BRIDGEPOINT
SUB-ACUTE AND REHABILITATION

July 21, 2016

Veronica Longstreth, RN, MSN
Interim Program Manager
Department of Health - HCFD/HRLA
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

Dear Ms. Longstreth:

BridgePoint Sub-Acute and Rehabilitation Capitol Hill received its Quality Indicator Survey (QIS) and Licensure Survey on June 13, 2016 through June 20, 2016. Enclosed you will find the Plan of Corrections (Form CMS 2567 and State Form) in response to the Statement of Deficiencies.

If you have any questions regarding the Plan of Corrections, please do not hesitate to contact me on (202) 594-2581.

Respectfully submitted,

Keysha Dale, NHA

Cc Cassandra Kingsberry, RN, Supervisory Nurse Consultant – DOH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	06/20/2016

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Bridgepoint Sub-Acute and Rehab at Capitol Hill from June 13, 2016 through June 20, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 36 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	Please begin typing your responses here:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administration | (X6) DATE: 7/21/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - millliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		

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F 246	Continued From page 2 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews for one (1) of 36 stage 2 sampled residents, it was determined that facility staff failed to provide Resident #77 with a call bell device to accommodate his/her needs. Resident #77 The findings include: A review of the quarterly Minimum Data Set completed May 7, 2016 revealed that under Section I (Active Diagnoses) the resident was coded as quadriplegic (paralysis; loss of use of all four limbs and torso). Under Section G (Functional Status) the resident was coded as totally dependent on staff for bed mobility, transfers, eating, dressing, toilet use, bathing and personal hygiene. A face-to-face interview was conducted with Resident #77 on June 17, 2016 at approximately 5:00 PM. Resident #77 stated, " ...I suffered a spinal cord injury about four (4) years ago and I am unable to move my arms ... " Immediately following the interview, an observation of resident ' s room was conducted. It was noted that Resident #77 had a ' push button ' call bell placed next to his/her right arm. The resident was asked if he/she could use it. He/she answered, " No, because I cannot move	F 246	1. There were no residents affected by the result of this practice. An assessment was conducted on resident #77's ability to use other devices. A breath call bell system was ordered for resident on 6/18/16; resident #77 and Staff were also educated on how to use the breath call system. 2. A facility wide audit was conducted to identify other residents who potentially have needs that require special accommodations. There were no negative findings of audit. 3. Nursing staff will be educated on indicators for accommodation (e.g. paraplegia, quadriplegia, sensory deficits and adaptive devices. Care plans will also be created for residents with special needs and interventions will include the possible use of special assistive devices. 4. Unit Managers will conduct daily random audits will be conducted to ensure call bell systems are appropriately placed and resident is able to access the mouth piece. Monitoring for compliance will be reported to the QA Committee until 100% compliance is met for 3 Consecutive months.	6/18/16 6/20/16 8/11/16 8/11/16

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F 246	Continued From page 3 my arms" . The resident was asked; how do you ask for help when you need it? The resident replied, "I holler". On June 17, 2016 at approximately 5:40 PM a tour of the resident ' s room was conducted in the presence of Employee #2 (the Director of Nursing) and Employee #5 (the 6th floor unit manager). The resident was asked if he/she could press the button on his/her call bell. The resident replied that he/she was unable to do so as he/she is unable to move his/her arms. At this time a face-to-face interview was conducted with the manager of the unit. The manager was asked how does the staff know when the resident needs assistance. The manger stated, " He/she calls out to request help." There was no evidence that facility staff implemented measures and/or provided a device to accommodate Resident #77 ' s physical abilities as it relates to the use of a call system.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on June 16, 2016 between 10:00 AM and 2:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services to	F 253		

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F 253	Continued From page 4 maintain a sanitary environment as evidenced by exhaust vents that failed to provide suction in three (3) of 37 resident's rooms, dusty window blinds and over-the-bed light fixtures in 11 of 37 resident's rooms, step-on trash cans that failed to open in three (3) of 37 resident's rooms, a defective bed in one (1) of 37 resident's rooms, over-the-bed light fixtures that did not illuminate in four (4) of 37 resident's rooms, a faulty toilet in one (1) of 37 resident's rooms, a broken heating unit in one (1) of 37 resident's rooms, and marred walls in seven (7) of 37 resident's rooms. The findings include: 1. Exhaust vents were not suctioning in three (3) of 37 resident's rooms surveyed including rooms #6144, #6131 and #5153. 2. Window blinds and over-the-bed light fixtures were soiled with dust in 11 of 37 resident's rooms including rooms #6131, 6123, 5157, 5154, 5144, 5143, 5133, 5125, 4143, 4127, and #4113. 3. Step-on trash cans were not functioning as intended as the lids would not open in three (3) of 37 resident's rooms including rooms #5153, #5143 and #5133. 4. The top of the bed in room #4130 would not adjust when that function was initiated and failed to operate as intended, one (1) of 37 resident's rooms surveyed. 5. The over-the-bed light fixture did not light up when tested in resident's rooms #6142, #5154, #4156, #4127, four (4) of 37	F 253	**483.15(2) HOUSEKEEING AND MAINTENANCE SERVICES** **Response to findings # 1-8** 1. There were no residents affected by the result of this observation. All identified exhaust vents that did not suction in rooms 6144, 6131 & 5153 were immediately corrected. Window blinds and over bed lights with dust in rooms 6131, 6123, 5157, 5154, 5144, 5143, 5133, 5125, 4143, 4127, & 4113 were corrected by EVS. Non-functional step on trash cans in room 5153, 5143, & 5133 were removed and replacements were ordered on 6/17/16. Bio-med was notified regarding the malfunction of the top of bed in room 4130. Bulbs and ballasts were changed for non-functional over bed light fixtures in rooms 6142, 5154, 4156, & 4127. Facility plumber repaired failed flushing toilet in room 5131 and Cover to heating system in room 6131 was immediately tightened and addressed by Engineering Department. Marred walls in rooms 5154, 5153, 5125, 4156, 4154, 4139 & 4127 will be repaired by outside contractor. 2. A complete audit was conducted of all rooms on the 4th, 5th, and 6th floors was conducted on 7/13/16 to ensure that all walls are clear, exhaust vents were suctioned, window blinds are dust free, trash cans, light fixtures are functional, operable toilets and heating system covers. 3. The Director of Plant Operations conducted training with both Housekeeping and Maintenance staff about reporting the identified deficient practices and correcting immediately. Weekly Ambassador and monthly Environment of Care (EOC) Rounds will be conducted.	6/16/16 6/16/16 6/17/16 6/17/16 8/11/16 7/13/16 7/14/16 and 7/15/16

