STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	06/27/2017

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BRINTON WOODS HEALTH & REHAB OF WASHINGTON DC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Brinton Woods Health and Rehabilitation Center of Washington, D.C. from June 20, 2017 through June 27, 2017. Survey activities consisted of a review of 40 resident clinical records during Stage 1; review of 29 sampled residents during Stage 2; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families, and facility staff. 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. Complaint investigations for C-17-061, DC00003391 and C-17-062, DC00003392 were also conducted during this survey period of June 20, 2017 through June 27, 2017. 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 cc - cubic centimeters cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide COPD - Chronic Obstructive Pulmonary Disease CRF - Community Residential Facility	F 000	Please begin typing here: Brinton Woods of Washington D.C. LLC, "BWDC" is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the Facility's written allegation of Compliance for deficiencies cited. However submission of this Plan of Correction does not constitute Admission of facts or conclusions Cited.	08/11/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	Continued From page 1 D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) LE- Lower Extremity MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner O2- Oxygen ORIF - Open Reduction Internal Fixation PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth PO2- Pulse oximetry POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party	F 000		

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F 000	Continued From page 2 Sol- Solution S/P- Status Post TAR - Treatment Administration Record Tx- Treatment UE- Upper Extremity	F 000		
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 23, 2017, at approximately 10:00 AM, it was determined that the facility failed to maintain resident's environment in proper working condition as evidenced by dusty exhaust vents in 12 of 34 resident's rooms, a lack of hot water from one (1) of five (5) shower stalls on the second floor, missing call bell pull cords from one (1) of five (5) shower stalls on the second floor and one (1) of 34 residents rooms, missing overhead light pull strings from three (3) of 34 resident's rooms, burnt out light bulbs in three (3) of 34 resident's rooms, soiled bathroom floors in two (2) of 34 resident's rooms, marred walls in three (3) of 34 resident's rooms, a foul odor in two (2) of 34 resident's rooms and clutter in two (2) of 34 resident's rooms. The findings include: 1. Exhaust vents soiled with dust in 12 of 34 resident's rooms including Rooms #326, 324, 314, 243, 227, 226, 225, 210, 207, 141, 139, and 113.	F 253	1. Exhaust vents in rooms #326, 324, 314, 243, 227, 226, 225, 210, 207, 141, 139, and 113 were all cleaned. Hot water stem replaced on second floor shower stall. Call bell cord for shower room on third floor and room 346 Replaced immediately. Pull string on over bed light in rooms 127,214,346 replaced . Light bulb replaced in rooms 207,210B, 243A replaced, Bathroom flooring cleaned 225 and 227. Walls repaired in rooms. 207,226,330. Cleaned and disinfected rooms 225 and 230. Cleaned and decluttered 240 and 326. There were no residents affected by the alleged deficient practice. 2. The exhaust vents throughout the facility were checked and cleaned. Shower stalls were checked for hot water. The call bell pull cords checked in shower stalls and replaced if required. Audit rooms for light bulbs, clean bathroom, and condition of walls, odor and clutter. Each item corrected as deemed appropriate .	08/11/2017

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F 253	Continued From page 3 2. No hot water available in one (1) of five (5) shower stalls located in the shower room on the second floor. 3. The call bell pull cord for one (1) of five (5) call bells located in the shower room on the third floor and one of 34 resident's rooms (#346) was missing. 4. The pull-string from the overhead light in three (3) of 34 resident's rooms was missing (Rooms #346, 214, and 127). 5. The top lightbulb from the overhead light fixture in three (3) of 34 resident's rooms did not illuminate when tested (Rooms 207, 210B, and 243A). 6. The bathroom floor in two (2) of 34 resident's rooms soiled with many stains (Rooms #225 and 227). 7. Walls marred in three (3) of 34 resident's rooms including rooms #207, 226, 330. 8. Offensive, foul odor evident in two (2) of 34 resident's rooms (Rooms #225 and 230). 9. Two (2) of 34 residents' rooms cluttered with many bags, boxes, straws, napkins, sodas and juice (Rooms #240 and 326). The observations made, in the presence of Employee #14 or Employee #15, were acknowledged.	F 253	3. The maintenance director and/or designee will inspect resident room and shower rooms, to provide preventive maintenance for our rooms and shower rooms as appropriate. 4. The maintenance and/or designee will audit resident and shower rooms to ensure the rooms are in proper condition and present monthly for x 3 months then quarterly x 2 months. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	08/11/2017
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		08/11/2017

