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 _____	08/17/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Brinton Woods of Washington DC August 11, 2016 through August 18, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 35 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 C. Diff - Clostridium Difficile CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)	F 000	Please begin typing your responses 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12 Sept 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 G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Infectious Disease ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set mcg/act - micrograms/actuation Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before	F 247		

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F 247	Continued From page 2 the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that facility staff failed to provide notice to Resident #158 prior to a roommate change. The findings include: A resident interview was conducted on August 15, 2016 at approximately 10:30 AM. A query was made regarding "Have you been moved to a different room or had a roommate change in the last nine [9] months?" the resident responded "yes" and that [he/she] was not given notice when the roommate change occurred. A review of the clinical record for Resident #158 lacked documentation that the resident was provided notice before he/she received a new roommate on August 2, 2016. A face-to-face interview was conducted on August 18, 2016 with Employee #7 at approximately 9:30 AM. He/she revealed that the process is that the resident or responsible party is notified prior to roommate changes and that it is documented in the medical record by Social Workers and if it occurs when they are not present the nursing staff will document.	F 247	1. Resident #158 was notified about receiving a room mate. Resident #158 was assured that in future room changes that social services and/or nursing staff would notify him of the room changes. 2. The resident (s) involved will be notified by nursing personnel and/or Social Services staff prior to the room changes being made. The 6-108 form will be sent to the required areas. The social service staff and/or nursing staff will document in Point Click Care that the resident(s) was notified of the room change prior to the change being made. 3. Proposed resident room changes will be discussed in interdisciplinary meetings prior to offering. Notification for room changes will be audited for compliance by Social Services for the next ninety days. 4. Social Services will review DC 6-108 Monday through Friday to ensure all changes were completed properly. Progress notes will be reviewed to ensure documentation reflects the resident's notification. The tracking tool results will be submitted to the QA committee for review. The QA committee will determine the need for further audits or actions.	10/02/16

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F 247	Continued From page 3 A face-to-face interview was conducted with Employee #4 on August 18, 2016 at approximately 12:00 PM. When queried, the employee acknowledged that the resident was not informed prior to his/her roommate being changed. The record was reviewed on August 18, 2016.	F 247		
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 August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary environment as evidenced by loose privacy curtains in five (5) of 37 residents' rooms, dusty exhaust vents in three (3) of 37 residents' rooms, soiled shower floors in one (1) of three shower rooms and one (1) of three clinical sink hopper in the facility that failed to flush when tested. The findings include: 1. Privacy curtains were detached and hanging off the hooks in five (5) of 37 resident rooms including rooms #143, 227, 242, 319 and #341. 2. Bathroom exhaust vents were soiled with	F 253	1. No residents were harmed or affected by the findings. 2. The privacy curtains in these rooms were either replaced or re-attached on 8/16/16. The bathroom exhaust in these rooms were cleaned on 8/16/16 The floor to all three shower rooms were cleaned on 8/17/16 The hopper on the third floor soiled utility room was repaired on 8/16/16 3. An audit was conducted on all bathroom exhaust and privacy curtains on 8/17/16 Housekeeping has been re-instructed to check exhaust vents and curtains daily 4. Maintenance Director and/or designee will also check exhaust vent monthly when cleaning a/c filters on resident room units. Environmental Service Director and/or designee will inspect curtains, vents, hoppers, and shower room floors on a weekly basis. Results of audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/02/16

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F 253	Continued From page 4 dust in three (3) of 37 resident rooms (#108, 307 and 319). 3. The floor to one (1) of three (3) shower rooms in the facility was soiled. 4. A clinical sink hopper located in the soiled utility room on the third floor failed to flush and was not functioning as intended, one (1) of three (3) clinical sink hoppers in the facility. These observations were made in the presence of Employee #15 who confirmed the findings.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	1. Resident #39 and #160 Care plans have been updated with goals and approaches to address the impaired vision and behavioral symptoms respectively. 2. Care plans will be audited to ensure goals and approaches address residents' comprehensive assessment. 3. The Nurse Educator and/or designee will educate Nurse Managers and Charge Nurses on developing goals and approaches to address the residents' comprehensive assessment. 4. The ADON and/or designee will audit care plans monthly x 3 months then quarterly x2. MDS coordinator will randomly audit care plans monthly and notify DON of discrepancies. Results of audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/02/16

