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	HFD02-0001	A. BUILDING: _____ B. WING _____	01/16/2018

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L 000	Initial Comments	L 000		

The Annual Licensure Survey was conducted at Brinton Woods Health and Rehab Center at Dupont Circle from January 9, 2018, through January 16, 2018. Survey activities consisted of a review of 9 sampled residents. The following deficiencies were based on observations, record review, and staff interviews. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of DCMR Title 22 Chapter 32.

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
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team

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L 000	Continued From page 1 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 - 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 Trach- Tracheostomy @- at	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L 051		

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L 051	Continued From page 2 (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on resident and staff interviews and record review for six (6) of nine (9) sampled residents, the charge nurse failed to update/revise the comprehensive care plan with goals and approaches to address the following: three (3) residents with aggressive behaviors towards other residents, to discontinue care plans that did not accurately reflect one (1) resident's current health care needs, to address behavioral health care needs for one (1) resident and to address the use of a cardiac care device for one (1) resident. Residents' #87, 130, 216, 141, 149 and 367. Findings included... 1. The charge nurse failed to update the care plan to address physical aggressive behaviors of Resident # 87.	L 051	1. Resident # 87 care plan has been reviewed and updated to reflect goals and approaches related to resident's aggressive behaviors documented 07/29/2017 & 09/12/2017.	

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L 051	Continued From page 3 Review of the Nursing Progress notes for Resident # 87 revealed: "On July 29, 2017, at 15:39, Resident #87 used her foot to kick [Resident #83's] wheel chair after being verbally aggressive towards the resident in the main dining room. Resident #87 stated that she kicked [Resident #83's] wheelchair because "He ...reported me ...to the social workers that I bought a cigarette from store and I keep cigarettes ...After the incident immediately both residents were separated and removed to different areas of the facility ..." "On September 12, 2017, at 17:10 [5:10 PM], "[Resident #87] was interviewed re: complaint by nurse that she refused to allow another resident (Resident # 40) to enter her room and hit her in the face with a bag that has items from the Gift Shop. [Resident #87] ...admitted that she did hit her as she plays in the water in the bathroom and no one does anything about it. Further-the-more, the facility [can't] put her out as she knows her Rights ..." A review of Resident # 87's care plan with a focus area entitled, " ...Potential to display aggressive behavior including verbal abuse and kicked another resident wheelchair ...by using her feet ..." care plan was not updated with new goals and new interventions to address Resident # 87's behavior after she kicked another resident and after she hit another resident in the face with a bag that contained items from the gift shop. During a face-to-face interview with Employee	L 051	Resident # 130 report of "being threatened by roommate" has been investigated, documented and reported to state to state agency. Resident # 130's person centered care plan has been initiated to reflect interventions and services to attain or maintain resident's highest practicable physical, mental, and psycho-social well being. Resident # 216 care plan has been reviewed and updated with new goals and approaches to address resident's physical aggressive behavior documented 12/20/2017. Resident # 141 inaccurate care plans for anticoagulation related to Atrial Fibrillation and impaired skin integrity has been discontinued. Resident # 149 medical records has been reviewed to ensure that psychiatric follow up notes and recommendations are available with notes to confirm resident's IDT meetings. Care plan was reviewed and updated to address resident's behavioral health care needs and psychosocial well-being.	

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L 051	Continued From page 4 #16 on January 12, 2018, at approximately 11:22 AM, he acknowledged that the care plan was not updated to include interventions to monitor Resident #87's aggressive behavior and to protect the other residents. 2. Charge Nurse failed to develop a care plan to meet the goals and approaches to address a resident with behaviors. Resident #130. During an interview on January 9, 2018, at 12:36 PM with Resident #130, the Resident stated, "three months ago I was threatened by my roommate; I overheard him say he was going to stab me in my back." "He needed a lot of care, and the nurses would come in all through the night and this would disturb my sleep, and I did not like that, they moved him, and I had to sign a contract." A review of Resident #130 medical record showed a Social Work Progress Note with a date of September 12, 2017, "Decision was made to transfer roommate as both had made threats to each other and [Resident #130] will remain in the room effective 9/12/17, as each resident have a right to safety, comfort, and care". "He was introduced to his new roommate and was told this will be the last chance of moving anybody away from the room he may be the next to move because this is the third resident moved from the room." During an interview on January 12, 2018, at approximately 10:00 AM with Employee #13, Nurse Manager, "I know of one incident where the resident reported that they keep giving his roommate medication every 4 hours and it was interfering with his sleep, the social worker was	L 051	Resident # 367 no longer resides in the facility. 2. Facility residents have the potential to be affected. Nurse Managers will complete facility wide audit of residents' medical records to ensure that residents care plans are comprehensive reflecting accurate clinical and psycho-social presentation of residents. 3. Staff Development Coordinator will in-service IDT members on the importance of timely and accurately completing comprehensive care plans for residents to meet residents' clinical and psycho-social needs. 4. Director of nursing will conduct random audit of resident's medical records daily during clinical rounds to ensure that resident's care plans meet state guidelines and IDT meetings are documented. Audit results will be reported to QA committee monthly for three months.	2/28/18

