STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	04/30/2018

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 Long Term Care Survey was conducted at Deanwood Rehabilitation & Wellness Center from April 23 through April 30, 2018. Survey activities consisted of a review of 53 sampled residents. The following deficiencies are based on observation, record review, 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 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 CFU Colony Forming Unit 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	F 000	**DEANWOOD REHABILITATION AND WELLNESS CENTER DISCLAIMER.** Facility submits this plan of correction under procedures established by the Department of Health In order to comply With the Department's directive to change Conditions which the Department alleges are deficient under state Regulations Relating to long term care. This should not be construed as either a waiver of the Facility's right to appeal and to Challenge the accuracy or severity of the alleged Deficiencies or any Admission of any wrong doing.	6/10/18

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

CNHA 5/31/18

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	F 000		6/10/18

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
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
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
SCSA Significant change status assessment
Sol- Solution
TAR - Treatment Administration Record
Trach- Tracheostomy
TX- Treatment

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F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) . §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 53 sampled residents, facility staff failed to convey within 30 days of the resident's death a final accounting of funds in accordance with state law for Resident #T1. Findings included... A review of the facility Trial Balance record dated April 27, 2018, showed a pending balance for $1121.37 for Resident #T1 who expired at the facility on March 11, 2018.	F 569	F569 **Corrective action for the residents affected:** 1. This facility cannot be retroactively correct the deficiency. Education will be provided to Business Office Manager and Accounts Payable Representative to ensure resident funds is conveyed within 30days upon discharge, eviction or death in accordance with State law. **Identification of others with potential to be affected.** All resident residing in the facility have potential to be affected. 1. Immediate house wide audit of residents Funds will be completed to ensure resident funds is conveyed within 30days upon discharge, eviction or death in accordance with State law. Any issue found will be addressed. **Measures to prevent recurrence:** Education will be provided to Business Office Manager and Accounts Payable Representative to ensure resident funds is conveyed within 30days upon discharge, eviction or death in accordance with State law. **Monitoring corrective action:** Monthly audit will be completed by Manager and Accounts Payable Representative to ensure resident funds is conveyed within 30days upon discharge, eviction or death in accordance with State law. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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F 569	Continued From page 3 During an interview on April 27, 2018, with Employee #17, Accounts Payable Representative, he stated, "I found the mistake, it's being taken care of now." Facility staff failed to convey Resident #T1's, funds and provide a final accounting within 30 days of the resident's death. Employee #17, acknowledged the finding at the time of the record review.	F 569		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584	F584 **Corrective action for the residents affected:** 1. All identified window blinds in resident rooms identified were cleaned on 4/24/18. 2.The hopper sink located on 5 south was repaired on 4/30/18. 3.The water dispensers from the ice machines on 2 North and 2 South were cleaned on 4/24/18 **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1.An audit of all window blinds was completed to assure any dusty blind were cleaned. No residents were identified as affected. 2.An inspection throughout the facility has been conducted to inspect Hopper sinks .Any issues found during this inspection have been addressed to ensure the facility stays in compliance No residents were identified as affected.	6/10/18

