/10** **8/25/10** **9/3/10** **9/15/10**

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L 099	Continued From page 14 in the three-compartment sink and on two (2) of two (2) occasions staff members failed to correctly test and verify the concentration of the sanitizing solution in the dishwashing machine. The findings include: 1. The convection oven, the toaster oven and the gas stove were soiled. 2. Test tray temperatures for apple juice and pineapple/carrots/raisins salad were forty-eight degrees Fahrenheit (F) and exceeded allowable limit of forty-one degrees F. 3. The temperature of the wash solution in the three-compartment sink was 104 degrees F and was far below the expected minimum temperature of 110 degrees F. 4. The rinse water compartment of the three-compartment sink was constantly leaking and could not hold the rinse water solution efficiently. 5. The rug in front of the freezer was stained and soiled. 6. One (1) of one (1) staff member was unable to state the expected temperature of the washing solution for the three-compartment sink and two (2) of two (2) staff members failed to properly test and verify the concentration of the sanitizing solution for the dishwashing machine. These observations were made and acknowledged by Employee #7 who was present at the time of the observations.	L 099	**L426 Maintains Effective Pest Control Program** **1. Immediate Response:** 7/20/10 Room was cleaned and the pest control company was called. **2. Risk Identification:** 7/20/10 Pest Control Company came out and checked all areas and treated appropriately. **3. Systemic Changes:** 9/15/10 Staff educated as to how to prevent fruit flies and other insects and proper reporting of insect sightings so that areas can be treated. **4. Monitoring:** 9/15/10 Pest control rounds will be conducted 3X monthly with action items addressed and results will be reported at Quarterly QA meetings.	

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L 161	Continued From page 15	L 161		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to remove four (4) expired medications from two (2) of three (3) medication carts observed. The findings include: 1. The facility staff failed to remove expired medications and discontinued medications from the medication carts. On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired and drugs were observed in the medication carts as follows: Expired Medications: 1 Bottle of Guaituss 100 gm /5ml syrup, expired June 22, 2010 1 Bottle of Diabetic Tussin syrup, expired June 30, 2010 1 Bottle of Tussin CF 100gm/ 5ml syrup, expired July 11, 2010 1 Bottle of Nitro stat 40 mg capsule expired July 4, 2010 The above findings for the medication carts were acknowledged by Employee #4 on July 19, 2010, at the same time of the observation.	L 161		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of	L 206		

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L 206	Continued From page 16 occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: 22DCMR 3232.4 Based on record review and staff interview for one (1) resident, it was determined that facility staff failed to inform State Agency that a resident who fell sustained an injury. Resident #12. The findings include: 22 DCMR 3232.4 stipulates, " Each incident shall be documented in the resident ' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. " According to an incident report completed by the facility on June 19, 2010, " Resident fell out of bed to the floor while the CNA [Certified Nursing Assistant] was trying to put [his/her] (resident) on the bed pain. " The nurse ' s note dated June 19, 2010 at 4:30AM, documented, " At 2:50AM resident fell out of left side of her bed while [Certified Nursing Assistant] was trying to put her on the bedpan. Resident observed lying prone on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. CNA reported that resident's head hit walker as she fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial,	L 206		

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L 206	Continued From page 17 4cm [long] x 0.2 cm wide. " The record lacked evidence that the incident regarding the head injury was documented on the incident report A face-to-face interview with Employees #1 and Employee #2 conducted on July 23 at approximately 10:00AM. Both acknowledged the injury was not documented on the incident report. The record was reviewed July 20, 2010.	L 206		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 20, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by soiled privacy curtains in two (2) of 13 rooms surveyed, water was dripping from a ceiling vent on one (1) of three (3) units surveyed, a faulty call bell cord in one (1) of 13 rooms surveyed and a damaged air conditioner cover and grill in one(1) of 13 rooms surveyed. The findings include: 1. Privacy curtains were soiled and stained in rooms # 105 and # 123. 2. Water was dripping from the ceiling vent in the special care dayroom located in the Lisner Lane unit.	L 410		

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L 410	Continued From page 18 3. The cover and grill to the air conditioning system in room #134 were damaged. These findings were acknowledged by Employees # 4 and # 9 who were present at the time of observation.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility. The findings include: Flying insects were observed in room #123 and environmental services area. These findings were acknowledged by Employees # 8 and # 9 who were present at the time of observation.	L 426		

