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	095034	A. BUILDING ______ B. WING ______	09/27/2019

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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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Long Term Care Survey was conducted at Carroll Manor Nursing & Rehabilitation from September 23, 2019 through September 27, 2019. Survey activities consisted of a review of 54 sampled residents. The following deficiencies are based on observation, record review and resident 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 resident census during the survey was 212.

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
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal

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

TITLE: Executive Director

(X6) DATE: 11-25-2019

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 Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse 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) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy	F 000		

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F 000	Continued From page 2 PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000	Carroll Manor makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, it's officer, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by the State and Federal laws.	
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in	F 567	1) The resident account authorizations for residents #116, 215, 214, 103, and 15 were obtained by the finance department on or before 10/27/2019. 2) The Business office manager or designee reviewed the current accounts for the current residents to ensure that account authorizations were in place to manage their funds on or before 10/27/2019. 3) The Business Office Manager educated the finance office associates on ensuring that there are account authorization in place to manage resident funds on or before 10/27/2019. The Business Office Manager or designee will audit 100% of the new resident account on a monthly basis times 3 months to ensure that account authorizations are in place to manage resident funds. 4) Results of the monthly audits will be discussed in the monthly QAPI meeting times 3 months to ensure substantial compliance.	10/27/2019

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F 567	Continued From page 3	F 567		

an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for five (5) of 197 sampled residents with a resident funds account, facility staff failed to show written authorization for the facility to manage the residents' personal funds.

Findings include ...

Review of the facility's "Resident Fund Management Service" form documented," By my signature below, I hereby authorized the facility named above to established and mange an FDIC (Federal Deposit Insurance Corporation) insured interest bearing resident fund or burial account with the options as specified above..."

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F 567	Continued From page 4 Review of the facilities trial balance as of September 24, 2019, showed the following residents had asterisk (*) next to their names indicating that the resident's, that had transferring accounts (automatic transfer of care cost payments due the facility) were missing an application: Resident # 116 Resident # 215 Resident # 14 Resident # 109 Resident # 15 There was no evidence that facility staff ensured that five (5) of the 197 resident accounts had signed applications authorizing the facility to manage their funds. The Employee representing the business office was asked to provide proof that the five (5) residents had given the facility authorization to manage their funds. Employee #17, acknowledged the findings, during a face-to-face interview on 9/21/19, at 10:25 AM. Facility staff failed to show written authorization for the facility to manage five (5) residents' personal funds.	F 567	1) The Advance Directive information was offered and for resident #'s 123,77,82,106,117 and 149 and their responses were documented in their medical record on or before 10/27/2019. 2) The Social Worker or designee reviewed current resident documentation to ensure that advanced directives were offered, obtained and documented in the resident records. 3) The Director of Social Services or designee educated the social services team on ensuring that advance directives are offered, obtained and documented in the residents' records. The Social Workers will randomly audit 33 percent of the residents medical records on a monthly basis times 3 months to ensure that advance directive information is offered, obtained, and documented in the resident medical records. 4) The results of the audits will be discussed during the monthly QAPI meeting times 3 months to ensure substantial compliance.	10/27/2019
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		

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F 578	Continued From page 5	F 578		

to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:

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F 578	Continued From page 6	F 578		

Based on record review and staff interview for seven (7) of 54 sampled residents, facility staff failed to allow the Resident/Healthcare Agent the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to develop an advance directive. Residents' #23, #77, #82, #106, #108, #117, and #149.

Findings include . . .

1. Resident #23 was admitted to the facility on 1/9/19, with diagnoses which include Atrial Fibrillation, Chronic Kidney Failure, Heart Failure, Hypertension, and Hyperlipidemia.

A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #23 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive.

During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.

2. Resident #77 was admitted to the facility on 2/25/08 with diagnoses which include Alzheimer's, Dementia, Hyperlipidemia, Hypertension, Diabetes Mellitus, Peripheral Vascular Disease, and Cataract.

A review of the clinical record and the electronic

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F 578	Continued From page 7	F 578		

medical records (EMR) failed to show evidence that Resident #77 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive.

During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.

3. Resident #82 was admitted to the facility on 7/29/17 with diagnoses which include Anemia, Hyperlipidemia, Hypertension, Diabetes Mellitus, Peripheral Vascular Disease, and Major Depressive Disorder.