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F 278	Continued From page 4 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews for one (1) of 29 stage 2 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data	F 278	2. Residents that wear eye glasses and/or corrective lenses MDS will be audited to ensure correct coding is done. 3. Residents that wear eye glasses and/or corrective lenses MDS will be reviewed during interdisciplinary team conference and/or Case Mix meeting to ensure coding is done based on RAI manual coding standards. 4. Residents that wear eye glasses and/or corrective lenses MDS will be audited monthly x 3 months then quarterly x2 by ADON and/or designee. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	8/11/2017

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F 278	Continued From page 5 Set (MDS) for the use of corrective lenses under Section B (Hearing, Speech, and Vision) for Resident #144. The findings include: Facility staff failed to code the MDS for Resident #144's use of corrective lenses. A face-to-face interview with Resident #144 occurred on June 20, 2017, in the resident's room at approximately 2:30 pm, in the presence of Employee #8. The resident was observed wearing eyeglasses. On June 20, 2017, a medical record review revealed Minimum Data Set assessments dated January 31, 2017, and April 27, 2017. The assessments revealed the facility staff documented the numeral two (2) in Section B1000 (Ability to see in adequate light with glasses or other visual appliances). This coding indicates the resident has "Moderately impaired-limited vision; not able to see newspaper headlines but can identify objects." Also, Section [B1200] Corrective Lenses (contacts, glasses or magnifying glass) was coded as "0" indicating the resident does not wear glasses. Further review of the "Edit Note Section" revealed documentation which indicated that Resident #144 "has glasses on at all times when asked if they helped with reading the resident responded, no."	F 278		

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F 278	Continued From page 6 The medical record lacked documented evidence that the MDS was code to accurately reflect the resident's condition. During a face-to-face discussion with Employee #10 on June 20, 2017, Employee #10 acknowledged writing the information in the "Edit Note" section and completion of Section B1000 and B1200.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279	1. Resident #223 Care plan has been corrected to reflect goals and approaches to address the resident's visual impairment. 2. Residents coded under Section B with visual impairment MDS and care plan will be audited to ensure there are goals & approaches to address the visual impairment. 3. Residents with visual impairment care plans will be reviewed during the Interdisciplinary team conferences to ensure goals and approaches are addressing the visual impairment. 4. The MDS coordinator and/or designee will audit residents will visual impairment care plan to ensure the goals & approaches are present monthly for x 3 months then quarterly x 2 months. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions. .	08/11/2017

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F 279	Continued From page 7 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview for one (1) of 29 stage 2 sampled residents, it was determined that facility staff failed to develop a care plan with appropriate goals and objectives to address visual impairment for Resident #223.	F 279		

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F 279	Continued From page 8 The findings include: On June 26, 2017, at 11:00 AM, a review of an admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of June 01, 2017, revealed Resident #223, was coded under Section B (Vision) as Impaired- sees large print, but not regular print in newspapers/books. The clinical record lacked evidence of the development of a care plan with goals and approaches to address the resident's visual impairment. During a face-to-face interview conducted on June 26, 2017, at approximately 12:00 PM, Employee #8 acknowledged the findings.	F 279		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309	1. The nurse providing care for #169 was educated on how to properly administer antihypertensive medications to #169. The resident's blood pressure must be taken prior to administering the medication. 2. An audit was completed on other residents receiving anti-hypertensives and no residents were noted to affected by this allegedly deficient practice. 3. Random medication pass observations will be administered to licensed nurses by Nurse Managers, Nurse Educator and/or ADON. Residents who receive anti-hypertensives will be included in the medication pass observations to	08/11/2017

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F 309	Continued From page 9 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 29 sampled residents, it was determined that facility staff failed to assess the blood pressure (B/P) before administering one (1) resident's antihypertensive medication (Lisinopril) (Resident #169.) The findings include: On June 20, 2017, at 9:52 AM, during a medication administration observation, Employee #5 was observed administering Lisinopril (antihypertensive medication) tablet 10 mg to Resident #169. Before administering the Lisinopril, the employee failed to assess the resident's B/P.	F 309	Ensure B/P is obtained and reviewed prior to anti-hypertensive medication administration. 4. The results of medication pass observations will be submitted to the QA committee.. The QA committee will determine the need for further audits or actions.	08/11/2017