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F 584	Continued From page 4 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations made on April 24, 2018, between 9:45 AM and 3:30 PM, the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable as evidenced by dusty window blinds in seven (7) of 53 resident rooms, one (1) of six (6) malfunctioning hopper sinks and two (2) of six (6) soiled water dispensers. Findings included ... 1. Window blinds were dusty in seven (7) of 53 resident rooms. 2. The hopper sink located on 5 South did not flush when tested, one (1) of six (6) hopper sinks in the facility. 3. The water dispensers from the ice machines on 2 North and 2 South were soiled throughout,	F 584	3. An inspection throughout the facility has been conducted to inspect the water dispensers from the ice machines to assure the facility stays in compliance. No residents were identified as affected. **Measure to prevent recurrence:** Housekeeping /Maintenance staffs have been in-serviced on the importance of providing necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interiors **Monitoring Corrective action:** Random Environmental audits will be conducted by the Director of Engineering/ Director of house keeping services weekly times 3, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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F 584	Continued From page 5 two (2) of six (6) water dispensers in the facility. These observations were made in the presence of Employee #21 and Employee #22 who acknowledged the findings.	F 584		
			F641	**6/10/18**
F 641 SS=D	Accuracy of Assessments 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, resident and staff interviews and record review for (1) of 53 sampled residents, the facility failed to accurately code the resident's oral status on the Minimum Data Set (MDS) assessment. Resident #125. Findings included... The clinical record showed that Resident #125 was admitted to the facility on November 23, 2016, with the following diagnoses: Alzheimer's Dementia, Chronic Kidney Disease Stage 3, Glaucoma, Hypertension, and Adult Failure to Thrive. Resident #125 was observed eating lunch in her room on April 23, 2018, at approximately 12:30 PM. Resident #125 was asked how she liked her food. Resident #125 stated, "I don't like this mashed food ... maybe if I had dentures, I can eat better."	F 641	**Corrective action for the residents affected:** Resident #125 was reassessed on 4/27/18. The MDS section was modified on 4/27/18 Section LO200B, of the MDS of ARD 11//30/17 for resident #125 was modified on 4/27/18 to reflect the accurate coding of oral status. Resident suffered no negative outcome. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. All residents' oral status will be assessed, for natural or no natural tooth (edentulous) for accurate coding per RAI instructions. Any issues found during the assessment will be resolved and or modified. No residents were identified as affected. **Measures to prevent recurrence** MDS coordinators will receive formal education on the assessments and coding of Section LO200B oral status per RAI Manual guidelines. MDS coordinators, will review all records, Assess and perform residents interview of all residents in the building and new admission of their oral status prior to coding and upon coding the MDS daily.	

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F 641	Continued From page 6 Review of the "Admission/Readmission Screener" form dated November 25, 2016, showed on the "Oral/Nutritional" section that Resident #125 was assessed as edentulous [lacking teeth]. Review of the Annual MDS Assessment completed on December 6, 2017, showed that section L0200 Dental/Oral Status was marked as "None of the above were present" indicating the resident was not edentulous [the resident has teeth]. During a face-to-face interview with Employee #16 on April 25, 2018, at approximately 2:30 PM, she stated, "[Resident #125] never had any teeth since she got admitted. She has requested for dentures, and she is being followed by the dentist." During an interview on April 25, 2018, at 3:10 PM, Employee #5 acknowledged that the Annual MDS assessment was not coded accurately to reflect Resident #125's oral status.	F 641	**Monitoring Corrective action:** MDS coordinators will complete audits to include all OBRA and Medicare assessments weekly times 4, then monthly times 3. The findings will be completed and reported to The Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
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 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	F656 **Corrective action for the residents affected:** Resident #383 was reassessed on 4/26/18 The smoking section of comprehensive care plans were modified and updated on 4/26/18. Resident suffered no negative outcome. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected.	6/10/18