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F 253	Continued From page 5 resident's rooms. 6. The toilet in room #5131, one (1) of 37 resident's rooms failed to flush when tested on several occasions. 7. The cover to the heating system in room #6131 was completely separated from the unit and needed to be secured, one (1) of 37 resident's rooms surveyed. 8. Walls in seven (7) of 37 resident's rooms were marred including rooms #5154, #5153, #5125, #4156, #4154, #4139 and #4127. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 253	4. All findings will be reported to the QA committee by the Director of Plan Operations until 100% compliance is met for 3 consecutive months.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 6 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 36 stage 2 sampled residents it was determined that facility staff failed to accurately code Section E Behaviors on the admission and discharge Minimum Data Set (MDS) for one (1) resident and to accurately code Section I, diagnosis for one (1) resident who had a diagnosis of cancer. Resident #141 and #160 The findings include: 1a. Facility staff failed to accurately code the admission MDS for Behaviors for Resident #141. A review of the resident's admission MDS with an Assessment Reference Date (ARD) of February 25, 2016 revealed the resident was	F 272	**483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **Response to # 1a – resident # 141** 1. The record of resident # 141 was reviewed for the incorrect coding of Section 'E' Behavior. The identified resident #141 was discharged on 3-25-16 back to the community, making it a closed record and therefore no further measure could be taken. 2. An audit was conducted of residents Section "E" Behavior and no other residents were found to have been affected by miscoding. 3. Both Social Workers and MDS Coordinators were educated on the importance of accurately coding MDS Section E behaviors on the admission and discharge. An Audit tool was developed to make certain Section 'E' is accurately coded and the Behavior is accurately captured, to ensure coding of all MDS' meet Medicare/Medicaid Criteria. 4. MDS Coordinators will perform weekly random audits, reviewing findings during the during IDT meetings. Monitoring for compliance will be reported by the MDS Coordinator until 100% compliance is met for 3 consecutive months.	6/21/16 thru 7/1/16 6/29/16 6/21/16 6/21/16

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F 272	Continued From page 7 coded in Section E Behavior: E0900. Wandering - Presence and Frequency (Has the resident wandered?) was coded "3" Behavior of this type occurred daily; E1000. Wandering - Impact (a) Does wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)? Was coded "1" yes; (b) Does the wandering significantly intrude on the privacy of activities of others? Was coded " " yes. A review of the Nurse's Progress Notes and Social Work Notes from February 18, 2016 through February 25, 2016 showed no evidence of the resident wandering, getting into potentially dangerous places or intruding on the privacy of activities of others. A face-to-face interview was conducted with Employee #11 on June 17, 2016 at approximately 1:00 PM who acknowledged that he/she coded the MDS incorrectly. Facility staff failed to accurately code the admissions MDS for behaviors. The record was reviewed on June 17, 2016. 1b. Facility staff failed to accurately code the discharge MDS for Behaviors for Resident #141. A review of the resident's discharge MDS with an ARD of March 25, 2016 revealed the resident was coded in Section E Behavior: E0900. Wandering - Presence and Frequency (Has the resident wandered?) was coded "3" Behavior of this type occurred daily. A review of the Nurse's Notes and the Social Work Notes from February 18, 2016 through	F 272	1.The record of resident #160 was reviewed for the incorrect coding of Section 'I' Active Diagnoses. The identified resident #160 was discharged on 3-21-16 back to the community, making it a closed record and therefore no further measure could be taken. 2.An audit was conducted of residents Section "I" Active Diagnosis and no other residents were found to have been affected by miscoding. 3. MDS Coordinators were educated on accurately coding resident diagnosis. An Audit tool was developed to make certain Section 'I' Active Diagnosis is accurately captured meeting all MDS Medicare/Medicaid Criteria. 4.MDS Coordinators will perform weekly random audits, reviewing findings during the during IDT meetings. All findings will be reported monthly to the QA Committee for a consecutive (3) months or until 100% compliance.	6/17/16 6/21/16 6/29/16 6/21/16

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F 272	Continued From page 8 March 25, 2016 showed no evidenced of the resident wandering. A face-to-face interview was conducted with Employee #11 on June 17, 2016 at approximately 1:00 PM who acknowledged that he/she coded the MDS incorrectly. Facility staff failed to accurately code the discharge MDS for behaviors. The record was reviewed on June 17, 2016. 2. Facility staff failed to accurately code Resident #160's admission Minimum Data Set (MDS) for diagnosis of Cancer. A review of the closed clinical record for Resident #160 revealed that facility staff failed to accurately code Section I, Active Diagnoses - I0100 Cancer on the admission Minimum Data Set [MDS] dated March 12, 2016. The box located next to Section I0100 - Cancer was left "blank" indicating that the resident was not coded for the diagnosis of Cancer. A review of the "History and Physical" dated and signed by the physician on March 5,2016 revealed the following: "Working Diagnosis: (1) s/p [status post] Septic Shock (2) HCAP [Healthcare Associated Pneumonia] (3) Dysmobility, (4) resolved resp. [respiratory] Failure, (5) Lymphoma [Cancer], (6) HTN [Hypertension]. " A review of the "Physician's Admission Order Sheet and Plan of Care" dated March 4, 2016 and signed by the physician revealed the following diagnoses: Chronic Encephalopathy,	F 272		

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F 272	Continued From page 9 UTI [Urinary Tract Infection], Chronic Cholecystitis, Hypokalemia, HTN [hypertension], Angioimmunoblastic Lymphoma[cancer], Normocystic Anemia, Septic Shock and Deconditioning. The clinical record lacked evidence that facility staff accurately coded Resident #160 ' s Admission MDS for the diagnosis of Cancer. A face-to-face interview was conducted with Employee # 17 on June 20, 2016 at approximately 2:30 PM. The employee reviewed the clinical record and acknowledged the finding. The record was reviewed June 20, 2016.	F 272		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 36, stage 2 sampled residents, it was determined that facility staff failed ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by failure to: follow physician ' s orders for the administration of a diuretic medication and	F 309	1. The identified **Resident#17** had no notable negative outcomes with a systolic blood pressure <120mm HG, per Physician Orders (P.O.) **Resident#17** had no notable/reported negative outcomes from receiving more than one eye drop medication at the same time. Licensed nurses were re-educated on monitoring blood pressure per physician orders in regard to specific medications and eye drop Administration. **Resident#109** had the antibiotic treatment reordered After the C-Diff culture report was obtained. **Resident #130** was scheduled for surgery. MD orders requested medication to be held. Consulting Physician orders needed clarification. Resident had no negative outcome due to medication being on hold. 2. A medical record audit was conducted for **Resident #17** including medication administration records **was also completed to ensure compliance with** Physician orders for medication administrative Parameters. No other residents identified with negative outcomes from eye drop administration. Resident#109 a medical record review of other residents with diagnosis of C. Diff was conducted for compliance with Physician orders. No other residents were identified. Resident#130 a medical record review of other Residents with pre-op orders was conducted. No	6/13/16 6/15/16