A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #82 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive.

During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.

4. Resident # 106 was admitted to the facility on 9/17/09 with diagnoses which include Parkinson's Disease, Cerebrovascular Disease, Hypertension, Peripheral Vascular Disease, Atrial Fibrillation, and Major Depression.

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F 578	Continued From page 8	F 578		

A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #106 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive.

During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.

5. Resident #108 was admitted to the facility on 12/3/03, with diagnoses to include Hypotension, Hyperlipidemia, End-stage renal disease, Dementia, Diabetes Mellitus, Major Depression, and Cataract.

A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #108 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive.

During a face-to-face interview with Employee #8 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.

6. Resident #117 was admitted to the facility on

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F 578	Continued From page 9 3/3/16 with diagnoses which include Peripheral Vascular Disease, Atrial Fibrillation, Heart Failure, Hypertension, Osteoarthritis, and Dementia. A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #117 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive. During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding. 7. Resident #149 was admitted to the facility on 12/4/18 with diagnoses which include Osteoarthritis, Heart Failure, Diabetes Mellitus, Anemia, Hypertension, and Macular Degeneration. A review of the clinical record and the electronic medical records (EMR) failed to show evidence that Resident #149 or his/her representative was informed and provided written information concerning the right to accept or refuse medical or surgical treatment and, at the resident's option to formulate an advance directive. During a face-to-face interview with Employee #9 at approximately 11:00 AM on 9/26/19. The employee acknowledged the finding.	F 578		
F 641	Accuracy of Assessments	F 641		

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F 641 SS=D	Continued From page 10 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 54 sampled residents, facility staff failed to accurately code the Minimum Data Sets (MDS) for one (1) resident with a diagnosis of Anxiety, and for one (1) resident with a diagnosis of Hypothyroidism. Residents' #95 and #115 Findings included . . . 1. The facility staff failed to accurately code the MDS for Resident #95's diagnosis of Anxiety. Resident #95 was admitted to the facility on 10/21/15, with diagnoses to include Osteoarthritis, Peripheral Vascular Disease, Hypertension, Hyperlipidemia, Chronic Kidney Disease, Anxiety, and Cataract. Review of the Annual Minimum Data Set [MDS] dated 7/23/19, showed that under Section C [Cognitive Patterns] C1000 Cognitive Skills for daily living Resident #95 was coded as a "3" which indicates the resident's cognition is severely impaired (never rarely made decision). Under Section, I [Active Diagnoses], I5700 [Anxiety Disorder] the indicator box was left blank indicating "not coded for Anxiety."	F 641	1) The assessment for resident #115's MDS was modified on 9/30/2019 to include the diagnosis of hypothyroidsm. 2) The MDS coordinators conducted and audit of current residents' most recent MDS to ensure that active diagnosis are coded in section I of the MDS. 3) The MDS coordinators were educated by the MDS manager on ensuring that current diagnosis' are coded in section I of the MDS. The MDS coordinators will randomly audit 33 percent of the MDS assessments times 3 months to ensure that active diagnosis' are coded in the MDS. 4) The results of the monthly audits will be discussed in the monthly QAPI meeting times 3 months to ensure substantial compliance.	10/27/2019

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F 641	Continued From page 11 A face-to-face interview was conducted on 9/26/19 at approximately 11:04 AM with Employee #12. The employee acknowledged the findings. 2. The facility staff failed to accurately code the MDS for Resident #115's diagnosis of Hypothyroidism. Resident #115 was admitted to the facility on 8/13/18, with diagnoses to include Hypertension, Encephalopathy, Atrial Fibrillation, Dementia, Hyperlipidemia, and Hypothyroidism. Review of the Annual Minimum Data Set [MDS] dated 7/30/19, showed that under Section C [Cognitive Patterns] C1000 Cognitive Skills for daily living Resident #95 coded as a "3" which indicates the resident's cognition is severely impaired (never rarely made decision). Under Section, I [Active Diagnoses], I3400 [Thyroid Disorder] the indicator box was left blank indicating "not coded for Hypothyroidism." A face-to-face interview was conducted on 9/26/19 at approximately 11:04 AM with Employee #12. The employee acknowledged the findings.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		