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F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 35 Stage 2 sampled residents, it was determined that facility staff failed to initiate a care plan with goals and approaches to address one (1) resident ' s impaired vision and one (1) resident's behavioral symptoms. Residents #39 and #160. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches for Resident #39 who had impaired vision and was diagnosed with Cataracts. A review of an Eye Exam Consultation Record dated January 28, 2016 revealed the following diagnosis and treatment: " Age related nuclear cataract, bilateral - Cataracts - OU [both eyes]- moderate/dense --- monitor 6mos[months]/PRN [as needed]. " A review of the Annual MDS (Minimum Data Set) dated March 9, 2016 revealed that Resident #39 in Section B1000 " Vision " is coded as " Impaired " . Section V, Care Area Assessment Summary revealed in care area #4 "Visual Function" that a check mark was placed in the boxes allocated for "Care Area triggered" and "Care planning decision" indicating "care plan needed." A review of the clinical record lacked evidence of a care plan with goals and approaches to address Resident #39's impaired vision.	F 279		

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F 279	Continued From page 6 A face-to-face interview was conducted on August 17, 2016 at approximately 11:05 AM with Employee #4 who acknowledged the aforementioned findings. The record was reviewed on August 17, 2016. 2. Facility staff failed to initiate a care plan with goals and approaches to address Resident #160's behavioral symptoms. A history and physical examination dated February 20, 2016 revealed Resident #160's diagnoses included: " Hypertension, Seizure Disorder, Status Post Brain Abscess ... Neurological: Poor, uncooperative [with] exam ... " An admission MDS (Minimum Data Set) dated February 26, 2016 revealed Section E0800 Behavioral Symptoms (rejection of care) was one of the triggered care areas to be addressed in the care plan. A review of Resident #160 ' s comprehensive care plan lacked evidence of a care plan with goals and approaches to address the resident ' s behavioral symptoms. A face-to-face interview was conducted with Employee #3 on August 17, 2016 at approximately 11:20 AM. After review of the aforementioned he/she acknowledged the findings. The clinical record was reviewed on August 17, 2016.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 7 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that facility staff failed to review and revise Resident #95's care plan to reflect an integrated approach with the participation of hospice, the facility, and the resident or representative. Resident #195. The findings include: A review of the Physician's Order Sheet dated November 8, 2015 directed: Admit to [Hospice Agency Name]. Hospice start date [November 13, 2015].	F 280	1. Resident #195 care plan has been updated. 2. All residents receiving Hospice services care plans will be audited to ensure disciplines and/or teams responsible for implementing interventions of the hospice care plan are identified. 3. Hospice will attend care plans and care plans will be reviewed with the interdisciplinary team during the resident's first scheduled care plan meeting. 4. ADON and/or designee will audit care plans monthly 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.	10/02/16

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F 280	Continued From page 8 A review of Resident #95's care plan revealed a care plan for "Resident has a terminal prognosis r/t [related/to] [Diagnosis named]" with goals and approaches initiated November 9, 2015. However, the care plan lacked specific identification of the disciplines and/or team [hospice vs. nursing home] responsible for implementing the interventions of the hospice care plan. A face-to-face interview was conducted on August 16, 2016 with Employee #4. After review of the aforementioned he/she acknowledged the findings.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that facility staff failed to follow acceptable standards of practice for administering an oral aerosol inhalation treatment per the manufacturer ' s specifications. Resident #109. The findings include: According to " GlaxoSmithKline Company-www.flovent.com " ; Revised July 2016-	F 281	1. Nurse administering the Flovent HFA Inhaler has been in-serviced on how to properly administer Flovent HFA Inhaler. 2. All residents receiving Flovent HFA Inhaler be identified and times of administration. 3. The Nurse Educator will provide training to Licensed Nursing staff on administering Flovent HFA Inhaler with return demonstration. Nurse Managers will randomly observe licensed nurses Administering Flovent HFA Inhaler.	10/02/16