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F 309	Continued From page 10 administer eye medication according to manufacturer ' s specifications for one (1) resident; obtain a stool specimen for Clostridium Difficile (C. Diff) in accordance with physician ' s orders for one (1) resident and clarify a preoperative order to withhold anticoagulant medications for one (1) resident. Residents #17, 109, and 130. The findings include: 1. Facility staff failed to follow physician's prescribed parameters for the administration of Resident #17 ' s diuretic medication, Furosemide [brand name Lasix]. [Diuretic - a medication that promotes the production of urine]. A review of Resident #17's History and Physical examination signed by the physician October 14, 2015 revealed his/her diagnoses included: Urinary Retention, Dementia, Sarcoidosis, DVT (Deep Vein thrombosis), and HTN (Hypertension). Review of the April 2016 Physician ' s order sheet (POS) directed, " Furosemide 40mg tablet: Lasix (1 tab [tablet] by mouth every day for Edema: hold for systolic blood pressure less than 120). The April 2016 Medication Administration Record [MAR] revealed, " Furosemide 40mg (Lasix) 1 tab by mouth every day for Edema hold for SBP [less than symbol] 120 ... " The MAR revealed that Furosemide 40 mg was administered to the resident when his/her SBP was less than 120 mmHg as follows: April 3, 2016 - 112/60 April 4, 2016 - 113/60	F 309	F 309continued other orders required clarification from the Physician. Consultative process reviewed and staff educated on Review of physician consult recommendations, Clarification of orders as indicated and final review by Manager signature to ensure full implementation. 3.All Licensed staff was re-educated on Best practices regarding medication administration. Staff will be educated on Lasix administration and BP Parameters. An audit tool was created to monitor Residents with BP parameters. All licensed staff was re-educated on adhering to physician orders in regard to specimen collection and process for specimen collection was also reviewed with staff. Education with staff began on 6/13/16 regarding the correct administration of eye drops. All licensed nurses will complete an annual eye administration competency via demonstration and a daily audit tool for reviewing labs will be developed. 4. **Resident#17** monthly audits will be conducted and Reported to the QA Committee. **Resident#109** the Evening shift coordinator will conduct review daily the Laboratory service log to ensure receipt of lab results And follow-up with action steps. **Resident# 130** Report findings form consultation Reviews monthly to the QA Committee and determine If further interventions are necessary. Monitoring for compliance will be reported to the QA Committee by the Director of Nursing until 100% Compliance is met for 3 consecutive months.	7/20/16 6/13/16 6/13/16 8/11/16 8/11/16

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F 309	Continued From page 11 April 6, 2016 - 116/71 April 9, 2016 - 116/71 April 11, 2016 - 116/68 April 13, 2016 - 110/60 April 14, 2016 - 107/61 April 16, 2016 - 111/83 April 18, 2016 - 110/70 April 20, 2016 - 110/70 April 23, 2016 - 106/75 April 24, 2016 - 104/64 April 25, 2016 - 101/71 April 26, 2016 - 106/69 April 27, 2016 - 111/63 April 28, 2016 - 113/70 April 30, 2016 - 119/ (no diastolic reading recorded) The May 2016 MAR revealed, " Furosemide 40mg (Lasix) 1 tab by mouth every day for Edema hold for SBP < 120 ... " The MAR revealed that Furosemide 40 mg was administered to Resident #17 when his/her SBP was less than 120 mmHg during the month of May as follows: May 1, 2016 - 119/ (no diastolic reading recorded), May 3, 2016 - 106/77 April 5, 2016 - 106/76 April 6, 2016 - 103/63 April 7, 2016 - 110/60 April 8, 2016 - 106/72 April 10, 2016 - 112/70 April 13, 2016 - 107/60 April 14, 2016 - 115/64 April 15, 2016 - 117/68 April 19, 2016 - 113/63 April 21, 2016 - 110/69 April 23, 2016 - 106/75	F 309		

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F 309	Continued From page 12 April 24, 2016 - 111/69 April 25, 2016 - 100/69 April 26, 2016 - 105/60 April 30, 2016 - 110/75 A review of the June 2016 " Physician ' s order sheet (POS) " directed, " Furosemide 40mg [milligram] tablet: Lasix (1 tab by mouth every day for Edema: hold for systolic blood pressure [SBP] less than 120). The June 2016 MAR revealed, " Furosemide 40mg (Lasix) 1 tab by mouth every day for Edema hold for SBP < 120 ... ". The MAR revealed that Furosemide 40 mg was administered to the resident when his/her SBP was less than 120 mmHg During the month of June as follows: June 1, 2016 - 100/65 June 2, 2016 - 107/60 June 3, 2016 - 118/66 June 5, 2016 - 115/65 June 6, 2016 - 118/60 June 8, 2016 - 109/76 June 9, 2016 - 119/60 June 11, 2016 - 100/65 June 12, 2016 - 105/71 June 13, 2016 - 107/57 A face-to-face interview was conducted with Employee #13 on June 13, 2016 at approximately 11:00 AM. He/she acknowledged that Lasix was administered to Resident #17 outside of prescribed parameters. The record was reviewed on June 13, 2016. 2. Facility staff failed to administer Resident #17 ' s eye medications in accordance with	F 309		

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F 309	Continued From page 13 manufacturer ' s specifications. According to the manufacturer, Allergan, Inc. ' s prescribing information, Brimonidine Tartrate Ophthalmic Solution, 0.15% is indicated for lowering intraocular pressure in patients with glaucoma. It may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. " If more than one topical ophthalmic product is being used, the products should be administered at least 5 minutes apart ... " <http://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021764s005lbl.pdf> According to the June 2016 physician ' s orders, original order date of October 4, 2015 directed Brimomidine Tartrate 0.15% Drops (Instill 1 drop to each eye twice daily for Glaucoma; Dorzolamide - Timolol 22.3-6.8/1 Drops (Instill 1 drop in each eye twice daily for glaucoma.) A medication observation was conducted on June 13, 2016 at approximately 10:35 AM with Employee #13, the following was observed: Employee #13 donned (put on) a pair of nonsterile gloves, removed the Resident #17 ' s glasses, cleansed the resident eye lids, removed gloves, washed hands, replaced a clean pair of nonsterile gloves, and retrieved a facial tissue. At 10:40 AM Employee #13 administered 1 drop of Brimomidine Tartrate 0.15% drops to each eye. At 10:42 AM Employee #13 administered 1 drop of Dorzolamide-Timolol. Employee #13 failed to wait five (5) minutes between the installation of the two (2) different eye drop solutions. An observation of the Brimomidine Tartrate	F 309		

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F 309	Continued From page 14 storage container included a label attached from pharmacy instructing " wait 5 min [minutes] in between eye meds [medications] ... " The storage container for Dorzolamide-Timolol included a label from pharmacy which instructed " wait 5 minutes between meds ... " A face-to-face interview was conducted on June 13, 2016 at approximately 1:30 PM with Employees #3 and #13. Both acknowledged that Employee #13 should have waited 5 minutes between the administration of eye drops. 3. Facility staff failed to obtain a stool specimen for Clostridium Difficile (C. Diff or Difficile - an infection, a bacterium that causes diarrhea) in accordance with physician ' s orders for Resident #109. A physician ' s order dated April 25, 2016 directed; " ... BMP (Basic Metabolic Panel) [May 2, 2016], Recheck stool for C. Difficile [May 2, 2016] ... Vancomycin oral 250mg via PEG (Percutaneous Endoscopic Gastrostomy) tube every 6 hours for C. Diff/Colitis ...stop order [Discontinue May 11, 2016]... " A review of the April 2016 and May 2016 Medication Administration Record [MAR] revealed Resident #109 received Vancomycin 250mg via PEG tube every 6 hours for C.Diff/Colitis from April 25, 2016 to May 11, 2016. A review of the clinical record lacked evidence that facility staff followed through on the physician ' s order to obtain the resident's stool specimen for C. Difficile.	F 309		