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L 051	Continued From page 5 involved, and a contract was signed, the care plan could say more about how we will maintain resident safety." At the time of the review, there is no documented evidence of harm to the resident. A review of Resident#130's medical record lacked evidence of a person-centered care plan with interventions and services to attain and or maintain the resident's highest practicable physical, mental and psychosocial well-being. 3. The charge nurse failed to update the care plan to address physical aggressive behaviors of Resident #216. A review of the Nursing Progress note with a date of December 20, 2017, at 12:42 PM revealed, "At about 8:45 AM this morning resident was approached while she was in her room with complaints of having attacked [Resident # 120] ...by approaching her bedside, pulling away her curtains, and seizing her water pitcher and splashing water on her, her bed and on the floor ..." A review of the care plan with a focus area entitled " ...Potential to demonstrate physical aggressive behaviors r/t (related to) anger, poor impulse control ..." was not revised with new goals and new interventions to address Resident # 216's behavior after she attacked another resident. During a face-to-face interview with Employee #26 on January 12, 2018, at approximately 11:22 AM, she acknowledged that the care plan was not updated to include interventions taken to monitor Resident #216's aggressive behavior and to protect the other resident.	L 051		

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L 051	Continued From page 6	L 051		

4. The charge nurse failed to discontinue care plans that did not accurately reflect Resident #141 current health care needs.

A review of the Resident #141's care plan on January 18, 2018, at 3:00 PM showed that a comprehensive care plan initiated on August 10, 2017, included a focused problem which read "Resident #141 on anticoagulation related to atrial fibrillation and is at risk for bleeding; and having impaired tissue integrity related to incontinence associated dermatitis to buttocks and perineal area". Goals and approaches were developed to address the focused problem.

A review of the current Medication Administration Record for January 2018, did not show any evidence that Resident #141 is on any anticoagulation therapy.

A review of the current Treatment Administration Record for January 2018, did not show any evidence of the resident currently having a skin impairment.

During a face-to-face interview with Employee # 25 on January 18, 2018, at approximately 11:30 AM, he acknowledged that the facility failed to discontinue an inaccurate care plan.

5. The charge nurse failed to provide to develop and implement a person-centered care plan with interventions that include and support for the Resident's behavioral health care needs. Resident # 149

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L 051	Continued From page 7 An observation on January 9, 2018, at 10:00 AM showed resident lying in bed with bed sheet covering his face and Resident stated: "I don't want to be interviewed, just go." During an interview on January 9, 2018, at 11:30 AM, Employee #31, Registered Nurse, stated," I have been working with the resident for the past two weeks, and I try to converse with him but he always turns his face, and he is always angry and talks with anger to all the staff that work with him. He refuses dialysis, and his sister has to convince him to go, he only gets out of bed to go to dialysis, and he does not talk to his roommate or participate in activities. It seems like once he started dialysis, he became like this, he is not verbally abusive, but he talks to everyone with anger, he never threatened staff, and he eats well and takes his medications, but I am not sure if they put in for a psychiatric consult." During an interview on January 9, 2017, at 1:30 PM, Employee #13, Clinical Manager, stated, "yes, I know that they put in for a psychiatric consult they come to see him, but they sometimes don't put the notes in the chart." They have IDT (interdisciplinary team) meetings, but I am not sure if the notes are in the chart, or if there is an updated care plan in the chart. "I am glad that you are saying this now so that we can know what to do." The facility staff did not provide evidence of IDT meetings or a person-centered care plan with interventions to support the resident's behavioral health. A review of Resident #149 medical record showed, a Progress Note with a date of January 16, 2018, with the following diagnoses: Chronic Kidney Disease, Stage 3, Hemiplegia and	L 051		

