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 _____	04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 BURROUGHS AVE. NE WASHINGTON, DC 20019

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on March 24, 2021 through April 7, 2021. Survey activities consisted of a review of 11 sampled residents. 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. This includes the facility's non compliance with 42 CFR §483.80 infection control regulations. The resident census was 254. Listed below is a directory of abbreviations and/or acronyms that may be utilized throughout the body of this report: AV- arteriovascular/arteriovenous b/p - blood pressure ESRD - End Stage Renal Disease FR - French MAR - Medication Administration Record mcg- microgram MD - medical doctor MDS - Minimum Data Set mg- milligram PCC - Point Click Care PPE - Personal Protective Equipment Q - every r/t - related to Rt - right Sat - Saturday TAR - Treatment Administration Record Thu - Thursday Tue - Tuesday v/s - vital signs X - times	F 000	Disclaimer: Facility submits this plan of correction Under procedures established by the Department of Health to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to long term care. This should not be construed as either a waiver of the facility's right to appeal or to appeal or to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrongdoings.	
F 552	Right to be Informed/Make Treatment Decisions	F 552		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 4/21/21

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 552 SS=D	Continued From page 1 CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 11 sampled residents, facility staff failed to inform the resident's responsible party of his quarantine status. Resident #9. Findings included ... Resident #9 was admitted to the facility on 10/25/2018, with multiple diagnoses including Heart Failure, Chronic Respiratory Failure, Chronic Pulmonary Edema, Chronic Kidney Disease- Stage 3, Human Immunodeficiency Virus and Hypertension. A review of the resident's quarterly Minimum Data Set dated 02/01/2021, documented in Section C	F 552	F552 Corrective action for residents affected. Resident #9 was assessed on 4/8/2021 Resident suffered no negative outcome, MD Updated. ADON/Designee conducted audit on all residents to identify residents that the facility staff did not ensure the responsible party was updated on the status of the resident. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRANCE: 1) ADON/ Designee will conduct house wide audit to ensure responsible parties are updated on residents' status by 4/21/21. 2) IDT Team will conduct audit to validate that nurses are updating responsible parties of residents current health status by 4/21/21	4/21/2021

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F 552	Continued From page 2 (Cognitive Pattern) that the resident had a "Brief Interview for Mental Status" score of "00" indicating that Resident #10 has a "severe cognitive impairment." A review of the Treatment Administration Records (TARs) from 02/26/2021, to 03/07/2021, showed an order with the start date of 02/26/2021, that instructed staff to monitor, "V/S (vital signs) Q (every 4 hours for 10 days [for COVID-19 exposure] ..." Further review of the TAR from 02/26/2021, to 03/07/2021 showed the nursing staff initialed that the resident's vital signs were being monitored every four hours. A review of the nursing progress notes from 02/26/2021, to 03/07/21, lacked documented evidence that Resident #9's responsible party was made aware of his quarantine status that started on 02/26/2021. During a telephone interview conducted on 04/07/2021, at approximately 10:00 AM, Employee #2 (Director of Nursing) acknowledged the finding and stated that he did not see in the medical record where staff made the resident's responsible aware of his quarantine status on 02/26/2021. At the time of the survey, the facility's staff failed to inform Resident #9's responsible party of his quarantine status.	F 552	F552 3) Unit Managers/Designee, will audit all Documentations to ensure responsible parties are updated on residents' current health status by 4/21/21. 4) In-service will be provided to all clinical team by staff development team/ Designee, to all clinical staff to ensure responsible parties are notified of a change in resident's status by 4/21/21. MONITORING CORRECTIVE ACTIONS: IDT team will validate during grand rounds that nurses are updating responsible parties of residents' current health status by 4/21/21 ADON/ Designee will conduct random audits to ensure nurses are notifying responsible parties of changes in health status. Findings will be addressed and handed to the Quality Assurance Committee weekly x 4, then monthly x 3 until 4/21/21.	4/21/21
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F 583	F583 CORRECTIVE ACTION FOR RESIDENTS AFFECTED: Resident # 10 was assessed on 4/8/21. Resident suffered no negative outcome, MD	

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F 583	Continued From page 3 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, for one (1) of 11 sampled residents, the facility's staff failed to provide privacy for a resident while performing incontinent care. Resident #10.	F 583	F583 made aware. Unit Managers conduct rounds to ensure all residents are provided privacy during care. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRANCE: 1) House wide in service provided by Staff Educators to all clinical staff members to provide privacy to All residents while providing incontinent care by 4/21/21. 2)ADON/ Designee will conduct house wide audit to ensure privacy is provided to all residents during incontinent care by 4/21/21. 3)Unit managers/Designee will carry out random audit to ensure residents are provided privacy during care by 4/21/21. 4)IDT team members will ensure residents are provided privacy to all residents' while providing care by 4/21/21. MONITORING CORRECTIVE ACTIONS: ADON//Designee will conduct random rounds to ensure all residents are provided privacy during incontinent care daily until 4/21/21. Findings will be addressed, and report given to Quality Assurance Committee weekly x4, then monthly x 3 until 4/21/21.	4/21/21