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F 281	Continued From page 9 pp 33-35; stipulates: " How to use your Flovent HFA inhaler ... Step 2. Hold the inhaler with the mouthpiece down [canister should be pointed upward] ... " On August 11, 2016 at approximately 10:10 AM, Employee #18 was observed administering an oral inhalation aerosol treatment to Resident #109. Employee #18 instructed the resident to take a deep breath in and out. Proceeded to position the mouthpiece of the inhaler in the resident's mouth in an upward position [canister was pointed downward]. A face-to-face interview was conducted with Resident #109 after the medication was administered. A query was made, if he/she felt the effect of the medication? He/she responded, "Yes, I felt it going down." A face-to-face interview was conducted with Employee #18. He/she was queried regarding the correct positioning of the mouthpiece of the inhaler in the resident's mouth. He/she stated, "It should be positioned with the mouthpiece in the down position with the canister pointing up. That's the way I usually administer it." The observation and record review were conducted on August 11, 2016. Crossed Referenced 483.25 (F309)	F 281	4. Pharmacy Services will send a list of residents receiving Flovent monthly to the DON for the next 3 months then quarterly x2. The Nurse Educatior and/or Nurse Managers will observe a medication pass on licensed nurses administering Flovent Inhaler monthly x3 months then quarterly x2. The results of the medication administration observation will be brought to the QA committee. The QA committee will determine the need for further actions	10/02/16
F 309 SS=D	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	F 309		

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F 309	Continued From page 10 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 two (2) of 35 Stage 2 sampled residents, it was determined that facility staff failed to clarify physician's orders to rinse the resident's mouth following an oral aerosol inhalation and failed to administer an oral aerosol inhalation treatment per the manufacturer ' s specifications for one (1) resident; and failed to follow through on an Infectious Disease [ID] appointment for one (1) resident. Residents' #109 and #160. The findings include: According to " GlaxoSmithKline Company-www.flovent.com " ; Revised July 2016-pp 33-35; stipulates: " How to use your Flovent HFA inhaler ... Step 2. Hold the inhaler with the mouthpiece down [canister should be pointed upward] ... Step 7. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it..." 1a. Facility staff failed to clarify physician's orders to rinse Resident #109's mouth following an oral aerosol inhalation treatment. On August 11, 2016 at approximately 10:10 AM, Employee #18 was observed administering an	F 309	1. Resident # 109 physician order has been clarified. The resident will rinse with thickened water or be provided a swab for their oral cavity, after receiving the aerosol. 2. Residents receiving Flovent Inhaler will be reviewed to ensure they are receiving instructions to rinse their mouths after the medication is administered. 3. The Nurse Educator and/or Designee will educate/train the licensed nursing staff on proper administration of Flovent to include resident rinsing his/her mouth after the inhalation is administered. ADON and/or designee will audit residents receiving Flovent Inhaler for next 3 months to ensure they are rinsing after the medication is administered. 4. The audits will be submitted to the QA committee for review. The QA committee will determine the need for further audits or actions.	10/02/16

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F 309	Continued From page 11 oral inhalation aerosol to Resident #109. Resident #109 had a physician's order for Flovent HFA (Hydrofluoroalkane - propellant in the inhaler) 110 mcg/act (micrograms)/(actuation) - 1 puff inhale orally two times a day for SOB (shortness of breath) (After administration of flovent, monitor resident to rinse mouth with water and spit completely.) The employee administered Resident #109 one (1) puff from the Flovent inhaler. After administering the inhaler, the employee did not instruct the resident to rinse his/her mouth with water. A face-to-face interview was conducted with Employee #18 at approximately 10:00 AM. He/she was queried regarding not having the resident rinse with water and spit after administering the flovent. He/she replied, that since the resident is on aspiration precautions, [she/he] is not instructed to rinse with water because of the possibility of the resident swallowing it. Facility staff failed to clarify physician's orders to rinse Resident #109's mouth following an oral aerosol inhalation treatment. The observation and record review were conducted on August 11, 2016. 1b. Facility staff failed to administer an oral aerosol inhalation treatment per the manufacturer ' s specification. Resident #109 On August 11, 2016 at approximately 10:10 AM, Employee #18 was observed administering an	F 309		