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F 656	Continued From page 12 §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 (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 record review and staff interview for two (2) of 54 sampled residents, facility staff	F 656	1) Resident #107's careplan was updated to include psychotropic medication on 9/27/20169. Resident #117s Careplan was updated to include nebulizer treatment usage on 9/26/2019. 2)Based on the record review there were no other resident care plans identified to need an update. 3) The Nurse Manager or designee will audit 33% of the resident care plans on a monthly basis times 3 months to ensure that the careplans are person-centered. 4)The results of the audits will be discussed during the monthly QAPI times 3 months to ensure substantial compliance.	10/27/2019

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F 656	Continued From page 13 failed to develop and implement a comprehensive person-centered care plan for the use of psychotropic medications for one (1) resident and the use of nebulizer treatments for one (1) resident. Residents' #107 and #117. Findings include. . . 1. Resident #107 was admitted to the facility on June 30, 2017 with diagnoses to include Anxiety Disorder, Depression and Psychotic Disorder; Thyroid Disorder, Hypertension and Diabetes. Review of the Physician's Order Sheet showed a Physician's Orders dated February 11, 2019 which directed Risperidone (used to treat certain mental/mood disorders) 0.5mg PO daily for psychotic episodes and behavior disturbances and Cymbalta (used to treat depression and anxiety) 30mg PO Bid for Depression. Review of Annual MDS dated May 14, 2019 Section N0410 (Medications Received) showed the resident was coded for receiving Antidepressant and Antipsychotic medications. However, review of the resident's care plans failed to show any evidence of a care plan that was developed for the resident's use of Antidepressant and/or Antipsychotic medications. Facility staff failed to develop and implement a comprehensive person-centered care plan for	F 656		

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F 656	Continued From page 14	F 656		

Resident# 107 use of psychotropic medications. Employee #8 acknowledged the finding during face-to-face interview on September 27, 2019 at approximately 11:00 AM.

2. Resident #117 was admitted to the facility on 3/3/16 with diagnoses which include Atrial Fibrillation, Heart Failure, Hypertension, Pulmonary Edema, and Dementia.

Review of the Physician's Order Sheet dated 9/2019, showed the following current medication orders:

5/31/19 " Albuterol Sulfate solution (used to treat wheezing and shortness of breath) for Nebulization 1.25mg/3ml, Administer 1 vial via nebulizer three times a day as needed for Wheezing."
6/3/19 "Rinse nebulizer cup and allow to dry after each neb treatment before storage 3 times per day during the day, evening, night."
6/3/19 "Change neb tubing and neb cup every week on Monday 1 time per day every Monday"
6/3/19 "Change oxygen tubing every week on Monday 1 time per day every Monday"

A review of the Quarterly Minimum Data Set dated 7/30/19 showed that under Section I [Active Diagnoses] I0600 Resident #117 was coded for Heart Failure (e.g., congestive heart failure and Pulmonary edema).

A review of the resident's care plan failed to show goals and approaches for the resident's use of nebulizer treatment as needed.

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F 656	Continued From page 15 A face-to-face interview was conducted with Employee #9 on 9/26/19, at approximately 3:00 PM. The employee reviewed the record and acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 657	1) The Careplan for resident #43 was revised/ updated on 9/27/19 to include resident-centered goals and approaches for oxygen therapy. Resident #415's careplan was updated on 9/27/2019 to include resident-centered goals and appraches for foley catheter care. 2) Based on record review there were no other resident careplans identified to need an update. 3) The Nurse Managers were educated on updating careplans to ensure that they are person-centered. The Nurse Managers or designee will audit 33 percent of the resident care plans on a monthly basis time 3 months to ensure that the care plans are person-centered. 4) The results of the audits will be discussed during the monthly QAPI times 3 months to ensure substantial compliance.	10/27/2019

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F 657	Continued From page 16	F 657		

interview for two (2) of 54 sampled residents, facility staff failed to revise/update care plan with resident-centered goals and approaches for one (1) resident's use of oxygen and for Foley catheter care for one (1) resident. Residents' #43 and #415.

Findings included...

1. Review of Resident 's #43 admission record showed resident was admitted to the facility on 12/4/13 ,with the diagnoses which include Hypertension, Gastroesophageal Reflux Disease, Shortness of Breath, Edema and Heart Failure.

Review of the Admission Minimum Data Set [MDS] dated 7/9/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "12" which indicate resident is cognitively intact.