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F 656	Continued From page 7 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 one (1) of 53 sampled residents, the facility failed to develop a smoking care plan for Resident # 383 who was identified as a smoker upon admission to the facility.	F 656	1.All the Assistant Director of Nursing/Designee will complete house wide assessment/audit of residents' smoking status. 2. Assistant Director of Nursing/ Designee will develop comprehensive care plan within 7 days after completion of the comprehensive assessment. 3. All the Assistant Director of Nursing/Designee will review, and revise care plans to assure smoking care plans are initiated/ modified in a timely manner. Any issues found during the audit/ assessment will be resolved and or modified. No residents were identified as affected. **Measures to prevent recurrence** Licensed Nurses will be in-serviced on the Importance of ensuring comprehensive assessment of residents' and Initiating/modifying smoking care plans in a timely manner. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents' smoking status weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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F 656	Continued From page 8 Findings included... The resident was admitted to the facility on April 18, 2018, with diagnoses which included Schizophrenia, Unspecified, Type 2 Diabetes Mellitus without Complications, Chronic Viral Hepatitis C, Bipolar Disorder, Altered Mental Status, Unspecified, and Noncompliance with other Medical Treatment and Regimen. Review of the "Smoking Evaluation" form completed on April 18, 2018, revealed the resident was assessed as being a smoker and determined by the interdisciplinary team to be a safe smoker. Review of the resident's care plans failed to reveal a care plan with goals and interventions to address safe smoking. During a face-to-face interview with Employee #10 at approximately 4:00 PM on April 25, 2018, the employee acknowledged the record lacked a smoking care plan.	F 656		6/10/18
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	F 657	F657 **Corrective Action for resident affected.** Resident # 207 was reassessed on 4/26/18 Resident was reassessed again on 5/29/18 Nutrition care plan was revised and updated on 4/26/18 to reflect the physician order of Regular diet, Regular texture, thin Consistency (double portion), No seafood.	6/10/18

Resident

suffered no negative outcome.

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F 657	Continued From page 9 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 record review and staff interview for one (1) of 53 sampled residents, the facility failed to revise the care plan for one (1) resident's change in diet. Resident #207. Findings included... Resident #207 was admitted to the facility February 12, 2018, with diagnoses to include End-stage Renal Disease with dependence on renal dialysis. The resident was coded as having a therapeutic	F 657	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. The interdisciplinary team will review and revise care plans to assure nutrition care plans are updated with appropriate diet order in a timely manner. Any issues found during the audit will be addressed. No Residents were identified as affected. **Measure to prevent Recurrence:** Interdisciplinary team and all staff involved in the Care planning process will be in-serviced to ensure Nutrition care plan is revised and modified in a timely manner. **Monitoring Corrective Action:** Lead Dietitian/Director of Nursing or designee will complete random audits of resident's Medical records to ensure the interdisciplinary team is reviewing/modifying nutrition care plan to reflect any diet changes in a timely manner. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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F 657	Continued From page 10 diet under Section K0510 (Nutritional Approaches) on the Admission MDS completed on February 19, 2018. The Physician's Order dated April 17, 2018, directed, "Regular diet, Regular texture, Thin consistency, (double Portion), No seafood." The current care plan initiated date February 13, 2018, and reads: "Focus: The resident is at nutritional risk r/t [related to] ESRD [end stage renal disease] w [with]/hemodialysis and requiring therapeutic diet (Renal/LCS) with fluid restriction. Goal: The resident will maintain intake of 75% of at least 2 [two] meals/Day. Intervention: Provide Renal/LCS [low concentrate sweet] diet, regular texture (double portion) per preference." A review of the resident's current care plan for diet lacked evidence that facility revised the plan with new goals and approaches to address the resident change in diet. Employee #15 acknowledged the finding during a face-to-face interview on April 26, 2018, at 11:00 AM and he presented a copy of the care plan updated on April 26, 2018.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689	**F689** **Corrective action for resident affected:** The identified urge protectors in resident rooms were mounted and secured on 4/24/18 **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected.	6/10/18

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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) COMPLETION DATE
F 689	Continued From page 11 accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on April 24, 2018, between 9:45 AM and 3:30 PM, the facility failed to maintain resident's environment free of accident hazards as evidenced by surge protectors that were not secured in three (3) of 53 resident rooms. Findings included ... Surge protectors were not mounted or secured in three (3) of 53 resident rooms. These observations were made in the presence of Employee #21 and/or Employee #22 who acknowledged the findings.	F 689	An inspection throughout the facility has been conducted to inspect surge protectors. Any issues found during the inspection was Corrected on 4/24/18 **Measure to prevent recurrence:** Maintenance staffs have been in-serviced to assure that surge protectors are well mounted and secured.in resident rooms. **Monitoring Corrective action:** Random Environmental audits will be conducted by the Director of Engineering or designee weekly times 3, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756	F756 **Corrective action for resident affected:** 1.This facility cannot be retroactively correct the deficiency. Education was provided to Physicians, Nurse Practitioners and Licensed Nurses on the importance of addressing the Pharmacist's Consultation Report/Medication Regimen Review to specify what action would be taken and document the rationale for the action in a timely manner. Resident # 49 was assessed on 4/30/18, Resident suffered no negative outcome.	6/10/18