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L 000	Initial Comments An annual licensure survey was conducted on July 19, 20 and 23, 2010. The following deficiencies were based on observations, staff and resident interviews and record review. The total sample was 15 residents based on a census of 60 on the first day of survey. There were four (4) supplemental records.	L 000	**L051 (1) Notification of Changes** **1. Immediate Response:** Resident #1's physician was informed of resident's change in depressive symptoms and behaviors. Resident evaluated. **2. Risk Identification:** All resident records were reviewed for documentation of significant change in depressive symptoms and behaviors and subsequent physician notification for the last quarter. **3. Systemic Changes:** Social Service and licensed nurses were in-serviced on physician notification when observing and documenting significant change in resident's symptoms of depression and/or behaviors. **4. Monitoring:** The Director of Social Services or her designee will perform a sample audit of records to assure the physician was notified of residents with significant change in depressive symptoms and/or behaviors. Findings of this audit will be presented at the Quarterly Quality Assurance Meeting.	**7/23/10** **9/3/10** **9/3/10** **9/15/10**
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interviews for three (3) of 15 sampled residents, it was determined that the charge nurse failed to notify	L 051	**L051 (2&3) Develop Comprehensive Care Plans** **1. Immediate Response:** Care Plan for resident #3 was completed for the use of 9 or more medications. Care plan for resident #5 was completed for self administration.	**7/23//10**

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L 051	Continued From page 1 the physician of Resident #1's depressive symptoms and behaviors for one (1) resident failed to initiate a care plan for the potential adverse interaction of the use of nine (9) or more medications for one (1) resident and failed to initiate a care plan for self administration of eye drops for one (1) resident. Residents # 1, 3 and 5. The findings include: 1. The charge nurse failed to notify the physician of Resident #1's depressive symptoms and behaviors Resident #1 was admitted to the facility on January 6, 2010. According to an admission Minimum Data Sets [MDS] completed January 15, 2010, his/her diagnoses included: Cerebrovascular accident, Emphysema, Glaucoma, Cervical Stenosis, Ataxia, BPH, and peripheral neuropathy. A review of the resident's clinical records revealed a "Physician Order Record" signed and dated June 29, 2010 that directed the following: medications: "Calcarb 600/D oral tablet 600-400 mg -unit 1 tablet PO [By mouth] before dinner 4 PM special instructions ..." "Colace oral capsule 100mg 1 capsule PO 1 time a day 9 AM ..." "Ensure plus oral liquid 1 cans PO 3 times a day ..." "Ensure plus oral liquid 1 cans PO 3 times a day ...for a total of 6cans per day ..." "Flomax oral capsule extended release 24 hour 0.4 mg 1 capsule PO 8:00 PM ..." "Lasix ...oral tablet 20mg 1 tablet PO 1 time a	L 051	**(L051 2&3 Develop Comprehensive Care Plans Continued)** **2. Risk Management:** An audit was completed of the care plans for all residents (a) using 9 or more medications (b) self administering medication. Care plans in place. **3. Systemic Changes:** Staff were in-serviced on the need to care plan for residents on 9 or residents who self medicate. **4. Monitoring:** A random sample of 10% of care plans will be reviewed by DON/designees monthly to check for presence of care plans for 9 or more meds and self administering medications. Findings will be reported at QA meeting. **L052 (1)Allergy** **1. Immediate Response:** Family contacted for clarification of fish allergy. Order written that states resident is allergic to fish, not shellfish. **2. Risk Identification:** Residents with food allergies reviewed. There were no other residents affected. **3. Systemic Changes:** Staff will be in-serviced on correctly documenting food allergies, and need to have allergies stated on POS. **4. Monitoring:** DON/designees to audit records and report findings to QA committee.	**9/15/10** **9/2/10** **9/15/10** **7/27/10** **9/1/10** **9/15/10** **9/15/10**

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L 051	Continued From page 2 day ..." "Loratadine oral tablet 1 tablet PO ..." "Multi-minerals oral tablet 1 tablet PO ..." "Potassium chloride crys CR oral table extended release 10 meq 1 tablet ..." "Acetaminophen Extra strength 500mg 2 tablets PO PRN every 6 hours-PRN for temperature >100 . ." A further review of the resident's clinical record revealed the following: Social Service Progress Notes: " April 20, 2010 " ...Resident demonstrates some symptoms of depression including irritable mood, feelings of hopelessness and uselessness, and a decline in socialization in the past 6 week ...Resident also can become verbally aggressive, swearing at nurses providing care and making sexually inappropriate comments. These behaviors are also easily redirected ..." The resident's clinical record lacked documented evidence that the physician was notified of the aforementioned resident's presentations. A further review of the physician's progress notes in the resident's clinical record lacked documented evidence that the physician addressed Resident #1's depressive symptoms and behaviors. A face-to-face interview was conducted on July 23, 2010, at approximately 9:00 AM with Employees #1 and 11. After reviewing the resident's clinical record, they both acknowledged that the resident's clinical record lacked documented evidence that the physician was notified of Resident #1's depressive symptoms and behaviors. According to Employees #1 and	L 051	**L052 (2)Labs** **1. Immediate Response:** Labs obtained. **2. Risk Identification:** Audit of physician's progress notes completed for past 90 days. Charge Nurse/DON to review physician's charts after visits to assure orders are correctly entered. **3. Systemic Changes:** Physician in-served on procedure of flagging orders when written. **4. Monitoring:** Audit of 10% of physician charts by DON or designee done monthly and reported at quarterly QA meeting. **L052 (3)Physician Order** **1. Immediate Response:** Order for self administration of eye drops obtained. **2. Risk Identification:** Records checked to make sure that any resident self-administering medications has orders in place. **3. Systemic Changes:** Licensed nursing staff in-serviced on need to obtain physicians order for all self-administered medications. **4. Monitoring:** DON/designee will audit the medical record for all residents who self administer medication to assure physician order in place. Results of audit will be reported at Quarterly Meetings.	**7/13/10** **9/10/10** **8/31/10** **9/15/10** **7/22/10** **7/23/10** **9/15/10** **9/15/10**