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F 309	Continued From page 15 A face-to-face interview was conducted with Employees #5 and #10 on June 16, 2016 at approximately 4:00 PM regarding the lack of a stool specimen. Both acknowledged the stool culture was not obtained in accordance with the physician ' s order. The record was reviewed on June 16, 2016. 4. Facility staff failed to clarify a preoperative order to withhold Aspirin and Levonox (the therapeutic use for both medications include, to help prevent the formation of blood clots) for Resident #130. A review of the June 2016 Physician ' s Orders signed and dated by the physician on June 13, 2016 directed, " Aspirin chewable 81mg [tablet] via peg [percutaneous endoscopic gastrostomy tube] tube every day for anticoagulant; Lovenox 0.4 ml inject [subcutaneous] every day for anticoagulant " According to the History and Physical examination signed by the physician August 28, 2015 Resident #130 was admitted with diagnoses that included, Craniectomy [an opening cut into the skull] A review of the facility's " Interim Order Forms " directed the following: May 23, 2016, " Resident is scheduled for Implant [Cranial] on June 15, 2016 " May 25, 2016, " 4. ASA [Aspirin] and Lovenox, hold the following medications for days ASA and Lovenox per cardiologist recommendation.	F 309		

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F 309	Continued From page 16 The aforementioned pre-operative orders dated May 25, 2016 were written without recording the number of days the nurse was to withhold the administration of Aspirin and Lovenox prior to the day of surgery. A review of the " Admission Testing -Pre-Op [pre-operative] Instructions " form dated May 31, 2016 revealed, " Surgery dated: June 15, 2016 ... The following are important steps to address before your surgery: ...Medications: ...Hold the following medications for (days) __ [this space was blank] ASA (aspirin) ...before your surgery ... " The next step in the instructions, "Stop aspirin 6/1/16 [had a line drawn through the instruction] (per cardiologist recommendations). " In addition, there was no evidence that a specific number of days was recorded on the designated line of the pre-op instructions to direct the facility staff to withhold the administration of Aspirin and Levonox A review of the June 2016 Medication Administration Record revealed that: Aspirin Chewable 81mg was signed with a nurse's initials [in the designated signature boxes] as given on June 1 and 2, 2016. The medication was not signed as given and the word " Hold " was written in the designated signature boxes during the period of June 3 through 15, 2016. Levonox 0.4 ml sub-q every day for anticoagulant was given on June 1, 2016 and withheld from June 2 through 15, 2016. There was no evidence that facility staff communicated with the resident ' s attending	F 309		

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F 309	Continued From page 17 physician or the cardiologist to obtain and/or clarify the exact number of days to withhold the administration of Aspirin and Levenox prior to June 15, 2016, the scheduled date of surgery. A face-to-face interview was conducted on June 15, 2016 at approximately 1:30 PM with Employee # 24. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on June 15, 2016.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews for one (1) of 36 stage 2 sampled residents, it was determined that facility staff failed to adequately assess Resident #32 ' s tracheal site to ensure that necessary treatment and services were provided. Subsequently, the resident developed unstageable pressure ulcer(s) in the tissues surrounding the trachea (peritracheal region) that were initially assessed at advanced stages. Resident #32 The findings include:	F 314	1.Resident#32 had a skin alteration at the tracheostomy site that healed prior to 6/17/16 observation. Following identification of the skin alteration at the tracheostomy site, a treatment plan had been developed by the facility. a) Staff was in-serviced with Respiratory Techs on Preventing medical device-related pressure ulcers. b) Clinical staff was re-educated on Policy#CP-507 "Tracheostomy Care" on 6/17/16. c) Nursing staff on the 6th floor were educated regarding observation and assessment of ostomy sites and surrounding skin. The Rehab Department conducted an assessed the residents and made recommendations for turning and repositioning of cervical areas. 2. A head to toe skin check was conducted on all residents with devices that could possibly cause an alteration on the skin. There were no new skin alterations identified. 3. a) Skin sheets were designed to include all possible ostomy/medical device sites. A skin sheet was customized for each resident specific areas of the body that are at risk for skin alteration. b) skin assessments will be completed twice weekly and PRN on shower days. c)both Nurses and Respiratory Therapist will collaborate on the skin assessment of the tracheostomy site. Each discipline will document their assessment. d) On 7/8/16 all Licensed Nurses were educated on proper assessment and documentation of the skin. e)The IDT and Wound team met to confirm the protocol for skin integrity and wound management program.	5/6/16 6/17/16 6/17/16 7/6/16 7/5/16 7/8/16 7/19/16

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F 314	Continued From page 18 Policy: Tracheostomy Care, Policy Number: CP.507 effective date December 2014, Revision/Review Date: 2/2016 Stipulated, " Policy: A. Tracheostomy care will be provided to tracheostomy tube, neck, and stoma site B.I.D. (twice daily) and PRN [as needed] (for excessive discharge and/or grossly soiled drain sponges), or as ordered by physician ...Procedure: B. Tracheostomy Care: ...13. Examine neck and stoma for any breaks in skin integrity. Clinically competent staff member documents in appropriate area of patient ' s medical record. Documentation should include...4. Notification of any changes to patient ' s nurse and attending physician and/or Pulmonologist ... " According to the " Comprehensive Physical Assessment " completed and signed by the registered nurse on April 22, 2016, Resident #32 was 82 years old, ventilator dependent and had diagnoses that included: respiratory failure, hypertension, debility, encephalopathy and status post cerebrovascular accident. The assessment included that the resident was " unaware of surroundings " and in a vegetative state. The History and Physical form signed and dated by the physician on April 23, 2016 revealed that Resident #32 ' s diagnoses included, CVA (Cerebrovascular accident) with encephalopathy and respiratory failure, HTN (hypertension), morbid obesity and that the resident ' s skin was intact on admission. The admission Minimum Data Set (MDS) dated April 22, 2016 revealed:	F 314	4. Skin sheets will be audited weekly and immediate corrective action will be taken for newly identified sites will be reported during inter-shift report. Monthly audits will be conducted by the wound team. All findings will be reported to the QA Committee by the Director of Nursing until 100% compliance is consistently demonstrated for (3) months.	8/11/16