Review of the physician's order sheet dated 8/1/19 showed "02 (Oxygen) 2L/M (minute) nasal cannula (N/C) as needed for Shortness of Breath (SOB)."

Further review of the Treatment Administration Record showed "O2 2L/M N/C as needed for SOB"

Review of the medical record showed a care plan which did not include goals and approaches for a resident's use of oxygen therapy (as needed).

Facility staff failed to show evidence of a

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revised/updated resident-centered care plan to include goals and approaches for oxygen therapy for Resident #43.

During a face-to-face interview on 9/27/19 at 11:30 AM, Employee #6 acknowledged the findings.

2. Review of Resident 's #415 admission record showed resident was admitted to the facility on 7/15/19, with the diagnoses which include Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection and Heart Failure.

Review of the Admission Minimum Data Set [MDS] dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "15" which indicates resident is cognitively intact. Further review of the MDS showed Section H [Bladder and Bowel] H0100 Appliances, Indwelling catheter (including suprapubic catheter and nephrostomy tube) is selected to indicate the resident has an indwelling catheter (Foley).

Review of the physician's order sheet dated 8/1/19 showed, "change Foley bag 1 time per day every 7 days during night"

Review of the medical record showed a care plan "Problem: Indwelling catheter for urinary retention." Approaches: Assess fluid and hydration status and record the findings, Assess for any previous diagnostic test, urine culture post residual void, Monitor for acute pathologies putting resident at risk for urinary incontinence ..."

Facility staff failed to show evidence of a

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F 657	Continued From page 18 revised/updated resident-centered care plan to include goals and approaches for Foley catheter care. During a face-to-face interview on 9/27/19 at 10:40 AM, Employee #6 acknowledged the findings.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to provide care in accordance with acceptable standards of practice as evidenced by a registered nurse signing and placing an order on a form intended for the physician/prescriber to complete and sign. Resident # 214. Findings included... Facility staff (registered nurse) signed a medication regimen review form for a medication dose reduction that was intended for the prescriber/physician to sign. Review of Resident # 214 discharge summary showed resident was admitted to the facility on 6/18/19 and discharged to home on 8/1/19.	F 658	1) The medication regimen review form was signed by the physician on 9/27/2019,. 2) Based on record review, there were not other medication regimen review forms signed by a nurse. 3) Lincensed nursed were inserviced on "not to sign" medication review forms that are addressed to physicians. The unit manager or desingee will audit 33 percent of the medication regimen review forms times 3 months to ensure that they are signed by the prescriber of physician 4)Results of the audits will be discussed during the monthly QAPI meeting times 3 months to ensure sustantial compliance.	10/27/2019

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Review of Resident # 214's closed record on 9/27/19 at 3:00 PM showed [Pharmacy Name] note to Attending Physician/Prescriber dated 7/24/19 which reads "Colchicine (works by decreasing swelling and lessening the buildup of uric acid crystals that cause pain in the affected joint) should be used cautiously in geriatric patients ...recommend review and determine if she is a candidate for further dose reduction.

Further review of the form showed a box "Agree" and the box was checked to indicate the recommendation was accepted. A further review of the form showed "order to d/c (discontinue) colchicine and collect lab." The form dated 7/29/19 is signed by a registered nurse; however, the form was intended for the signature of a physician/prescriber to either agree or disagree with the pharmacist recommendation.

Facility staff failed to adhere to acceptable standards of practice as evidenced by a registered nurse signing and placing an order on a form intended for the physician/prescriber to complete and sign.

During a face-to-face interview on 9/27/19 at 4:00 PM Employee #4 stated she is not the physician the nurse should have not signed the form. At the time the form was reviewed Employee #4 acknowledged the finding.