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L 051	Continued From page 8 Hemiparesis affecting left the non-dominant side, Anemia, Fracture of Nasal Bones with unspecified severity, Major Depressive Disorder, recurrent, unspecified... A further review of the medical record shows a nurses entry with a date of November 9, 2017, "resident has been crying on and off, resident seems depressed; resident expressed that he does not look the same anymore and after dialysis, he doesn't feel the same that he wished he had a twin ..." A Medication Management Assessment form with a date of December 4, 2017, under section order diagnostic tests [Medication Orders: Zoloft 50 mg PO QAM depressed mood]. The medical record lacked evidence of care planned interventions for behavioral health care needs that create an environment that promotes emotional and psychosocial well-being. On January 16, 2018, at 3:00 PM Employee# 13 acknowledged the findings. 6. The charge nurse failed to update the care plan to address the use of a cardiac hugger for Resident # 367. During a face-to-face interview on January 10, 2018, at 11:00 AM, Resident # 367's Powere Of Attorney (POA) stated, "when my mother was admitted they did not know how to use the cardiac hugger and I had to train them because at first, they were not using it". A review of Resident # 367's medical record showed History and Physical dated 12/31/2017	L 051		

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L 051	Continued From page 9 Resident # 367's was admitted to the facility after Coronary Artery Bypass Grafting (CABG) on 12/18/2017. Further review of resident physician's order with a date of 12/29/2017 showed "wear cardiac hugger and do not lift anything greater than 5lbs (pounds) for 2 months from date of surgery (12/20/17)". The resident's care plan initiated 12/28/2017, lacked evidence the care plan was revised to include goals and approaches to managing the resident's cardiac care to include applying cardiac hugger and weight lifting limitations. Employee #3 acknowledged the findings during a face-to-face interview on January 16, 2018, at approximately 10:00 AM.	L 051		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that facility staff failed to meet 0.6 [six tenth] hour for Registered Nurses/APRN [Advanced Practice Registered	L 056	1. Additional registered nurses/ APRN were added to the daily staffing schedules to provide a minimum daily average of four and one tenth hours of direct nursing care per resident per day of which at least six tenth hours are provided by a registered nurse/ APRN. 2. As all residents have the potential of being affected by this deficient practice, none were affected. 3. The Administrator or designee will educate the staffing coordinator on the important of keeping the Daily nursing schedule NHPPD at 4.1 with .06 provided by RN's or APRN's. The Staffing Coordinator or designee will check the Nursing Schedule daily for compliance.	

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L 056	Continued From page 10 Nurses] hours on four (4) of 10 days reviewed; and four and one tenth (4.1) hours of direct nursing care per resident day on eight (8) of 10 days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted with the Staffing Coordinator on January 10, 2018 at approximately 3:00 PM. According to the District of Columbia's Municipal Regulations for Nursing Facilities 3211.5: Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4 A review of the Registered Nurses/APRN [Advanced Practice Registered Nurses] hours for January 01 through January 10, 2018 determined that for four (4) of the 10 days the Registered Nurses/APRN [Advanced Practice Registered Nurses] fell below the required six tenth (0.6) hour. The staffing for the four (4) days is outlined below:	L 056	4. The Staffing Coordinator or designee will report the findings from the audits at the daily morning meeting and reported quarterly at the Quality Assurance meeting.	2/28/18

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L 056	Continued From page 11 January 01, 2018 = 0.48 January 06, 2018 = 0.52 January 07, 2018 = 0.52 January 09, 2018 = 0.57 A review of the direct nursing care per resident per day hours determined that the staffing levels failed to meet the required four and one tenth (4.1) hours of direct nursing care per resident day on eight (8) of 10 days reviewed. The staffing for the eight (8) days is outlined below. January 01, 2018 = 3.69 January 02, 2018 = 3.93 January 04, 2018 = 3.95 January 05, 2018 = 4.04 January 06, 2018 = 3.59 January 07, 2018 = 3.59 January 09, 2018 = 3.94 January 10, 2018 = 3.94 As outlined above the facility failed to comply with the requirement of the District of Columbia's Municipal Regulation; Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels which stipulates that, "each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse." The finding was acknowledged by Employee #34 at the time of the review,	L 056		
L 067	3214.1 Nursing Facilities	L 067		