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F 314	Continued From page 19 In Section C (Cognitive Patterns) the resident was coded as severely impaired. In Section G0110 (Functional Status) the resident was coded as totally dependent, requiring assistance of one or two people for bed mobility, dressing, eating, toilet use, and personal hygiene. In Section G0400 (Functional Limitation and Range of Motion) the resident was coded as being impaired on both sides (upper and lower) extremities. In Section I (Active Diagnoses) the resident was coded as having " Respiratory failure, Trach [tracheostomy], Ventilator, Cerebrovascular Accident and Hypertension. Under Section M 0150 the resident was coded as being at risk for developing pressure ulcers. In Section M 0210 (Current Number of Unhealed Pressure Ulcers) the resident was coded as " 0 " indicating that the resident was admitted without pressure ulcers. The "Pressure/stasis ulcers/skin conditions" care plan initiated on April 22, 2016 revealed "Interventions: assess skin integrity at least Q (every) shift, massage around boney prominences, turn and reposition Q (2) two hours, pressure relief mattress or specialty, skin assessments as on admission, readmission. Quarterly ...and as needed. A physician ' s telephone order dated May 6, 2016 [no time noted] directed: "Cleanse left trach (tracheostomy) site wound with nss (normal saline solution) pat dry and apply Skin Prep (Skin	F 314		

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F 314	Continued From page 20 prep - a liquid film-forming dressing that forms a protective film to protect skinhttp://www.woundsource.com/product/skin-prep-protective-dressing) q [every] shift until seen by wound team ...Wound consult on 5/9/16. " The clinical record lacked evidence of a comprehensive assessment of the resident ' s tracheal site wound to correlate with the physician ' s telephone wound treatment order of May 6, 2016. The nurse ' s notes and physician notes lacked evidence of identification, characteristics (such as the stage, thickness, size etc.) and/or an assessment of an alteration in the skin integrity at the tracheal site to warrant obtaining an order for wound treatment on May 6, 2016. According to a physician ' s progress note dated May 7, 2016: "Peritracheal Ulcer ...Post-surgical tracheal wound expanded due to pressure now unstageable ... " A nurse ' s entry dated May 7, 2016 at 12 PM read: " ...wound treatment to trach site done. Right wound noted with 100% granulation tissue ø [no] drainage noted ...appeared dark ... " A nurse ' s entry recorded May 7, 2016 at 11:30 AM, " SBAR [Situation Background Assessment Recommendation]/ Acute Change in condition report...two open areas noted on Trach site ... " An entry documented by the physician consultant on May 7, 2016 (no time entered) read as follows: "Wound Care Physician Assessment ... Etiology-post surgical; Side/Arrangement: peritracheal: duration [less than symbol] 10 days size 0.2 x 1.5	F 314		

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F 314	Continued From page 21 x 0.1cm; Drainage Serosanguinous; 50% granulation. " A physician ' s order dated May 7, 2016 at 11:00 AM, directed: "Cleanse right open area with nss pat dry, apply Xeroform (A sterile mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate and Petrolatum) q daily until seen by wound team. According to the " Wound and Skin Care Progress Note" dated May 8, 2016, " Location Neck- Trach ...Characteristics etiology/ unstageable r/t(related to) medical device ... " A physician ' s order dated May 9, 2016 at 2:40 PM, directed: " Trach site cleanse with wound cleanser, then apply Xeroform gauze daily. " A review of the Respiratory Therapist Notes and the Nursing Progress Notes from April 22 through from May 6, 2016 revealed that tracheal care was completed at minimum twice a day. According to a nurse ' s note dated May 9, 2016 at 2:30 PM: "Seen by wound nurse for Trach site wound which measures 2x3 and necrotic ...wound is device induced pressure ulcer ...new order to clean with wound cleaner and apply Xeroform gauze q daily." According to the "Wound Care Physician" assessment form dated May 14, 2016 "Duration [less than symbol]10 days ' size 0.2 x 1.5 x 0.1cm 100 % necrosis." According to the " Wound and Skin Care Progress Note" dated May16, 2016, " Wound #1	F 314		

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F 314	Continued From page 22 Neck- Trach site: Characteristics etiology/ unstageable r/t [related to] medical device ...2 x 3 cm ...treatment: Xeroform gauze dressing daily as per order. Wound #2 location: Lt (left) side of the trach ... Characteristics etiology/ unstageable r/t medical device. Black dry eschar ...1x1.5 cm ...treatment keep open to air. " According to the National Pressure Ulcer Advisory Panel, " Pressure Ulcers in Adults: Predication and Prevention, " page 2, " When eschar is present, accurate staging of the pressure ulcer is not possible until the eschar has sloughed or the wound has been debrided." Resident #32 was observed on June 14, 2016 at 10:00 AM lying in bed on his/her back with his/her head flexed forward, chin resting on the right shoulder, with a dressing observed in the peritracheal area and trach collar in place. Resident #32 ' s plan of care included assessment(s) by rehabilitation services as directed by the physician ' s admitting orders dated April 22, 2016, " Rehabilitation (rehab) Screen for PT (physical therapy) OT (occupational therapy), Speech therapy..." An Occupational Therapy Screen was conducted on April 25, 2016 and revealed, " Pt (patient) is not currently a rehab candidate. Pt is dependent in a vegetative state and presents with no contractures...Discharge to SNF (Skilled Nursing Facility) unit on restorative program." According to the April and May 2016 " Restorative Flow Sheets " the resident received Passive Range of Motion exercises for bilateral upper extremities and bilateral lower extremities.	F 314		

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F 314	Continued From page 23 A face-to-face interview was conducted on June 17, 2016 at approximately 11:30 AM with Employee # 24. When queried he/she stated the resident flexes his/her head to the right with her /his chin pointed down and this caused the pressure on the trach device which caused the development of the pressure ulcer. He/she further stated that trach care is routinely done by the respiratory therapists. The employee acknowledged that there was no pressure relieving device or interventions implemented to reposition the resident ' s head/neck away from the trach collar after the pressure ulcers were detected. A face-to-face interview was conducted on June 17, 2016 at approximately 11:45 AM with Employee #21. When queried he/she stated respiratory does remove the inner cannula [of the trach] daily and replace it. He/she acknowledged that the resident flexes his/her head forward and placed pressure on the trach device. This placed him/her at risk for this type of breakdown and resident ' s skin is inspected daily during trach care. A face-to-face interview was conducted on June 20, 2016 at approximately 10:30 AM with Employee #18. He/she acknowledged that the resident was admitted without pressure sores to the trach area, and subsequently developed a two (2) unstageable areas below [underneath] the trach because of pressure from trach which was detected as unstageable before treatment was started. He/she was informed [of the pressure ulcer] by the respiratory therapist. He/she further acknowledged that no pressure relieving device(s) was implemented after the pressure	F 314		

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F 314	Continued From page 24 ulcers developed. A face-to-face interview was conducted on June 22, 2016 at approximately 11:00 AM. Employee #19 was queried if the resident currently had one or more pressure ulcers? He/she responded, "Yes, the Trach area has an unstageable pressure ulcer from the Trach pushing against his/her skin. " Respiratory therapists and registered nurses recorded/documented that tracheal care was done a minimum of twice daily from April 22 through June 6, 2016, however, there was no evidence that the facility staff assessed an alteration in the integrity of the resident ' s skin at the peritracheal region prior to the development and detection of unstageable pressure ulcers on May 6, 2016. The clinical record lacked evidence that a comprehensive assessment of the peritracheal wound(s) was conducted on May 6, 2016, the date physician treatment orders were obtained. A review of the Medication Administration Record [MAR] for May 2016 revealed that wound treatments were initiated on the 7:00 AM - 3:00 PM shift on May 7, 2016, and there was no record that treatment was performed on May 6, 2016 when the orders were obtained. Lastly, once the resident was assessed with pressure ulcers at the peritracheal region and it was determined to have originated secondary to pressure and " device induced " , there was no evidence that facility staff implemented pressure relieving measures such as a head repositioning schedule and/or adaptive device(s) to redistribute or minimize the potential pressure at the site of the resident ' s peritracheal region.	F 314		