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F 309	Continued From page 12 oral inhalation aerosol treatment to Resident #109. Resident #109 had a physician's order for Flovent HFA (Hydrofluoroalkane- propellant in the inhaler) 110 mcg/act - 1 puff inhale orally two times a day for SOB (shortness of breath) (After administration of flovent, monitor resident to rinse mouth with water and spit completely). Employee #18 instructed the resident to take a deep breath in and out. Proceeded to position the mouthpiece of the inhaler in the resident's mouth in an upward position [with the canister pointed downward]. A face-to-face interview was conducted with Resident #109 after the medication was administered. A query was made, if he/se felt the effect of the medication? He/she responded, "Yes, I felt it going down." A face-to-face interview was conducted with Employee #18. He/she was queried regarding the correct positioning of the mouthpiece of the inhaler in the resident's mouth. He/she stated, "It should be positioned with the mouthpiece in the down position[with the canister in the upward position]. That's the way I usually administer it." The observation and record review were conducted on August 11, 2016. 2. Facility staff failed to follow through on an infectious disease appointment for Resident #160. A history and physical examination dated February 20, 2016 revealed Resident #160 ' s	F 309		

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F 309	Continued From page 13 diagnoses included: " Hypertension, Seizure Disorder, Status Post Brain Abscess, HIV (Human Immunodeficiency Virus), and AIDS (Autoimmune Deficiency Syndrome) ... " The physician's order sheet and plan of care dated February 20, 2016 directed: " Abacavir (antiretrovirals) 300mg on (1) tab po (by mouth) daily for HIV, Lamivudine (antiretrovirals) 150mg (milligram)- 15ml (milliliters) po daily for HIV and Lopinavir-ritonavir (antiretrovirals)- two (2) tablets po BID (twice a day) for HIV ... " A review of the March 8, 2016 pharmacy consultation report read: " [Resident ' s name] .... receives antiretroviral therapy, Abacavir, Epivir, Kaletra.. The following monitoring plan for antiretroviral therapy is recommended .... (1) continuous therapy: CD4 count and viral load ... . Physician ' s response: I accept the recommendations(s) with the following modifications: Patient with ID [Infectious Disease] [follow-up]. Will [check] ID notes. Follow up ID on March 22, 2016. " An infectious disease consult dated: March 8, 2016 revealed: " Plan: RTC (Return to clinic) - 2 weeks ... " According to a nurse ' s note dated March 28, 2016 -1446 (2:46 PM)- " F/U with infectious disease on March 28, 2016 with [MD named] ... Appointment rescheduled..." A review of the medical record lacked evidence that the facility followed through on the infectious disease recommendation to return in two (2) weeks.	F 309	1. Resident #160 has been discharged from the facility therefore we are unable to reschedule the appointment. 2. Current residents' medical records will be reviewed for scheduled and unscheduled medical appointments. 3. Nurse Educator and/or designee will in-service Unit Clerks, Charge Nurses and Team Leaders on importance of setting up medical appointments for residents. The in-service will also include how to reschedule missed appointments and required documentation. 4. ADON and Nurse Managers will audit residents' appointments for the next three 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.	10/02/16