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F 309	Continued From page 10 A medical record on June 20, 2017 revealed a physician's order which directed, "Lisinopril Tablet 10mg via (by way of) G-Tube (Gastrostomy-Tube) one (1) time a day for HTN (Hypertension). Hold if SBP<110 or DBP<50. (Systolic Blood Pressure less than 110 or Diastolic Blood Pressure less than 50)." During a face-to-face interview conducted with Employee #5, immediately after the administering of the Lisinopril, the surveyor asked the employee the rationale for the lack of assessment of the resident's B/P. Employee# 5 responded, "I meant to take it, but I forgot. I was nervous because you were watching me." The employee assessed the resident's blood pressure which revealed a reading of 141/98. Employee# 5 acknowledged the findings.	F 309		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	1. Equipment determined to be soiled was cleaned. Food containers were also cleaned and any left over residue removed. The drain pipe that extended into the floor drain was corrected by the Maintenance Department. The Food Service Director has updated and re-assigned the cleaning of the ovens. The new guidelines mandate a, thorough, weekly cleaning done by utility staff and daily spot checks performed by, both, morning and evening cooks. There were no residents affected by this allegedly deficient practice.	08/11/2014

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F 371	Continued From page 11 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations made on June 20, 2017 at approximately 10:00 AM, it was determined that the facility failed to prepare and serve foods under sanitary conditions as evidenced by two (2) of four (4) soiled convection ovens, one (1) of one (1) soiled grease fryer, four (4) of four (4) soiled steam table covers, two (2) of eight soiled salad dressing containers and two (2) of two (2) drain pipes that extended into the floor drain. The findings include: 1. Two (2) of four (4) convection ovens soiled at the bottom. 2. The side panels to one (1) of one (1) grease fryer soiled with grease deposits. 3. Four (4) of four (4) steam table covers soiled and discolored. 4. A one-gallon plastic container of Ranch dressing and a one-gallon plastic container of Ceasar dressing stored in the walk-in refrigerator soiled on the outside with leftover residue. 5. Drain pipes from the tilt skillet and the steamers extended too far into the floor drain.	F 371	2. The Food service Director will conduct daily inspections of the fryer and kitchen equipment, to ensure sanitary requirements are being met and upheld. 3. The steam table discoloration has been corrected by thorough cleaning and removed the item that caused the discoloration. The Food Service Director has educated utility and dietary aides in proper cleaning and sanitation of steam tables. The Chef will conduct an in- service further educating staff on potential dangers of improper food storage. The steam table will be, completely, dismantled and cleaned with the close of business each day. The Chef will conduct food storage training with cooks and all diet aides. 4. The Food Service Director and/or designee will audit the cleanliness of convection ovens, grease fryers and steam tables monthly x 3months then quarterly x2. The Assistant Food Service Director and/or designee will audit the proper storage of foods housed in the walk-in refrigerator monthly x 3 months and then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	08/11/2017

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F 371	Continued From page 12 The observations made in the presence of Employee #12 or Employee #13 were acknowledged.	F 371		
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations made on June 20, 2017, at approximately 10:00 AM, it was determined that the facility failed to dispose of garbage in a sanitary manner as evidenced by loose trash bags improperly stored, on the ground beside the trash bins. The findings include: Loose items such as empty cans, paper and two (2) full trash bags were observed on the ground, next to the trash bins located outside the facility. The observation made, in the presence of Employee #13, were acknowledged.	F 372	1. On June 20, 2017, the loose trash bags were removed besides the trash bins and placed inside the trash bins. The Housekeeping and some Food Service staff cleaned outside the garbage disposal area. There were no residents affected by this allegedly deficient practice. 2. The Housekeeping and Food Service staff cleaned the outside garbage disposal area. 3. The Food Service Director and/or designee will conduct daily inspections of the garbage disposal area, to ensure sanitary requirements are being met and upheld. The Food Service Director will conduct a departmental in service concentrating on the proper disposal and sanitation measures of garbage area. 4. The Food Service Director and/or designee will perform random audits to ensure the garbage disposal area is clean and free of trash. The Assistant Food Service Director and/or designee will audit the proper disposal of refuse monthly x3 and then quarterlyx2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or action.	08/11/2017
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures	F 431	1. The medication refrigerators were checked and registered at the correct temperature. There were no residents affected by this allegedly deficient practice. The RN Night Supervisor is responsible to ensure the medication	08/11/2017

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F 431	Continued From page 13 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	Refrigerators are consistently recorded every night on all three units. 2. The Nurse Manager and/or Day Shift Charge Nurse will monitor the medication refrigerators logs daily to ensure compliance. 3. In the event the nurse manager and/or day shift charge nurse notes that the medication refrigerator log has not been annotated, the refrigerator's temperature will be taken and annotated on the log with date and time. 4. The medication refrigerator logs will be audited daily by QA Nurse for three months x 3 months then quarterly x 2. The results will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	08/11/2017