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L 051	Continued From page 3 11 after the face-to-face interview [July 23, 2010], the resident was seen by a psychiatrist and was prescribed medication for depression. The record was reviewed July 23, 2010. The findings include: 2. The Charge Nurse failed to initiate a care for the potential adverse interaction of the use of nine (9) or more medications for Resident #3. A review of the Physician Order Record for Resident #3 for July 2010, signed by the physician on July 2, 2010, revealed the following medication orders: Aricept, Aspirin, Colace, Ensure, Miralax, Sinemet, Vitamin D3, Zyprexa, Ativan, and Tylenol. A review of the care plan that were last updated on July 14, 2010, revealed that there was no problem identified and no care plan developed with appropriate goals and approaches for potential adverse drug interactions involving the use of nine (9) or more medications. A face-to-face interview was conducted with Employee #4 on July 19, 2010 at approximately 11:30 AM. After review of the care plans he/she acknowledged that the record lacked a problem identified or a care plan for the potential adverse interaction of the use of nine (9) or more medications. The record was reviewed on July 19, 2010 3. The charge nurse failed to initiate a care plan with appropriate goals and approaches for self	L 051	**L052 (4) Free of Accident Hazards/Supervision/Devices** **1. Immediate Response:** Resident #12 was immediately assessed to insure that safety measures and assisted devices were in place to protect against accidents. Safety measures include extensive assistance of two (2) persons for bed mobility and transfer. Assisted devices include two half side rails on a specially ordered bariatric bed. All assisted devices and safety measures were found to be in place and in compliance with physician orders and assessments. **2. Risk Identification:** The DON's RN designee went room by room to inspect each resident bed and its side rails to assure compliance with physician orders. The DON's RN designee reviewed each resident's MDS to assure all residents are provided with the necessary assistance for bed mobility and transfer. **3. Systemic Changes:** Rehab manager in-serviced staff on resident #12's safe bed mobility techniques, need for extensive assistance during transfer, and placement on bed pan. DON spoke with licensed nurses about supervision of C.N.A. staff to follow amount of assistance requirement to minimize potential for accidents	**7/20/10** **7/22/10** **9/15/10** **7/22/10**

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L 051	Continued From page 4 administration of medication for Resident #5. According to an "Interim Order Form" dated and signed March 23, 2010, it directed "resident may self administer eye drop with nurse supervision." A review of the plan of care for Resident #5 lacked problem identification, objectives and approaches for self administration of eye drops. A face-to-face interview was conducted with Employee #4 on July 20, 2010 at approximately 3:00 PM. He/she acknowledged that the record lacked a care plan for self administration of eye drops. The record was reviewed on July 20, 2010.	L 051	**(L052 (4) Free of Accident Hazards/Supervision/Devices Continued)** Rehab manager in-serviced nursing staff on safe bed mobility techniques for all residents. DON in-serviced nursing staff on the necessity of providing extensive assistance for bed mobility or transfer as indicated. **4. Monitoring:** Rehab manager will report any changes to side rail orders at safety committee weekly. DON/ or RN designee will conduct an audit of all beds and side rails with corresponding physician orders. The findings will be reported at the Quarterly QA meetings. Each resident will be reviewed on admission, quarterly and as needed for level of assistance to maximize safety. The findings will be reported at weekly safety committee meetings. RN managers will perform random observations of resident care every shift, every month to monitor appropriate level of assistance provided for bed mobility and transfer. The DON or her designee will review RN Manager audits and report findings at quarterly QA.	**8/30/10** **9/15/10**
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; (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	L 052		