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F 309	Continued From page 14 A face-to-face interview was conducted with Employee #3 regarding the resident' s follow-up ID appointment. He/she acknowledged the findings. The clinical record was reviewed on August 17, 2016.	F 309		
F 323 SS=D	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 August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to ensure that resident's environment remain free of accident hazards as evidenced by a missing light cover in the bathroom of one (1) of 37 resident's rooms surveyed. The findings include: The cover to the ceiling light in the bathroom of resident room #307 was missing and its electrical wires were exposed and accessible to residents, staff and/or the public, in one (1) of 37 resident's rooms surveyed. These observations were made in the presence of Employee #15 who acknowledged findings.	F 323	1. No residents were harmed or effected by the findings 2. Light cover in room 307 was replaced immediately on 8/16/16 3. Audit was conducted on all residents' bathroom light covers on 8/17/16 Housekeeping staff instructed to notify maintenance of any light covers noticed missing immediately 4. Environmental service director and/or designee will audit on weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=D	Continued From page 15 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 August 16, 2016 at approximately 9:30 AM, it was determined that the facility failed to serve foods under sanitary conditions as evidenced by four (4) of 16 soiled steam table wells in the facility. The findings include: Steam table wells located on the second floor dining room were soiled with leftover food residue, four (4) of 16 steam table wells surveyed. These observations were made in the presence of Employee #14 who acknowledged the findings.	F 371	1. There were no residents found to have been affected by the alleged deficient Practice. 2. On August 16, 2016, an observation of food service practice was conducted. Food residue was found in 4 out of 16 steam table wells. Soiled steam table wells were cleaned at the time of inspection. The Staff was educated by Asst. Food Service Director on the importance of cleaning each steam well before and after use. 3. The Food Service Staff will monitor daily the cleanliness of each steam table during meal time prior and after use. Corrective action will be implemented as needed. 4. The Food Service Director will report findings with corrective action to QA committee monthly x3 The QA committee will determine the need for further audits or action.	10/02/16
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders	F 386		

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F 386	Continued From page 16 with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that the physician failed to follow through on one (1) resident ' s diagnostic test. Resident #45. The findings include: An interim physician's order dated January 4, 2016 at 12:20 PM directed: " Psychiatry- F/U (Follow-up) for Resident' s Risperidone [secondary to] elevated prolactin level (hormone level made by the pituary gland)- 38.23 (high); (normal range-1.8-20.3) done on 12/21/15. " A review of the clinical record revealed: "Report of Consultation " [not dated], From: [Attending physician named], Report requested regarding: Psychiatry [follow-up] for resident ' s Risperidone use secondary to elevated prolactin level 38.23 (1.8-20.3) done on 12/21/15; Report: Findings: Will see today 1/11/16 ... [psychiatry signature] ... " A review of the psychiatry notes revealed the following: December 28, 2016- ... Axis I- Schizophrenia -Trileptal 150mg po bid for mood stabilization, Follow up in 2 weeks January 19, 2016- ...Axis I: Schizophrenia-	F 386	1.Resident number #45 elevated prolactin level has been addressed. 2. Pharmacy consultation reports will be audited to ensure recommendations have been addressed by the attending physician and/or other physician. 3. DON and/or designee to train Nurse Managers to audit pharmacy consultation reports to ensure the recommendations have been addressed. 4. The audits will be done for the next three months then quarterly x 2. The results of the audits will be submitted to the QA Committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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F 386	Continued From page 17 Continue current treatment, Follow up in [a] month March 28, 2016- ... Axis I: Schizophrenia- Continue current treatment, Follow up in a month June 13, 2016 ... Axis I: Schizophrenia, continue current treatment, Follow up in one month ... " A review of the attending physician ' s notes from January 2016 to August 2016 revealed no documentation regarding the resident ' s elevated prolactin level. There was no evidence in the clinical record that the attending and psychiatric physician followed up to review the status of the elevated prolactin level. A face-to-face interview was conducted with Employees #5 and #19 on August 17, 2016 at approximately 11:20 AM regarding the aforementioned findings. Both acknowledged the findings. Employee #19 stated he/she will follow-up. The clinical record was reviewed on August 17, 2016.	F 386		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 18 Professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined that the facility staff failed to remove one (1) resident ' s expired medications from the 2nd floor medication cart. The findings include: On August 18, 2016 at approximately 1:40 PM the medication storage observations revealed the following: Resident #176 had one (1) blister packet with a total of 21 Zolpidem 5mg tablets. The expiration	F 431	1. Resident #176 blister pack was removed from medication storage. 2. All medication storage areas have been checked for expired medications. 3. The nurse educator will provide in-services to licensed staff on discarding expired medications. Licensed nurses will be re- trained to review expiration dates when counting controlled medications. 4. ADON and/or designee will audit medication storage areas for expired medications monthly x3 months then quarterlyx2. The results of the audits will be presented to the QA Committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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F 431	Continued From page 19 date on the blister packet was July 31, 2016. The resident last received the medication on July 9, 2016 at 11:35 PM. The observation was made in the presence of Employee #16. He/she acknowledged the findings.	F 431		
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 August 11, 2016 at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of four (4) broken burner grates from the gas stove, two (2) of eight (8) steam wells covers with a missing handle, a malfunctioning temperature gauge and power light from one (1) of one (1) reach-in refrigerator, and a torn air curtain in the walk-in freezer. The findings include: 1. One (1) of four (4) burner grates from the gas stove in the main kitchen was broken and part of it was missing. 2. One (1) of four (4) steam table well lid from the steam table in the main dining room and one (1) of four (4) steam table well lid from the steam table on the third floor were missing a handle.	F 456	1. This deficient practice did not directly affect any resident. 2. On August 11, 2016 torn air curtain in a walk-in freezer and the steam table covers with missing handles were replaced. On August 17, 2016 broken burner grate was replaced on 8/23/16.The malfunctioning temperature gauge and power light on reach-in refrigerator is being assessed for repair or replacement. 3. On August 11, 2016 a walk through of the kitchen was conducted by the Assistant Food Service Director to check Kitchen equipment were in safe Operating condition. 4. The Food Service Director and/or designee will conduct random observation audits on kitchen equipment to ensure they are in safe operating condition. Broken equipment will be reported to maintenance for repair.	10/02/16