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F 431	Continued From page 14 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility staff failed to ensure that medication refrigerator temperatures were recorded every night on two (2) of three (3) nursing units. The findings include: Facility staff failed to ensure that the medication refrigerators temperature were consistently recorded every night on two (2) of three (3) nursing units (Units #2 and 3). On June 26, 2017, between the hours of 9:00 AM and 11:00 AM, a review of the "Medication Temperature Logs" revealed the nursing staff did not consistently record refrigerator temperatures on Nursing Units #2 and 3. The missing dates are as follows: Nursing Unit 2 March 14, 2017 March 15, 2017 May 16, 2017 June 10, 2017 Nursing Unit 3 June 23, 2017 June 24, 2017 Employees #4 and 9 acknowledged the findings at the time of the review.	F 431		
F 456	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE	F 456		

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F 456 SS=D	Continued From page 15 OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 29 sampled Stage 2 residents, it was determiend the facility staff used an unauthorized blood pressure cuff (one brought from the employee's home) to assess the resident's blood pressure (Resident #169). The findings include: On June 20, 2017, at approximately 10:00 AM, Employee #5 was observed assessing Resident #169's Blood Pressure (B/P) using a "[Store Brand], wrist monitor." No model (name) was discernable on the monitor. Upon completion of the blood pressure assessment, the surveyor asked Employee #5 where he/she had obtained the B/P monitoring device. The employee responded, "I brought it from home." The employee further explained the equipment was brought from home and approval had not been given by the facility for its use. There was no evidence the blood pressure monitor used by staff was cleared by the facility's biomedical department/contractor to ensure its accuracy.	F 456	1. The LPN using the unauthorized blood pressure cuff has been in-serviced on how to properly measure blood pressures on the appropriate equipment provided by the Facility. 2. The nine medication carts were checked to ensure that Facility approved blood pressure cuffs are available. Staff meetings were held each shift with licensed nursing staff to educate and enforce that only Facility approved equipment should be used in providing resident care. 3. Nurse Managers and/or designee will monitor medication carts for manual blood pressure apparatuses and other equipment storage areas to ensure facility approved equipment is readily available for resident care. The facility provides digital vital sign equipment and manual blood pressure equipment. Education and disciplinary action will be done anytime it is discovered unauthorized equipment is used. 4. Random medication pass observation will be done monthly; residents receiving anti-hypertensives with blood pressure parameters will allow the auditor to note the apparatus that is used to take the blood pressure. The DON and/or designee will audit each nursing unit monthly x3 months and quarterly x2 to for unauthorized blood pressure equipment. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	08/11/2017

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F 456	Continued From page 16 During a face-to-face interview with Employee #2 at approximately 2:00 PM on June 20, 2017, the employee stated that employees are not permitted to use personal equipment not approved by the facility. The observation shared with Employee #2 was discussed and acknowledged.	F 456		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514	1. The nurses administering the OxyContin have been re-in serviced on the proper method of documenting on the MAR and the narcotic control record. 2. All residents receiving OxyContin MARS will be audited to ensure documentation is completed correctly. 3. MARS will be reviewed for proper documentation during random medication observations. 4. Nurse Managers and/or designee will audit MARS for appropriate signatures for all residents receiving OxyContin x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	08/11/2017

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F 514	Continued From page 17 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to consistently and accurately document that one (1) resident received his/her OxyContin medication for pain on the MAR (Medication Administration Record) (Resident #201). The findings include: A review of the Medical Record on June 27, 2017, at 10:00 AM revealed the following: The May 2017 Physician's order dated May 2017 directed, "OxyContin HCL tablet 5 mg by mouth every 6 [six] hours as needed for pain." The Controlled Medication Utilization Record revealed the following: May 7, 2017, OxyContin 5mg was signed as given at 9:00 AM and 5:00 PM May 9, 2017, OxyContin 5mg was signed as given at 9:00 AM and 9:45 PM May 10, 2017, OxyContin was signed as given at 9:00 PM, 4:00 PM and 10:00 PM A subsequent review of the MAR revealed that on May 7, 9, and 10, 2017 at times listed above, there were no initials in the designated boxes indicating that the nursing staff administered	F 514		

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F 514	Continued From page 18 OxyContin 5 mg. During a face-to-face interview conducted with Employee #2, on June 27, 2017, at approximately 11:30 AM, the employee acknowledged the findings.	F 514		