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F 756	Continued From page 12 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 53 sampled residents, the resident's attending physician failed to address the pharmacist's Consultation Report/Medication Regimen Review to specify what action would be taken and document the rationale for Resident #49's use of Ferrous Sulfate (iron). Findings included ... Resident #49 was admitted to the facility on April 30, 2017, with diagnoses, which included Anemia, Anxiety Disorder and Dementia. Review of the current Physician's order and the	F 756	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents' Pharmacist's Consultation Report/Medication Regimen Review. 2.Any issues found during the audit/ assessment will be resolved and or modified. No residents were identified as affected. **Measures to prevent recurrence:** Physicians, Nurse Practitioners and Licensed Nurses will be in-serviced quarterly on the importance of addressing the Pharmacist's Consultation Report/Medication Regimen Review to specify what action would be taken and document the rationale for the action in residents' medical records in a timely manner. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents' Pharmacist's Consultation Report/ Medication Regimen Review weekly times 4, then monthly times 3 months.	6/10/18

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F 756	Continued From page 13 April 2018 Medication Administration Record shows Resident #49 has been receiving Ferrous Sulfate 325 mg by mouth two times a day for Anemia since May 13, 2017. Review of the medical record showed on December 21, 2017, the pharmacist conducted a Medication Regimen Review with a recommendation to reduce iron with [12/11/17] Hgb [Hemoglobin] =12.8. The recommendation was not addressed until March 8, 2018, when the resident's psychiatrist addressed the recommendation by responding "Other" and there were no additional comments recorded in the medical record to clarify the physician's response to "Other". There is no evidence the pharmacist's recommendation was addressed in writing by the attending physician to document his rationale for continued use of ferrous sulfate. During a face-to-face interview with Employee #15 at approximately 10:00 AM on April 30, 2018, he acknowledged the findings.	F 756	Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
			F812	**6/10/18**
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	F 812	**Corrective action for resident affected:** 1. The identified ice machine located in the main kitchen as cleaned on 4/24/18. 2. The identified fire suppression plastic Covers were soiled with a sticky substance and they were cleaned on 4/24/18 3. The identified kitchen hood baffles were soiled with were cleaned on 4/24/18.	

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F 812	Continued From page 14 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 made on April 23, 2018, between 8:55 AM and 3:00 PM, it was determined that the facility failed to prepare and serve foods under sanitary conditions as evidenced by one (1) of one (1) soiled ice machine, six (6) of six (6) soiled fire suppression covers, stained kitchen hood baffles, drain lines from one (1) of one (1) three-compartment sink and from one (1) of two (2) garbage disposal systems that extended into the drain and soiled water dispensers from two (2) of six (6) Ice machines in the facility. Findings included ... 1. One (1) of one (1) ice machine located in the main kitchen was soiled on the inside with a moist, yellowish substance. 2. Six (6) of six (6) fire suppression plastic covers were soiled with a sticky substance. 3. Kitchen hood baffles were soiled with grease deposits. 4. One (1) of four (4) drain lines from the	F 812	4.The identified drain lines from the three-compartment sink extended too far into the drain and it was fixed on 4/23/18. 5. The identified drain lines from the Garbage disposal system located close to the Fryer extended too far into the drain and it was fixed on 4/23/18. 6. The water dispensers from the ice machines on 2 North and 2 South were cleaned on 4/ 24/18. **Identification of others with the potential to be affected.** All residents residing in the facility have the potential to be affected. An inspection was done throughout the facility to ensure the inside of all ice Machines are clean, that the fire suppression plastic covers are clean, kitchen hood baffles are clean, all drain lines don't come too close to the drain, of all ice machine dispensers are clean. **Measure to Prevent Recurrence:** Maintenance, Housekeeping and Food & Nutrition Services staff will be in-serviced on the Importance of ensuring the Ice machine, fire Suppression plastic covers and the kitchen hood baffles are cleaned . Drain lines should not be extended too far in the drain and all ice machines dispensers are clean.	6/10/18