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F 456	Continued From page 20 3. The built-in thermometer and the power light from one (1) of one (1) reach-in/prep refrigerator in the main kitchen were out of service. 4. One (1) of seven (7) air curtains from one (1) of one (1) walk-in freezer was torn. These observations were made in the presence of Employee #14 who confirmed the findings.	F 456	5. Food Service Director and/or designee will audit weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to maintain call bells in good working condition as evidenced by a call bell that failed to alarm when tested in one (1) of 37 resident's rooms and one (1) of three (3) call bells in the shower room on the third floor that lacked a pull cord. The findings include: 1. The call bell in resident room #126, one (1) of 37 resident's rooms did not initiate an alarm when tested. 2. One (1) of three call bells in the shower room on the third floor was missing a pull cord.	F 463	1. No residents were harmed by the findings 2. Call cord was immediately replace in room 126 on 8/16/16 Pull cord was immediately replaced in third floor shower room on 8/16/16 3. Audit was conducted on all floors for call bells and pull cords 4. Full house audit of call bells is conducted on a quarterly basis. Maintenance director and/or designee will test call bells on weekly rounds. The audits will be done for the next three 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.	10/02/16

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F 463	Continued From page 21 These observations were made in the presence of Employee #15 who confirmed the findings.	F 463		
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 35 Stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) residents medical record was inclusive of the resident's Hospice documents. Resident #195. The findings include: A review of the Physician's Order Sheet dated November 8, 2015 directed: Admit to [Hospice Agency Name]. Hospice start date [November 13, 2015.]	F 514	1. Resident #195 hospice Initial Nursing assessment and the Physician's Plan of Care were re-added to the readily accessible clinical record. 2. All hospice residents' clinical records will be reviewed to ensure the initial nursing assessment and physician's plan of care is readily accessible. 3. The medical records clerk will in-service the unit clerks on maintaining the resident clinical records in accordance with accepted professional standards and practices: to specifically include Hospice information. 4. The ADON and/or designee will audit hospice residents' medical records for the next 3 months then quarterlyx2. The audits will be submitted to the QA Committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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F 514	Continued From page 22 After further review of the medical record there was no evidence that the hospice " Initial Nursing Assessment, and the Physician ' s Plan of Care " were readily accessible on the active clinical record. A face-to-face interview was conducted on August 16, 2016 with Employee #4. After review of the aforementioned he/she acknowledged the findings and had the documents faxed to the facility. The record was reviewed on August 16, 2016.	F 514		