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L 052	Continued From page 5 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. A. Based on record review and staff interview for three (3) of 15 sampled residents, it was determined that facility staff to provide sufficient nursing time to clarify allergy to shellfish for one (1) resident, to follow through with physician's plan to obtain labs for one (1) resident and to obtain a physician's order for self administration of eye drops for one (1) resident. Residents # 2, 3, and 5. The findings include: 1. Facility staff failed to clarify allergy to shellfish	L 052	**L091 Infection Control** **(1) Storage of Waste Boxes** **1. Immediate Response:** The two infectious waste boxes were immediately removed from the floor. **2. Risk Identification:** All areas of storage of waste boxes were checked, no other boxes were observed on the floor. **3. Systemic Changes:** All nursing, environmental and housekeeping staff in-serviced on the proper storage of medical waste boxes. **4. Monitoring:** ADON or designee will perform random audits and report findings at the Quarterly Quality Assurance Meeting. **L091 Infection Control** **(2) Hand Washing during Meal Serving** **1. Immediate Response:** Identified employee and in-serviced on infectious control practices and hand washing technique. Employee was reassessed for hand washing between residents while providing care. Employee was observed to wash her hands between residents care. **2. Risk Identification:** All nursing staff was observed/ reassessed on hand washing practice while providing care. **3. Systemic Changes:** Staff in-serviced on infectious control practices and hand washing between residents while providing care.	**7/23/10** **7/23/10** **9/15/10** **9/15/10** **7/20/10** **7/24/10** **7/24/10**

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L 052	Continued From page 6 for Resident #2. History and Physical dated and signed November 3, 2009, directed " See H&P [History and Physical] Sibley [October 25, 2009] and [May 29, 2009]. The [hospital] H&P dated October 25, 2009 and May 29, 2009, revealed "Allergies: Shellfish." The "Initial Nutritional Assessment "completed November 8, 2009, revealed " *no baked, fried fish* tuna [and] shellfish OK." According to the "Nutritional Risk Care Plan" dated November 23, 2009, revealed "Other: Allergy/intolerance to fish (tuna OK and shellfish OK)" According to the "Nutrition Risk Care Plan" dated February 17, 2010, revealed "Intolerance to fish (shellfish and tuna OK)." The "Quarterly Nutrition Review " dated and signed May 24, 2020, revealed " no baked or fried fish, tuna/shellfish OK. " A face-to-face interview was conducted with Employees #4 and Employee #17, both stated, "Resident #2 is not allergic to shellfish, she has eaten shrimp with no problem, she prefers not to have baked and fried fish." After reviewing the resident's clinical record both acknowledged the record lacked evidence of clarifying resident ' s allergy to shellfish. The record was reviewed July 19, 2010. 2 Facility staff failed to follow through with physician's plan to obtain labs on Resident #3. A review of the physician's progress note dated	L 052	**(L091 Infection Control (2) Hand Washing during Meal Serving Continued)** **4. Monitoring:** ADON or designee will perform a monthly staff observation for hand washing practices while providing care during mealtime and report findings at the Quarterly QA Meeting. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(1) Soiled Toaster Oven and Convection Oven** **1. Immediate Response:** Convection oven, toaster and stove were cleaned. **2. Risk Management:** All cooking equipment was checked for cleanliness. **3. Systemic Changes:** All Dietary staff was in-serviced on cleaning cooking equipment. Every Cook will be responsible for cleaning equipment after every meal. **4. Monitoring:** Cooks will sign daily "Opening Procedures" and "Closing Procedures" checklist. Heavy cleaning will be added to Tuesday cleaning schedule and signed off by cleaning personnel. Supervisor on Duty will check cleanliness and monitor aforementioned checklists. Director or designee will audit and report findings at Quarterly QA.	**9/15/10** **7/19/10** **7/19/10** **7/27/10** **9/15/10**