F 684 SS=D Quality of Care CFR(s): 483.25 F 684

§ 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

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F 684	Continued From page 20 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 54 sampled residents, facility staff failed to ensure treatment and care was in accordance with professional standards of practice according to physician's orders. Resident # 415. Findings included... Facility staff failed to follow physician's order to insert a Foley catheter (is a thin, sterile tube inserted into your bladder to drain urine) size 16 fr.(French). Review of Resident #415's admission record showed resident was admitted to the facility on 7/15/19, with the diagnoses which include Hypertension, Gastroesophageal Reflux Disease, Urinary Tract Infection and Heart Failure. Review of the Admission Minimum Data Set [MDS] dated 7/22/19, showed, Section C [Cognition] a Brief Interview for Mental Status [BIMS] score of "15" which indicate resident is cognitively intact. Further review of the MDS showed Section H [Bladder and Bowel] H0100 Appliances, Indwelling catheter (including suprapubic catheter and nephrostomy tube) is selected to indicate the resident has an indwelling catheter (Foley).	F 684	1) Physician order for foley size for resident #415 was updated to reflect the current cather inserted size of 18 on 9/27/2019. 2) Based on record review and resident assessment, there were no other foley catheter orders that needed to be updated with the actual cather size. 3) Licensed nursing staff was inserviced on ensuring that treatment was in occordence with physuician order. The unit manager or designee will audit 100 percent of residents with foley cathers on a monthly basis times 3 months to ensure that the size inserted reflects physician orders. 4) The results of the audit will be discussed during the monthly QAPI times 3 months to ensure substantial compliance.	10/27/2019

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F 684	Continued From page 21 Review of the physician's order sheet dated 8/1/19 showed "insert Foley catheter 16 French, inflate with 10 cc balloon every 30 days and prn (as needed) for urinary retention time per day every ..." Observation on 9/27/29 at 10:00 AM showed Employee #11 providing catheter care. Employee # 11 was asked what size is the Foley catheter? Employee #11 responded it should be size 18 but let me check. Employee #11 showed the catheter tubing (inserted into the patient) and stated "it is a size 16 not 18." Writer noted the Foley catheter inserted was a size 18. Facility staff failed to ensure treatment was in accordance to physicians' order. During a face-to-face interview on 9/27/19 at 10:00 AM, Employee #11 acknowledged the findings.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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 54 sampled residents, facility staff failed to ensure the dialysis communication form used to reflect ongoing	F 698		

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F 698	Continued From page 22 collaboration between the facility and dialysis staff was included in the medical record for Resident #108. Findings included... Facility staff failed to ensure the dialysis communication form used to reflect ongoing collaboration between the facility staff and dialysis staff was included in Resident #108's medical record. Resident #108 was admitted to the facility on 12/3/03, with diagnoses to include Hypotension, Hyperlipidemia, End-stage renal disease, Dementia, Diabetes Mellitus, Major Depression, and Cataract. Review of the Resident #108's medical records from 7/26/19 to 9/26/19, showed that Resident #108 goes to Dialysis on Tuesdays, Thursdays, and Saturdays. The resident's dialysis record for communication between the dialysis center and the facility was not included as part of the resident's medical record. Observation made on 9/25/19, at approximately 10:46 AM of the resident's dialysis communication record and the medical record showed that they were maintained in separate binder and not as a part of the resident's active clinical record. A face-to-face interview was conducted with Employee #8 on 9/25/19, at approximately 10:46 AM. She acknowledged the findings.	F 698	1) The dialysis communication form for resident #108 was included in the resident's medical record on 9/25/2019. 2) Dialysis communication forms were included in the medical record of the other resident, who reveives dialysis on 9/25/2019. 3) The Unit Managers were inserviced to ensure that the dialysis communication form is included in the medical record of residents, who receive dialysis. The unit manager or designee will audit 100 percent of the medical records of the residents, who recieve dialysis to ensure that the dialysis communication forms are in the medical records. 4) The result of the audits will be discussed during the monthly QAPI meeting to ensure substantial compliance.	10/27/2019

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by soiled floors on five (5) of five (5) resident care units. Findings included... During observations on September 23, 2019, at approximately 10:00 AM, Pantry floors on five (5) of five (5) resident care units were soiled with grime (dirt dark in color) throughout. Employee #13 acknowledged the findings during a face-to-face interview on September 23, 2019, at approximately 1:00 PM.	F 812	1) The pantry floors on the 5 residen units were cleaned on 9/23/19. 2) Upon observation there were no other identified areas that needed to be cleaned. 3) The pantry workers were inserviced on ensuring cleanliness of the pantry floors. The Dining Services Manager willrandomly observe 2 units per week times 3 months to ensure floor cleanliness. 4)Results of the observations will be discussed during the monthly QAPI to ensure substantial compliance.	10/27/2019