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F 314	Continued From page 25 A face-to- face interview was conducted with the Employee #5 (Unit Manager) on June 20, 2016 at approximately10:00 AM. After a review of the medical record, Employee #5 acknowledged the aforementioned findings. The medical record was reviewed on June 20, 2016.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on June 16, 2016 between 10:00 AM and 2:00 PM, it was determined that the facility failed to maintain the resident environment free of potential accident hazards as evidenced by damaged handrails on two (2) of three (3) resident care units, loose or missing floor tiles in three (3) of 37 resident rooms, and surge protectors that were not properly secured in two (2) of 37 resident rooms surveyed; and facility staff failed to determine the safety or lack thereof related to one (1) resident ' s known use of an electric heating pad. Resident #23. The findings include: Facility failed to maintain resident environment free of accident hazards as evidenced by	F 323	**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISIONS/DEVICES** **Response to # 1 – resident # 23** 1. Maintenance took immediate action to tighten and repair all identified loose handrails. All identified loose or missing floor tiles were properly secured and surge protectors were properly secured to walls. 2. A complete facility audit was conducted to assess any potential accident hazards within the environment. 3. The Director of Plant Operations conducted training with both EVS and Maintenance staff maintaining an environment that is free of accident hazards. Monthly EOC Rounds will be conducted by the Director of Plant Operations. 4. Monitoring for compliance will be reported to the QA committee by the Director of Plant Operations until 100% compliance is met for 3 consecutive months.	7/16/16 7/13/16 7/15/16

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F 323	Continued From page 26 damaged handrails on two (2) of three (3) resident care units, loose or missing floor tiles in three (3) of 37 resident rooms, and surge protectors that were not properly secured in two (2) of 37 resident rooms surveyed. The handrail located in front of room #5142 and the handrail located in front of room #4132 were both missing an end cap, and their sharp edges were exposed to residents, staff and visitors. Floor tiles were either loose or missing in resident room # 6139, #4154 and #4130, and posed a tripping hazard in three (3) of 37 resident rooms surveyed. Surge protectors were not mounted in residents' room #6142 and #5113, two (2) of 37 resident's rooms surveyed. These observations were made in the presence of Employee #9 who acknowledged the findings. 2. Facility staff failed to ensure that Resident #23 was free of potential accident hazards as evidenced by the resident's known use of an electric heating pad in the absence of a safety assessment. An observation of Resident # 23's room was conducted on June 15, 2016 at approximately 10:48 AM. During this time the resident stated, "I am cold." The resident was observed with a heating pad covered in a blue colored terry cloth bag and placed across his/her arms. In addition, the resident had a housecoat and blanket laying underneath the heating pad. The item was plugged into a wall in the resident's room. The	F 323	**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISIONS/DEVICES** **Response to # 2 – resident # 23** 1. The heating pad was immediately removed. The resident's skin was assessed by the nurse manager. Resident's family was notified about the heating pad. Staff was made aware to remove electrical devices that are not a part of a resident plan of care. 2. All equipment in each resident's room was checked by Maintenance staff and found no other negative findings. 3. Updated the facilities safety policy to include electrical devices. Revised the Admissions Packet to include rules on equipment. A reminder/facility update notice will be mailed to RPs to include the topic on electrical devices. New signage will be posted on all units regarding electrical devices. An Emergency Resident Council Meeting will be conducted to communicate the usage of electrical device within the facility. Electrical device safety will be added to the Facility Newsletter under the Safety Awareness Section. 4. Nursing staff will be educated on facility safety policy to include electrical devices. 5. Monthly room audits will be conducted during EOC rounds. Monitoring for compliance will be reported to the QA Committee by the Unit Managers until 100% compliance is met for (3) consecutive months.	7/15/16 7/15/16 8/11/16 8/11/16

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F 323	Continued From page 27 writing on the bag indicated, "house hold item number HOHP009S00". A face-to-face interview was conducted on June 15, 2016 at approximately 11:00 AM with Employee #14. A query was made regarding the use of the heating pad. Employee #14 stated that he/she saw the heating pad about three (3) days ago, but did not alert anyone. A face-to-face interview was conducted with Employee # 15 on June 16, 2016 at approximately 11:30 AM. He/she stated that on June 15, 2016 when he/she went into the resident ' s room to give the 8:00 AM medication, he/she did not see the heating pad, however when he/she returned around 11:00 am, he/she saw the heating pad and removed it. A face-to-face interview was conducted on June 15, 2016 at approximately 11:55 AM with Employee #3 a query was made regarding the use of the heating pad. He/she acknowledged that he/she was not aware of a heating pad used by Resident #23. A face-to-face interview was conducted on June 15, 2016 at approximately 2:50 PM with Employee #25. A query was made regarding the use of the heating pad. Employee #25 stated," a heating pad is not a facility approved item. We don't certify anything brought in by a patient." Facility staff failed to ensure that Resident #23 was safe from potential accident hazards as evidenced by failure to assess the safety of a heating pad known to be utilized by the resident and/or explore alternative methods for his/her	F 323		

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F 323	Continued From page 28 comfort/warmth.	F 323	**483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Findings #1**	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on June 13, 2016 at approximately 9:30 AM, it was determined that the facility failed to store and prepare foods under sanitary conditions as evidenced by 14 of 14 fruit bowls of honeydew and 23 of 23 salad bowls in cooler box #3 that were not labeled or dated, one (1) of one (1) soiled food warmer, 36 of 36 expired cartons of milk, a loose door from one (1) of two (2) convections ovens, one (1) of one (1) soiled pellet warmer and one (1) of two (2) soiled grease fryers, two (2) of five dented cooking pots, two (2) of two (2) dented sifters, and two (2) of two (2) eyewash bottles that were stored beyond their expiration date of March 2016. The findings include: 1. 14 of 14 fruit bowls of honeydew and 23 of 23 salad bowls were stored in the reach-in cooler box #3 and were not labeled or dated.	F 371	1. No residents were affected by this observation. The fruit & salad bowls located in the reach cooler box were immediately discarded. Employees were educated on proper storage procedures for preparing food products. — 6/14/16 2. The Director of Dietary Services conducted an audit on all prepared items. No other items were found to be prepared without labels or dates. — 6/14/16 3. Staff will be educated on how to properly store food items with labels and dates. — 6/14/16 4. The Director or designee will also conduct monthly inspections to ensure appropriate dating, labeling and rotations are included. Monitoring for compliance will be reported by the Director of Food Services to the QA Committee until 100% compliance is met for 3 consecutive months. **483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Findings #2** 1. The facility took immediate action and cleaned the identified soiled area. A daily food warmer cleaning schedule was developed on 6/14/16. All kitchen staff was educated on the protocol for daily cleaning tasks. — 6/14/16 2. The Director of Dietary Services conducted an audit of all equipment and utensils and other equipment used in the daily operations with no negative findings. — 6/14/16 3. Staff was educated on expectations of daily cleaning tasks. Supervisor on Duty or designee will conduct weekly audit of all cleaning schedules. — 6/14/16 4. Monitoring for compliance will be reported by the Director of Food Services to the QA Committee until 100% compliance is met for 3 consecutive months.	