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L 052	Continued From page 7 and signed April 13, 2010 indicated ... no recent labs; check CBC (complete blood count)... A review of the physician's orders for April 2010 lacked evidence of a CBC order. A review of the nurse's notes for April 2010 lacked documented evidence that a CBC was ordered. A review of the laboratory sheets lacked evidence that a CBC was ordered or drawn. A face-to-face interview was conducted on July 23, 2010 at approximately 10:30 AM with Employees #1, 2, and 13. After review of the clinical record he/she acknowledged that the clinical record lacked documented evidence that the CBC was ordered. Facility staff failed to follow through with the physician's plan to obtain labs on Resident #3. The record was reviewed on July 23, 2010. 3. Facility staff failed to obtain physician order for self administration of eye drops for Resident #5. A review of an Interim Order dated and signed June 22, 2010 directed, "Patanolol eye drops, ii gtts [two drops] ou [both eyes] twice a day [bid]." According to "Physician Order Record "dated July 16, 2010, directed, "Patanol Ophthalmic Solution 0.1% [two] drops both eyes [two] times a day". According to the Medication Administration Record [MAR] for July 2010, the resident	L 052	**L099 Food Procure, Store/ Prepare/ Serve – Sanitary** **(2) Rinse water in 3 compartment sink was not holding water** **1. Immediate Response:** Maintenance repaired mechanical stopper. **7/19/10** **2. Risk Management:** All stoppers on sinks throughout the kitchen were checked. **7/19/10** **3. Systemic Changes:** Dietary Staff was in-serviced on importance or reporting malfunctioning equipment to a supervisor immediately. **7/27/10** **4. Monitoring:** Dietary Personnel will check stoppers daily and report any malfunction immediately. Work orders will be submitted to Maintenance. Director will report work orders submitted at Quarterly QA. **9/15/10** **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(3) Temperature of pot wash sink 104** **1. Immediate Response:** Water was emptied and refilled with 110 degree water. **7/19/10** **2. Risk Management:** sink water temperatures were checked throughout kitchen. **7/19/10** **3. Systemic Changes:** Food Service Staff was in-serviced and temperature of water will be over 110 degrees. **7/27/10**	

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L 052	Continued From page 8 received Patanol Ophthalmic Solution at 9 AM and 5 PM every day. A face-to-face interview was conducted with Resident #5. He/she stated, "Yes, I put my own eye drops in my eyes, and it is for dry eyes." A face-to-face interview was conducted on July 20, 2010 at approximately 3:00 PM with Employees # 4 and Employee #17. Both stated, "[Resident #5] self administers his/her eye drops." The record was reviewed July 20, 2010. B. Based on observation, interview and record review for one (1) of 15 sampled residents, it was determined that facility staff failed to provide sufficient nursing time to implement safety measures and assistance devices to ensure safety from accidents for one (1) Resident who sustained a fall with injury while being turned in bed for Resident #12. The findings include: According to the annual and quarterly Minimum Data Sets [MDS] dated February 1, 2010 and May 3, 2010 respectively, Section I, Disease Diagnoses included Diabetes, Hypertension, Arthritis, Osteoporosis, Allergies, Cardiovascular Disease, and Cancer. Section G, Physical Functioning revealed the resident required extensive assistance of two (2) persons for bed mobility and transfer. Bed rails were coded for bed mobility and transfer and a mechanical lift was required for transfer. The resident had limited range of motion and partial loss of voluntary movement of the arm and leg on one side. Section K, Nutritional Status revealed Resident #12's height was 60 inches and weight	L 052	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(3) Temperature of pot wash sink 104 Continued)** **4. Monitoring:** Temperature log implemented and temperature will be taken and recorded three times per day. Director and supervisor on duty will monitor. Director will report findings at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve – Sanitary** **(4) Rug in front of freezer stained and soiled** **1. Immediate Response:** Rug was thrown away. **2. Risk Management:** All floors were checked throughout kitchen. **3. Systemic Changes:** Rubber safety mat was purchased to replace rug. **4. Monitoring:** Rubber safety mat was added to the Tuesday heavy cleaning list to check for rips and soil. Director will report any finding at Quarterly QA.	**9/15/10** **7/19/10** **7/19/10** **7/28/10** **9/15/10**

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L 052	Continued From page 9 225 pounds. Physician's orders signed June 2, 2010 prescribed the use of two ½ side rails for safe bed mobility. According to the "Nursing Monthly Summary" report for May and June 2010, " Ambulation/Rehab: Requires total transfer by staff 2 [two] persons." Resident #12 sustained a fall with injury as evidenced by the following nurse's notes: June 19, 2010, 4:30 AM, "At 2:50 AM resident fell out of left side of bed while [staff] was trying to put [resident] on the bedpan. Resident observed lying prone [face down] on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. [Staff] reported that resident's head hit walker as [resident] fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial, 4cm [long] x 0.2 cm wide. " June 19, 2010, 3:00 PM "...continues to complain of headache ...left eye swollen and dark colored ...new order to transfer to [hospital] emergency room at 10:50 AM." According to the emergency department discharge summary dated June 19, 2010, the resident sustained the following injuries: closed head injury, forehead laceration, facial contusion, cervical strain and multiple contusions. A face-to-face interview was conducted with	L 052	**L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(5) Apple juice and Pineapple/carrot/raisin salad were 48 degrees** **1. Immediate Response:** Juice and pineapple/carrot/raisin salad were thrown away. **2. Risk Management:** Cold temperatures were checked on other trays. **3. Systemic Changes:** Food Service staff was in-serviced on proper point of service temperatures. Juices will be poured from Vitality Juice Dispenser immediately after each meal and put into refrigerator to chill before the next meal. All cold items will be chilled and served in an insulated Alladin cup. **4. Monitoring:** Test Tray temperatures will be taken every week by Catering Associate. Director will report any finding at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(6) Staff was not specific on how to properly test or verify the concentration of the sanitizing solution for the dishwasher.** **1. Immediate Response:** Test strips were replaced with Chlorine Test Paper that was easier to identify color.	**7/19/10** **7/19/10** **7/27/10** **9/15/10** **7/19/10**