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	1) The solution for the 3 compartment sink was mixed correctly on 9/23/2019. The pans were air-dried on 9/23/2019. 2) The solution for the 3 compartment sink solution was mixed correctly on 9/23/2019. Based on the observation , the other cookware was dried appropriately on 9/23/2019. 3) The Dining staff was inserviced on ensuring that the 3 compartment sink solution is tested correctly and that cookware is dried appropriately. The dining services on a weekly basis times 3 months to ensure that the cookware is dried appropriately. 4) The results of the observations will be discussed during the monthly QAPI times 3 months for substantial compliance.	10/27/2019

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	095034	A. BUILDING ______ B. WING ______	09/27/2019

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F 880	Continued From page 25 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to prepare foods under sanitary conditions as evidenced by failure of staff to correctly test the sanitizing solution from the three-compartment sink and ensure that the sanitizing solution is mixed correctly, failure of staff to properly handle clean cookware and soiled floors on five (5) of five (5) resident care units.	F 880		

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F 880	Continued From page 26 Findings included... During observations of dietary services on September 23, 2019, at approximately 10:00 AM: 1. An employee was observed using the three-compartment sink to clean and sanitize pots and pans. When asked to test the sanitizing solution from the three-compartment sink, Employee #11 dipped the test strip into the solution and quickly withdrew it. Employee #11 was unable to verbalize how long the test strip should remain inserted in the sanitizing solution and what the expected result of the test should be. Employee #8 who was present at the time was asked to test the sanitizing solution and correctly completed the test. However, the sanitizing solution tested at less than 200 Parts per Million (PPM). Posted manufacturer's recommendations for testing the sanitizing solution are to dip the test strip in the solution for ten (10) seconds and the color change to the test strip should indicate a level between 200 to 400 PPM. The sanitizing solution was discarded and another solution was initiated. At the time of observation, Employee #13 had just begun to clean and disinfect the pots and pans. 2. Staff was observed using paper towels to dry small pans that had been cleaned through the dishwashing machine. There was no evidence that facility staff used the	F 880		

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F 880	Continued From page 27 appropriate drying method (such as drip dry) to reduce the spread of bacteria on the cookware. Employee #13 acknowledged the findings during a face-to-face interview on September 23, 2019, at approximately 1:00 PM.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to maintain mechanical and electrical equipment in good condition as evidenced by torn gasket from the walk-in freezer and one (1) ceiling light did not have a protective cover. Findings included ... During an environmental tour of the facility on September 24, 2019, between 10:30 AM and 12:30 PM: 1. One (1) of 10 ceiling lights located in the dining room on the fifth floor did not have a protective cover. 2. During a tour of dietary services on September 9, 2019, at approximately 10:00 AM, a gasket hanging loose from the bottom of the door to one (1) of one (1) walk-in freezer was torn. During a face-to-face interview on September 24, 2019, at approximately 12:30 PM, Employee #13	F 908	1) The ceiling light on the 5th floor was covered on 9/24/2019. The freezer gasket was replaced on 9/25/2019. 2) No other ceiling lights were identified to need gaskets. 3) The dining services staff was educated on the process for reporting items in need of repair. The dining services maager will randomly observe the dining rooms and kitchen on a weekly basis to ensure that maintenance needs are reported to maintenance. 4) Results of the observbation will be reporte during the monthly QAPI times 3 months to ensure substantial compliance.	

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

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F 908	Continued From page 28 and/or Employee #15 acknowledged the findings.	F 908		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in four (4) of 95 resident's rooms that did not emit an audio or visual alarm when tested. Findings included... During an environmental walkthrough of the facility on September 24, 2019, between 10:30 AM and 12:30 PM, call bells in resident rooms #309, #342, #450 and #522 did not alarm when tested, four (4) of 95 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. Employee #14 and/or Employee #15 acknowledged the above findings during a face-to-face interview on September 24, 2019, at approximately 12:30 PM.	F 919	1) The call bells in residnet room #'s 309, 342, 450, 522 were repaired don 9/24/2019. 2) No other calls bells were identified to be in need of repair. 3) Maintenance staff was inserviced on maintaining the call bell system in good working condition. The Maintenance manager or designee will randomly audit 33 percent of the resident call bells on a monthly basis times 3 months to ensure that they are in good working condition .	10/27/2019