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L 067	Continued From page 12 A comprehensive on-going in-service education program shall be provided by the facility and shall include training on the provision of resident care. This Statute is not met as evidenced by: 1. Based on staff interview and review of the facility's documentation for newly hired employees, the facility staff failed to ensure three (3) of 35 newly hired employees were trained on abuse prior to interacting and caring for residents in the facility. Findings included... A review of the "Abuse Prevention Program" revised December 2016 stipulates, "Require staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior." A review of the facility's documentation listing the newly hired employees within the past four (4) months revealed the following: A. Employee #28's hire date was September 26, 2017; she received orientation on October 17, 2017. According to the employee's timecard, she worked caring for residents for 120 hours from September 26, 2017, to October 16, 2017. B. Employee #29's hire date was November 2, 2017; she received orientation on November 9, 2017, According to the employee's time card she worked caring for residents for 29 hours from November 2, 2017, to November 8, 2017.	L 067	1. Employees #28, #29, and, #30 received abuse training after worked caring for residents as identified in the citation. No report of negative outcome received or noted due to this deficient practice. 2. Human resource director completed audit of newly hired employees. No other employee found to be in deficient practice. 3. Administrator will provide education to Staff Development and HR Director on the importance of providing abuse training to staff prior to interacting and caring for residents in the facility. 4. Director of nursing will conduct audit of newly hired employees monthly to ensure compliance for three months and report results of the audits to QA	2/28/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 13 C. Employee #30's hire date was November 16, 2017; she received orientation on November 21, 2017. According to the employee's timecard, she worked caring for residents for 24 hours from November 16, 2017, to November 20, 2017. There was no evidence that three (3) employees hired received abuse training before caring for or interacting with the residents. During a face-to-face interview with Employee #27 on January 11, 2018, at approximately 4:15 PM, she acknowledged the findings. 2. Based on observation and staff interviews of one (1) of nine (9) sampled residents, the facility staff failed to train staff in accordance with accepted professional standards of the care and indications for use of a cardiac hugger for Resident #367. Findings included ... The information on the teaching tool for the "Heart Hugger", provided by the residents family member on January 10, 2018, reveals, " ...The Heart Hugger is a sternal support harness worn by patients after cardiac bypass surgery." www.hearthugger.com The facility failed to train staff for placement and use of cardiac hugger Observations on January 9, 2018, at 11:30 AM showed Resident # 367 sitting at bedside wearing a cardiac hugger.	L 067	1. Resident # 367 no longer resides in the facility. Employee # 6 was immediately provided with education and training on the cardiac hugger and provided return demonstration. 2. Nurse Managers completed facility wide audit to ensure that employees received necessary training in providing care to residents with specific focus on cardiac vest or hugger. No other resident identified with the use of new cardiac device such as hugger or vest.	

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	HFD02-0001	A. BUILDING: _____ B. WING _____	01/16/2018

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L 067	Continued From page 14 During a face-to-face interview on January 10, 2018, at 11:00 AM, Resident # 367's POA (Power of Attorney) stated, "when my mother was admitted on December 28, 2017, they did not know how to use the cardiac hugger and I had to train them." During a face-to-face interview on January 10, 2018, at 11:30 AM, Employee #10 stated that she had been trained on the use of cardiac hugger. During a face-to-face interview on January 10, 2018, at 11:30 AM, Employee #6 stated that she was not given an in-service but knew how to apply the cardiac hugger from using one in the past. During a face to face interview on January 16, 2018, at 10:00 AM, Employee #3, Manager stated that cardiac hugger training has been done and provided an in-service sign-in sheet dated January 14, 2018. Employee #3 acknowledged the staff training was not done when the resident was initially admitted on December 28, 2017.	L 067	3. Staff Educator will provide training to nursing staff to ensure that employees have appropriate competencies and skills sets to provide related services and assure residents' safety. Training on specialized device will be provided upon admission, or as determined by residents' assessments, and individual care plans. 4. Director of nursing will conduct random audit of resident's medical records daily during clinical rounds to ensure that resident's care plans meet state guidelines and IDT meetings are documented. Audit results will be reported to QA committee monthly for three months.	2/28/18
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on resident interview, document review and staff interview for two (2) of nine (9) sampled residents, the facility staff failed to report an allegation of one (1) resident left unattended, and	L 206	1. Residents #144 and #367 were re-assessed during survey to ensure no negative outcome from the deficient practice. No negative outcome reported or noted on both residents. Concerns for residents #144 and #367 have been investigated and reported to state agency. Nurse Managers and Social Workers were immediately educated on completing reports with view of investigating and reporting concerns to state agency.	