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L 052	Continued From page 10 Resident #12 on July 20, 2010 at approximately 3:45 PM. Resident stated, "I fell out of the bed 2-3 weeks ago. The nurse was trying to put me on the bedpan, when I turned [an] there was no side rail for me to hold onto. So, I tried grabbing the wall, and I fell and hit my head. My eyeglasses broke. I had to get another pair. I had a cut over my eye and I was bleeding into my eye and my head was hurting. " A face-to-face interview was conducted with Employee #1 on July 23, 2010 at approximately 11:30 AM. He/she stated, "[Resident] had been complaining about the bed...the third replacement had one long side rail... the fall occurred while being assisted onto the bedpan." According to the clinical record, Resident #12 was prescribed ½ side rails for bed mobility and extensive assistance of two (2) persons for bed mobility and transfer in accordance with the quarterly MDS completed May 3, 2010. The record lacked evidence that two (2) side rails were implemented in accordance with physician ' s orders to assist the resident with bed mobilization. Additionally, there was no evidence that staff utilized the number of individuals to assist the resident with bed mobility. Facility staff failed to implement safety measures and assistance devices to ensure the resident's safety from accidents. The resident sustained a fall out of bed with subsequent injuries. The record was reviewed on July 20, 2010.	L 052	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(6) Staff was not specific on how to properly test or verify the concentration of the sanitizing solution for the dishwasher.** **Continued)** **2. Risk Management:** Ecolab was called immediately to check PPM. PPM was correct. **3. Systemic Changes:** All Dietary Personnel were in-serviced on how to use new Chlorine Test Paper. **4. Monitoring:** Supervisor will continue to monitor logs. Director will report any findings at Quarterly QA. **L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink** **1. Immediate Response:** Dietary Director informed the Dietary Personnel that the correct temperature is 110 degrees or higher. Sink was emptied and refilled. **2. Risk Management:** Water was emptied from sink and refilled with water and temperature was tested with thermometer.	**7/19/10** **7/27/10** **9/15/10** **7/19/10** **7/19/10**
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are	L 091		

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L 091	Continued From page 11 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: A. Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to provide a safe, sanitary and comfortable environment as evidenced by the improper storage of medical waste boxes in the soiled utility room. The findings include: Two (2) of four (4) infectious waste boxes were stored upright and directly on the floor in the soiled utility room. These observations were made in the presence of Employees #8 and #9 who acknowledged these findings during the survey. B. Based on observations and staff interview for two (2) of 15 sampled residents and four (4) supplemental residents, it was determined that facility staff failed to wash hands after direct resident contact during dinner meal. Residents #3, 4, A1, A2, A3, and A4. The findings include: Residents #3, 4, A1, A2, A3 and A4 were observed during dinner in the special care unit's dayroom on July 19, 2010 at approximately 4:05 PM... Resident #3 was observed seated on a chair by himself/herself. Resident # 4 was observed seated on by a table	L 091	**(L099 Food Procure, Store/ Prepare/ Serve - Sanitary** **(7) Staff unable to state the expected temperature of the wash solution on the 3 compartment sink Continued)** **3. Systemic Changes:** Dietary Personnel was in-serviced on correct temperatures. Temperature will be taken three times per day and recorded on log. **4. Monitoring:** Supervisor will check log daily. Director will report findings at Quarterly QA. **L161 Expired Drugs** **1. Immediate Response:** Identified expired and discontinued medications and removed from medication carts. **2. Risk Management:** Medications were checked in all storage areas to make sure there were no expired or discontinued medication. **3. Systemic Changes:** Education to nursing staff was done about necessity of removing meds upon discharge or expiration. **4. Monitoring:** Supervisor to monitor carts for expired/discharge medications. Findings will be reported by DON or designee at QA committee.	**7/27/10** **9/15/10** **7/23/10** **9/15/10** **9/15/10** **9/15/10**