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F 371	Continued From page 29 2. One (1) of one (1) food warmer was soiled at the bottom with leftover food residue. 3. 36 of 36 four-ounce cartons of fat free skim milk stored in the reach-in cooler box #3 were expired as of June 12, 2016. 4. The door handle to one (1) of two (2) convection ovens was loose. 5. The pellet warmer from the 'Heat Demand' heating system and one (1) of two (2) grease fryers were soiled. 6. Two (2) of five (5) cooking pots and two (2) of two (2) sifters were dented throughout. 7. Two (2) of two (2) eyewash bottles from the eyewash station in the dishwashing area were expired as of March 2016. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 371	**483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Response to finding # 3** 1. A procedure for storing expired dairy products was immediately developed by the Director of Food Services. All kitchen staff was educated on the procedure for storing expired dairy products. The storage coolers for expired dairy products were labeled. 2. An audit of all dairy products stored in the reach-in cooler was conducted with no negative findings. 3. Director of Food Services developed a written policy of proper storage procedures of expired product. The expired milk cooler was labeled. The staff was in-serviced on these system changes. 4. Director of Food Services will conduct a weekly audit of all dairy products. Monitoring for compliance will be reported to QA committee by the Director of Food Services until 100% compliance is met for 3 consecutive months. **483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Response to findings # 4** 1. Ecolab was called to tighten the door handle on the convection oven. 2. Director of Food Services conducted an audit to identify other broken equipment. No negative findings were identified. 3. Any equipment identified as inoperable or impaired will be reported to Maintenance Department. The reported items will be tracked on the electronic work order system. 4. Director of Food Services will conduct monthly inspections of all equipment to ensure all equipment is in working condition. Monitoring for compliance will be reported to the QA Committee by the Director of Food Services until 100% compliance is met for 3 consecutive months.	6/14/16 6/14/16 6/14/16 6/14/16
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	Continued From page 30 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and and staff interview for two (2) of 36 stage 2 sampled residents, it was determined that facility staff failed to practice hand hygiene in accordance accepted standards of practice during a medication administration observation a wound treatment observation for two (2) residents. Residents #17 and 115. The findings include: According to Centers for Disease Control and	F 441 6/14/16	**483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Response to finding # 5** 1. The identified soiled fryer was immediately cleaned. 2. Director of Food Services conducted an audit of all soiled equipment and other equipment used with no negative findings. 3. Staff was in-serviced on the daily expectations of ensuring that all pellet warmer and fryers are thoroughly cleaned. 4. Director of Food Services will conduct a weekly audit of all equipment to ensure items are cleaned and auditing tool signed. The Director of Food Services will monitor for compliance and report to the QA Committee until 100% compliance is met for 3 consecutive months. **483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Response to finding # 6** 1. Director of Food Services immediately discarded the dented cooking pots and sifters. 2. Director of Food Services conducted an audit of all equipment and utensils. No other dented items were identified during this audit. 3. Director of Food Services implemented an audit tool for assessing/monitoring the quality use of equipment. 4. Director of Food Services will conduct monthly inspections of equipment and smallwares to ensure no dented items are on site. All findings will be reported to the QA Committee by the Director of Food Services until 100% compliance is consistently maintained for three months.	6/13/16 6/13/16 6/14/16 6/13/16 6/14/16 6/14/16

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F 441	Continued From page 31 Prevention handwashing guidelines are as follows: "Wet your hands with clean, running water ...Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds ...Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them. " http://www.cdc.gov/handwashing/when-how-handwashing.html 1. Facility staff failed to practice hand hygiene in accordance with accepted standards during medication administration for Resident #17. A medication pass observation was conducted on June 13, 2016 at approximately 10:15 AM with Employee #13. The following occurred: Upon entering the residents room, water from the sink faucet was observed turn on (running water). Employee #13 placed hands under running water and began to wash hands without first applying soap, towel dried hands, turned the water off using the paper towel, donned (put on) non sterile gloves and began to administer medications. Upon completion of the oral (by mouth) medications, Employee #13 removed the gloves, applied soap and scrubbed hands for approximately less than six (6) seconds. A face-to-face interview was conducted with Employee #13 on June 13, 2016 at approximately 12:30 PM, who acknowledged the findings. The observation was conducted on June 13, 2016.	F 441	**483.35(i) FOOD PROCURE, STORE/ PREPARE/SERVE - SANITARY** **Response to finding # 7** 1. The expired products were discarded. Director of Food Services implemented a monthly audit tool to view expiration dates of the eyewash stations. 2. Director of Food Services conducted an audit to determine if other eyewash stations contained expired solutions. No other eyewash stations contained expired solution. 3. Director of Food Services will conduct an internal monthly inspection of the eye wash stations. All staff were educated on the monitoring of eyewash stations on 6/13/16. 4. All monthly inspection findings will be reported to the QA committee by the Director of Food Services until 100% compliance is consistently maintained for three months. **483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Response to findings - resident # 17** 1. Staff involved completed a just-in-time education and were coached on the proper protocols for hand hygiene related to infection control. 2. All residents are at risk for infection due to improper hand hygiene. 3. Staff will wash hands prior to entering resident room and upon exiting resident room. All hand sanitizers will be relocated outside of the resident's room. A self-learning packet with a test was distributed to all clinical staff. All clinical staff will complete a return demonstration competency. 4. Random handwashing observations using the 'Shoppers' program will be done monthly. All findings will be reported to the QA committee by the Infection Control Coordinator until 100% compliance is consistently maintained for three months.	6/13/16 6/13/16 6/13/16 6/13/16 8/11/16 6/19/16