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L 206	Continued From page 15 one (1) resident whom staff handled roughly. Residents #144 & 367. Findings included ... 1. Facility staff failed to report an allegation of staff rough handling of Resident #144. During a face-to-face interview on January 10, 2018, at approximately 11:30 AM with Resident # 144 stated the 3-11 CNAs (certified nursing assistants) were rough when they placed her in bed after she rolled on her floor mat. Resident # 144 also stated, "The manager was made aware and it has not occurred again." During a face- to- face interview with Employee # 3 at 12:00 PM on January 10, 2018, Employee # 3, stated she was aware of the concern and that she handled it by investigating and changing staff assignment, but was unable to substantiate abuse. Employee #3 provided documentation to demonstrate a complete investigation of rough handling allegations. However, when asked about reporting to the State Agency, the employee stated the incident was not reported. In addition, Employee #1 and Employee #2 acknowledged the finding on January 16, 2018, at approximately 4:00 PM during a face-to-face interview. 2. Facility staff failed to report an allegation that Resident #367 was left unattended.	L 206	2. Nurse Managers will interview facility residents and/ or responsible parties to identify any other outstanding concerns regarding any type of abuse. 3. Quality Assurance/Staff Development will provide training to management team. Training will focus on the importance of completing and reporting investigated resident / responsible parties' concerns to NHA with view of ensuring that appropriate state agency has been notified. 4. Facility social worker will present complaint / concern report log weekly during risk meeting for three months for review and completion including report being sent to appropriate state agency. Results of the weekly audit will be presented in QA meeting monthly for three months to ensure compliance. QA committee will determine the need for further audits and actions.	2/28/18

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L 206	Continued From page 16 During a face-to-face interview on January 10, 2018, at approximately 11:00 AM with Resident # 367's Power of Attorney (POA) stated that last week there was a concern with the resident and a staff member where she felt her mother had been left in the bathroom too long. During a face-to-face interview with Employee # 3 on January 10, 2018, at 1:00 PM, she stated that she was aware of the concern and following the investigation, she could not substantiate abuse. Employee #3 provided documentation to demonstrate a complete investigation of allegations of being left unattended for an extended period of time. However, when asked about reporting to the State Agency, the employee stated the incident was not reported. In addition, Employee #1 and Employee #2 acknowledged the finding on January 16, 2018, at approximately 4:00 PM during a face-to-face interview.	L 206		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's	L 306	1. The call bell in resident's room #415c that failed to initiate an alarm when tested was replaced during the time of the survey. 2. Other call bells in residents' rooms were checked. No other failed call bells were found.	

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L 306	Continued From page 17 room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations, the facility failed to maintain resident's call bell system in good working condition as evidenced by a call bell in one (1) of 57 resident's rooms that did not emit an alarm when tested. Findings included... Observations on January 12, 2018, at approximately 9:30 AM showed the call bell in resident room #415C failed to initiate an alarm when tested. Employees #36 and 37, present at time of observation, acknowledged the finding.	L 306	3. The Maintenance Director will educate facility staff to report call bell issues. The Maintenance Director will check all call bells for disrepair during the weekly environmental rounds. 4. The Maintenance Director will report the finding of the weekly environmental rounds at the Quality Assurance Meetings monthly X 3 months to ensure compliance.	2/28/18
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations, the facility failed to maintain resident's environment in proper working condition as evidenced by peeling paint and a stained ceiling bulkhead in one (1) of 57 resident's rooms.	L 410	1. The peeling paint and stained ceiling bulkhead in resident's room #215 C/D was repaired at the time of the survey. 2. Other residents rooms were checked for peeling paint and stained ceilings and repaired as needed. No other issues were found. 3. The Maintenance Director or designee will educate facility staff to report peeling paint or stained ceiling tiles if noticed.	

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L 410	Continued From page 18 Findings included... Observations on January 12, 2018, at approximately 10:20 AM showed peeling paint and stained ceiling bulkhead in resident room #215C/D, in one (1) of 57 resident's rooms. Observations made, in the presence of Employees #36 and 37, were acknowledged.	L 410	4. The Maintenance Director or designee will check residents rooms for peeling paint and stained ceilings during weekly environmental rounds. The Maintenance Director or designee will report the finding of the weekly environmental rounds at the Quality Assurance Meetings monthly X 3 months to ensure compliance.	2/28/18
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations, the facility failed to maintain essential equipment in safe operating condition as evidenced by a torn door gasket from one (1) of two (2) food warmers. Findings included... Observation on January 9, 2018 at approximately 9:00 AM showed a torn door gasket on the bottom food warmer, one (1) of two (2) food warmers. Employee #35, present at time of observation, acknowledged the finding.	L 442	1. The torn door gasket on the bottom of the food warmer was replaced during the time of the survey. 2. Other food warmers were check for torn gaskets. No others torn gaskets were found. 3. The Food Service Director will educate dietary staff to report torn or defective gaskets if noticed. 4. The Food Service Director will check the food warmers for torn or defective gaskets during there weekly environmental rounds. The Food service Director will report the finding of the weekly environmental rounds at the Quality Assurance Meetings monthly X 3 months to ensure compliance.	2/28/18