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L 091	Continued From page 12 by himself/herself. Resident #A1, A2, A3, and A4 were observed seated together at the same table. Employee # 10 was observed serving the residents their dinner trays. After he/she completed passing out some of the trays, he/she moved between Residents #4, A1, A2, A3, and A4 and assisted the residents with setting up their dinner trays and feeding He/she stood next to Resident #4 and fed him/her for approximately five (5) minutes. Returned Resident # 4's tray to the cart, outside the dayroom. Employee #4 returned to the dayroom with Resident A1's dinner tray. Resident A1 presented with difficulty keeping food on his/her fork. Employee # 10 stood by Resident A1 and fed him/her. Resident A2 expressed frustration opening his/her drinking straw. Employee #10 left Resident A1 to assist Resident A2. Employee #10 touched the end point of the straw that Resident A2 put in his/her mouth with his/her unwashed hands. Employee #10 left Resident A2 to assist Resident A3 back to the dayroom from the hallway. He/she gave Resident A3 a cup of ice cream and returned to Resident A1. Employee #10 assisted Resident #4 to his/her room. He/she went to the community kitchen across from the nurses 'station to collect Resident #3's dinner tray from the food warmer. He/she returned to the dayroom with Resident #3's dinner tray. He/she stood next to the resident	L 091	**L206 Documentation of Injury** **1. Immediate Response:** Corrected incident report sent to proper authorities. **2. Risk Identification:** Other incident reports involving injury were reviewed for correct documentation of injury and proper transmission. **3. Systemic Changes:** Licensed nursing staff in-serviced on proper documentation and transmission of incident reports. **4. Monitoring:** A random audit will be done monthly at safety committee meetings. The findings will be reported at the Quarterly QA meetings. **L410 Housekeeping and Maintenance Services** **(1) Privacy Curtains Stained** **1. Immediate Response:** Unable to remove ink stains from privacy curtains in room 105 and 123 therefore privacy curtains were replaced. **2. Risk Identification:** All other privacy curtains were inspected and replaced if indicated. **3. Systemic Changes:** Staff in-serviced on checking privacy curtains for cleanliness and lack of stains. **4. Monitoring:** Privacy curtains will be inspected on a monthly basis and findings will be reported at Quarterly QA meetings.	**9/2/10** **9/4/10** **9/15/10** **9/15/10** **7/20/10** **7/20/10** **9/1/10** **9/15/10**

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L 091	Continued From page 13 and fed him/her. Throughout the period of the above observations, Employee #10 failed to wash his/her hands after direct residents contact during dinner meal on July 19, 2010 at approximately 4:05 PM. He/she failed to wash his/her hands between residents 'care: He/she provided care for multiple residents at the same time without washing his/her hands. A face-to-face interview conducted at with Employee #10 on July 23, 2010 at approximately 1:20 PM. He/she acknowledged the above observation. He/she said, "I was trying to hurry-up with the feeding. All the residents required my help as you can see. I know better than that. "	L 091	**L410 Housekeeping and Maintenance Services** **(2) Ceiling Vent Dripping Water** **1. Immediate Response:** Vent closed and water dripping ceased. **2. Risk Identification:** All other ceiling vents on unit checked for water dripping and fixed if indicated. **3. Systemic Changes:** Staff in-serviced to check ceiling vents for dripping water during scheduled room checks. **4. Monitoring:** Engineering will monitor ceiling vents for dripping water on scheduled PM room checks and will report findings at Quarterly QA Meeting.	7/20/10 7/20/10 9/3/10 9/15/10
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 Regulations (DCMR), and Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made during tours of the dietary services on July 19 and 20, 2010, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by: one (1) of one (1) soiled toaster oven, one (1) of one (1) soiled convection oven, and one (1) of one (1) soiled gas stove; out of range temperatures on the test tray; a leak in the three-compartment sink, a stained and soiled rug in front of the freezer and on one (1) of one (1) occasion a staff member failed to correctly state the expected temperature of the washing solution	L 099	**L410 Housekeeping and Maintenance Services** **(3) Damaged AC Cover & Grill in Room 134** **1. Immediate Response:** Cover and grill removed, repaired and replaced. **2. Risk Identification:** All other grills and covers checked on unit and repaired if necessary. **3. Systemic Changes:** Engineering staff was in-serviced on need to check condition of air conditioner covers and grills. **4. Monitoring:** Air conditioner covers and grills will be monitored by engineering staff during scheduled PM room checks and finding will be reported at quarterly QA Meetings.	8/25/10 8/25/10 9/3/10 9/15/10