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F 441	Continued From page 32 2. Facility staff failed to practice hand hygiene in accordance with accepted standards during a wound observation for Resident #115. A wound observation was conducted on June 16, 2016 at approximately 11:30 AM with Employee #12. The following occurred: Employee #12 donned (put on) non sterile gloves prior to entering the resident ' s room, (without washing or sanitizing hands), he/she then explained to the resident what he/she was about to do, removed bed cover, repositioned the resident, lifted gown, and began to remove the dressing. After the wound observation was conducted, Employee #12 removed gloves, applied soap and scrubbed hands for approximately less than five (5) seconds. A face-to-face interview was conducted with Employee #12 on June 17, 2016 at approximately 1:00 PM, who acknowledged the findings. Facility staff failed to practice hand hygiene in accordance with accepted standards of practice.	F 441	**483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** **Response to findings - resident # 115** 1. Staff involved completed a just-in-time education and were coached on the proper protocols for hand hygiene related to infection control. 2. All residents are at risk for infection due to improper hand hygiene. 3. Staff will wash hands prior to entering resident room and upon exiting resident room. All hand sanitizers will be relocated outside of the resident's room. A self-learning packet with a test was distributed to all clinical staff. All clinical staff will complete a return demonstration competency. 4. Random handwashing observations using the 'Shoppers' program will be done monthly. All findings will be reported to the QA committee by the Infection Control Coordinator until 100% compliance is consistently maintained for three months.	6/16/16 8/11/16 6/19/16
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on June 13, 2016 at approximately 9:30 AM, it was determined that the facility failed to maintain essential kitchen equipment in safe working condition as evidenced	F 456	**483.70 ESSENTAIL EQUIPMENT, SAFE OPERATING CONDITION** 1. No residents were affected by this observation. Vendor was notified and conducted an inspection of the identified power cord that was not completely insulated. 2. Plugs were purchased on 6/29/16 and a complete audit was conducted of all kitchen equipment to ensure safe operating conditions on 7/13/16. 3. Monthly EOC inspections will be conducted by the Director of Plant Operations. Staff was educated on maintaining essential mechanical and electrical equipment is safe in operable condition. 4. All monthly inspection findings will be reported to the QA committee by the Director of Plant Operations until 100% compliance is met for three consecutive months.	7/14/16 7/13/16 7/15/16

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	095027	A. BUILDING _____ B. WING _____	06/20/2016

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F 456	Continued From page 33 by a power cord from one (1) of two (2) grease fryers that was not completely insulated. The findings include: The power cord from one (1) of two (2) grease fryers was not fully insulated and presented a safety hazard to staff. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 456		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations made on June 16, 2016 between 10:00 AM and 2:00 PM, it was determined that the facility failed to ensure that handrails are firmly secured in corridors as evidenced by loose handrails on one (1) of three (3) resident units. The findings include: The handrails located across from room #6144 and next to the linen closet room #6121 were loose. These observations were made in the presence of Employee #9 who acknowledged the findings	F 468	**483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS** **Response to findings rooms 6144 and 6121** 1. The Maintenance staff took immediately action with tightening and repairing all identified loose handrails noted across from Room #6144 and next to the linen closet near Room #6121. — 6/16/16 2. There were no residents affected by this deficient practice A facility wide inspection was conducted by the Maintenance staff to ensure that all corridor handrails are firmly secured. — 6/21/16 3. The Director of Plant Operations conducted training with Maintenance staff on Corridors having firmly secured handrails. Weekly Ambassador and monthly Environment of Care (EOC) Rounds will be conducted. — 7/15/16 4. All findings will be reported to the QA Committee by the Director of Plant Operations until 100% compliance is met for (3) consecutive months. — 8/11/16	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	F 505		

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F 505	Continued From page 34 The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 stage 2 sampled residents, it was determined that facility staff failed to ensure that the physician was promptly notified of the laboratory results so that prompt, appropriate action may be taken if indicated for Resident # 173. The findings include: The Physician's order dated May 20, 2016 at 12:35 PM directed, " Give an extra dose of Dilantin 300 mg now via g-tube (gastrostomy tube) (second to) Dilantin level of 8.5 µg/ml (Microgram per milliliter) for seizure. The stat Dilantin 200 mg bid (twice a day) for seizure via g-tube. Repeat Dilantin level on 5/23/16" A review of the May 2016 Treatment Administration Record [TAR] revealed that the Dilantin level was signed as completed on May 25, 2016. The nursing progress note written on May 25, 2016 at 9:30 PM specified, " ...Lab Dilantin level result received, 12.9 µg/ml [microgram per milliliter; normal range 10-20 µg/ml]. MD (medical doctor) to review the result when [he/she] comes on the unit." On June 16, 2016 at approximately 12:15 PM, a review of the clinical record was conducted with Employee #7. There was no evidence of the	F 505	**483.75(j)(2)(ii) PROMPLY NOTIFY PHYSICIAN OF LAB RESULTS** **Response to findings – resident # 173** 1. Resident # 173 showed no evidence of seizure activity. Dilantin level was 8.5 prior to lab order. Lab was repeated on 5-25-16, results were within normal limits. 2. No other resident was impacted. An audit of the laboratory log and TAR was done with results of specimens reconciled. 6/16/16 3. Re-educated licensed staff on adhering to physician orders in regard to specimen collection. Process for specimen collection was reviewed with staff. 8/11/16 Medical staff and nursing staff was educated about Regulation tag 505. 4. Evening Shift Coordinator will review laboratory service log daily to ensure receipt of laboratory results and follow-up action steps. The Director of Nursing or Designee will report all findings to the QA Committee until 100% compliance is met for 3 consecutive months.	6/20/16

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F 505	Continued From page 35 results of the May 25, 2016 Dilantin level. Employee #7 left the area and returned with a copy of the laboratory results dated May 25, 2016. The Dilantin level test result was 12.9 µg/ml (within normal range). There was no evidence that the physician was promptly notified of Resident #173 ' s Dilantin level results. A face-to-face interview was conducted on June 16, 2016 at approximately 12:45 PM with Employee # 7. After reviewing the clinical record, he/she acknowledged the findings. The record was reviewed on June 16, 2016.	F 505		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 36 stage 2 sampled residents, it was	F 514	**483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** **Response to findings – resident # 89** 1. Resident # 89 medical record cannot be corrected. 2. A review of other residents wound documentation was conducted. Wound notes were updated by the wound team. — 7/8/16 3. All nursing staff will be educated on the proper assessment and documentation of the skin. — 8/11/16 A wound meeting was held on 7-19-16 with the wound interdisciplinary team to confirm the system for the skin integrity/wound management program. — 7/19/16 4. Monthly random audits of the skin/wound section of the medical record; all findings will be reported by the Director of Nursing or Designee to the QA Committee until 100% compliance is consistently maintained for three months.	

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F 514	Continued From page 36 determined that facility staff failed to document the stage of Resident #89 ' s wound on the " Weekly Wound Documentation" sheet. Resident #89. The findings include: Facility staff failed to document the stage of the wound on the "Weekly Wound Documentation" sheet for Resident #89. A review of the " Weekly Wound Documentation" form dated May 30, 2016 revealed that Resident #89 had a community acquired sacral ulcer. On May 30 and June 6, 2016 there was no " Stage/Thickness " recorded on the form to convey the extent of the tissue damage to the wound. According to the "Wound and Skin Care Progress Note" completed by the facility ' s wound team, the stage/thickness of the sacral wound on May 30 and June 6, 2016 was "Unstageable". A face-to-face interview was conducted with Employee #24 on June 14, 2016 at approximately 11:16 AM. After reviewing the form Employee #24 acknowledged the findings. Facility staff failed to document the stage/thickness of Resident's sacral ulcer on the " Weekly Wound Documentation " form. The record was reviewed on June 14, 2016.	F 514		