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F 812	Continued From page 15 three-compartment sink extended too far into the drain. 5. Three (3) of four (4) drain lines from the garbage disposal system located close to the fryer extended too far into the drain. 6. The water dispensers from the ice machines on 2 North and 2 South were soiled throughout, two (2) of six (6) water dispensers in the facility. These observations were made in the presence of Employee #20 and/or Employee #22 who acknowledged the findings.	F 812	**Monitoring Corrective Action:** Random audits will be conducted by the Director Maintenance or designee, Director Food and Nutrition services or designee, Lead Dietitian or designee and Director of housekeeping or designee weekly times 3. Then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee Monthly for the next 3 months.	6/10/18
F 880 SS=D	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	F 880	**F880** **Corrective action for resident affected.** 1. Resident # 267 was reassessed on 4/24/18. Resident # 267 bed was wiped clean and bedspread was replaced with a clean one. Education was provided to Employee #13 following the infection control guidelines for safe handling of soiled linens which include: "Remove the dirty linens from the bed. Place the dirty linens in a plastic bag before placing them in the linen hamper. Do not place the linens on the floor or on any other surface to help control the spread of infection." Resident suffered no negative outcome.	6/10/18

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F 880	Continued From page 16 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: (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	F 880	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. 1. Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents to identify potential communicable disease or infection before they can be spread to another resident in the facility. 2. Any issues found during the audit/ assessment will be addressed.. No residents were identified as affected. **Measures to prevent recurrence** Facility staff will be in-serviced on infection Control/ prevention to ensure standard and transmission- based precaution are followed to to prevent spread of infection. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents to identify potential communicable disease or infection before they can be spread to another resident in the facility, weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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F 880	Continued From page 17 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 observation and staff interview for (1) of 53 sampled residents, the facility staff failed to follow accepted standards of infection control practices to prevent potential contamination and spread of infection related to handling soiled linens in a resident room. Resident # 267. Findings included ... According to the Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving, 2nd edition, Guidelines for Handling Linens include: "Remove the dirty linens from the bed. Place the dirty linens in a plastic bag before placing them in the linen hamper. Do not place the linens on the floor or on any other surface to help control the spread of infection." During an interview with Resident #267 on April 24, 2018, at 10:30 AM inside the resident's room, Employee#13 was observed carrying four (4) tied bags of soiled linens after rendering care to Resident # 586. At this time, Employee #13 placed the bags on top of Resident #267's clean bedspread. This observation was brought to Employee #13's	F 880		

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F 880	Continued From page 18 attention. Employee#13 stated, "I know this is an infection control procedure. I was told that we are not supposed to put dirty linens in the trash can so I just placed the bags on the bed first before taking them out." On April 24, 2018, at approximately 3:30 PM, Employee #14, Assistant Director of Nursing (ADON) on 2N (North) was asked to explain their process of handling soiled linens and trash. Employee#14 stated, "The Certified Nursing Assistant (CNA) has a hamper by the door to contain dirty linens and trash- one compartment is for dirty linens, one compartment is for trash. She should have disposed of the linens and the trash in the hamper. We made sure that we replaced Resident #267's bedspread with a clean one and we just did an in-service with the staff on how to handle soiled linens and trash."	F 880		