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L 099	Continued From page 14 in the three-compartment sink and on two (2) of two (2) occasions staff members failed to correctly test and verify the concentration of the sanitizing solution in the dishwashing machine. The findings include: 1. The convection oven, the toaster oven and the gas stove were soiled. 2. Test tray temperatures for apple juice and pineapple/carrots/raisins salad were forty-eight degrees Fahrenheit (F) and exceeded allowable limit of forty-one degrees F. 3. The temperature of the wash solution in the three-compartment sink was 104 degrees F and was far below the expected minimum temperature of 110 degrees F. 4. The rinse water compartment of the three-compartment sink was constantly leaking and could not hold the rinse water solution efficiently. 5. The rug in front of the freezer was stained and soiled. 6. One (1) of one (1) staff member was unable to state the expected temperature of the washing solution for the three-compartment sink and two (2) of two (2) staff members failed to properly test and verify the concentration of the sanitizing solution for the dishwashing machine. These observations were made and acknowledged by Employee #7 who was present at the time of the observations.	L 099	**L426 Maintains Effective Pest Control Program** **1. Immediate Response:** Room was cleaned and the pest control company was called. **2. Risk Identification:** Pest Control Company came out and checked all areas and treated appropriately. **3. Systemic Changes:** Staff educated as to how to prevent fruit flies and other insects and proper reporting of insect sightings so that areas can be treated. **4. Monitoring:** Pest control rounds will be conducted 3X monthly with action items addressed and results will be reported at Quarterly QA meetings.	**7/20/10** **7/20/10** **9/15/10** **9/15/10**

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L 161	Continued From page 15	L 161		
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interview, it was determined that the facility staff failed to remove four (4) expired medications from two (2) of three (3) medication carts observed. The findings include: 1. The facility staff failed to remove expired medications and discontinued medications from the medication carts. On July 19, 2010, between 10:00 AM and 4:30 PM, during the inspection of the medication storage areas, expired and drugs were observed in the medication carts as follows: Expired Medications: 1 Bottle of Guaituss 100 gm /5ml syrup, expired June 22, 2010 1 Bottle of Diabetic Tussin syrup, expired June 30, 2010 1 Bottle of Tussin CF 100gm/ 5ml syrup, expired July 11, 2010 1 Bottle of Nitro stat 40 mg capsule expired July 4, 2010 The above findings for the medication carts were acknowledged by Employee #4 on July 19, 2010, at the same time of the observation.	L 161		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of	L 206		

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L 206	Continued From page 16 occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: 22DCMR 3232.4 Based on record review and staff interview for one (1) resident, it was determined that facility staff failed to inform State Agency that a resident who fell sustained an injury. Resident #12. The findings include: 22 DCMR 3232.4 stipulates, " Each incident shall be documented in the resident ' s record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. " According to an incident report completed by the facility on June 19, 2010, " Resident fell out of bed to the floor while the CNA [Certified Nursing Assistant) was trying to put [his/her] (resident) on the bed pain. " The nurse ' s note dated June 19, 2010 at 4:30AM, documented, " At 2:50AM resident fell out of left side of her bed while [Certified Nursing Assistant] was trying to put her on the bedpan. Resident observed lying prone on the floor. Hematomas with bleeding, skin tear [at] left eyebrow. No other obvious injury. Neurochecks commenced. Ice packs applied to injured area. CNA reported that resident's head hit walker as she fell. Besides head injury, no other obvious injury. Lifted to bed by staff, head supported. Ice pack applied to left brow/forehead [times] 20 minutes. Skin tear [at] left brow is superficial,	L 206		

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L 206	Continued From page 17 4cm [long] x 0.2 cm wide. " The record lacked evidence that the incident regarding the head injury was documented on the incident report A face-to-face interview with Employees #1 and Employee #2 conducted on July 23 at approximately 10:00AM. Both acknowledged the injury was not documented on the incident report. The record was reviewed July 20, 2010.	L 206		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on July 20, 2010, it was determined that the facility failed to provide effective maintenance services in residents rooms as evidenced by soiled privacy curtains in two (2) of 13 rooms surveyed, water was dripping from a ceiling vent on one (1) of three (3) units surveyed, a faulty call bell cord in one (1) of 13 rooms surveyed and a damaged air conditioner cover and grill in one(1) of 13 rooms surveyed. The findings include: 1. Privacy curtains were soiled and stained in rooms # 105 and # 123. 2. Water was dripping from the ceiling vent in the special care dayroom located in the Lisner Lane unit.	L 410		

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L 410	Continued From page 18 3. The cover and grill to the air conditioning system in room #134 were damaged. These findings were acknowledged by Employees # 4 and # 9 who were present at the time of observation.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made during environmental tours of the facility on July 20 and 23, 2010, it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of crawling and flying pests observed in different areas in the facility. The findings include: Flying insects were observed in room #123 and environmental services area. These findings were acknowledged by Employees # 8 and # 9 who were present at the time of observation.	L 426		