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F 583	Continued From page 4 Findings included ... An observation on 03/24/2021, at approximately 12:00 PM on Unit 4 North revealed the following: -Residents' room #408 door was closed with signs indicating the two residents inside were on quarantine status. -After the surveyor knocked on the door and asked for permission to enter, Employee #10 (Certified Nursing Aide), gave the surveyor permission to enter. -Upon entering the residents' room, Resident #10 (408A) was observed lying in bed, with her body uncovered from the waist down, exposing her buttocks. -Employee #10, was observed providing incontinent care for Resident #10. A curtain between the two resident beds was pulled so that the resident in bed 408B could not see the resident in bed 408A at the time incontinent care was being provided. -However, the curtain toward the entry door had not been pulled, so Resident #10's uncovered body from the waist down was exposed to anyone walking in the door. During a face-to-face interview conducted on 03/24/2021, at approximately 12:15 PM, Employee #10 acknowledged the finding and stated that she did not pull the curtain all the way around the resident's bed because she had "closed the door."	F 583		4/21/21

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F 583	Continued From page 5 At the time of the survey, the facility's staff failed to provide privacy for Resident #10 while providing incontinent care.	F 583		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655	F655 CORERECTIVE ACTION FOR RESIDENTS AFFECTED: Resident # 1 was assessed on 4/8/21, resident suffered no negative outcome. Md made aware.. ADON/ Designee conducted house wide audit on all new admissions to ensure that baseline care plans for patients with foley's are in place on 4/8/21. IDENTICICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with foley's residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRANCE: In service will be provided to all nursing staff by Staff educators/Designee on the importance to develop a baseline care plan to residents who were admitted with foley by 4/21/21. House wide audit on all new admissions will be conducted to ensure the resident have all base line care plans 4/21/21. Unit managers/Designee will check to ensure all newly admitted residents have baseline care plans in line with their diagnosis by 4/21/21.	4/21/21

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F 655	Continued From page 6 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 11 sampled residents, facility staff failed to develop a baseline care plan to address a resident admitted with an indwelling catheter. Resident #1. Findings included ... Resident #1 was admitted to the facility on 03/19/2021, with diagnoses that included Pyelonephritis, Hydro-nephrosis, Pre-diabetes, Hypertension, Spinal Stenosis, and Chronic lower back pain. Review of the nursing progress notes showed: "3/19/2021 21:19 [9:19 PM] Admission Note ...Resident admitted with 16 FR (French) Foley ..." Review of the admission care plan dated 03/23/2021, revealed there was no focus area, with goals or approaches to address Resident #1's use of a Foley catheter. During a telephone interview conducted on	F 655	F655 MONITORING CORRECTIVE ACTIONS: ADON/Designee will audit all new admissions To ensure they have baseline care plans in line With their diagnosis by 4/21/21. IDT team will conduct random audits to ensure All residents with foley catheters have baseline care plan by 4/21/21. Findings will be addressed, and report given to the Quality Assurance Committee weekly x4, then monthly x 3 by 4/21/21.	4/21/21

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F 655	Continued From page 7 03/26/2021, at 12:38 PM, Employee #5 (Unit Manager) acknowledged the finding and stated, "I create the care plans for new admissions. I must have missed it on the discharge summary paperwork."	F 655		
F 656 SS=D	Facility staff failed to develop a baseline admission care plan for Resident #1. 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 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.	F 656	F- 656 CORRECTIVE ACTON FOR RESIDENTS AFFECTED: Resident #6 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. ADON/Designee will conduct house wide audit. To identify residents that the facility staff did not develop a person-centered care plan to include goals and approaches to address a resident refusal to take medication by 4/21/21. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility who are refusing medication have the potential to be affected.	4/21/21

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F 656	Continued From page 8 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 11 sampled residents, facility staff failed to develop a person-centered-care plan to include goals and approaches to address a resident's refusal of medications and a resident on dialysis. Resident #6. Findings included ... Resident #6 was admitted to the facility on 02/26/2021, with multiple diagnoses including Cardiac Arrhythmias, Sacral Stage III Pressure Ulcer, Right Heel Pressure Induced Deep Tissue Damage, Malignant Neoplasm of Endometrium and Depression. Review of the nursing progress notes showed the following: "03/13/21 at 10:15 AM, "resident refused medications ..."	F 656	F656 MEASURES TO PREVENT RECURRANCE: In service will be provided to all nursing staff to ensure that there is a person- centered care plan for residents who are refusing medication by 4/21/21. ADON/Designee will conduct house wide Audit to ensure that residents who are refusing medications have a person-centered care plan to include goals and approaches to reflect medication refusal by 4/21/21. Unit Managers/Designee will ensure that residents on their units who are refusing medication have care plans in place by 4/21/21. IDT team will validate during grand rounds that all residents who are refusing medication have a care plan in place to address that issue by 4/21/21.	4/21/21

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F 656	Continued From page 9 "03/14/21 at 9:05 AM, "resident refused medications ..." "03/15/21 at 11:27 AM, "resident refused medications ..." "03/16/21 at 13:13 (1:13 PM), "resident refused medications ..." "03/17/21 at 13:57 (1:57 PM), "resident refused medications ..." Review of the March 2021 Medication Administration Record (MAR) dated from 03/13/2021, to 03/20/2021, showed that Resident #6 refused the following medications: "Digoxin [used for atrial fibrillation] 125 mcg (microgram) one (1) tablet by mouth every day (9:00 AM) from 03/13/2021, to 03/18/2021. "Thiamine [dietary supplement] 100 mg (milligram) one (1) tablet by mouth every day (9:00 AM) from 03/13/2021, to 03/16/2021, and 03/18/2021. "Tylenol [pain medication] 325 mg two (2) tablets by mouth 30 minutes prior to dressing change. Review of the resident's care plans on 03/18/2021, revealed the facility's staff failed to initiate a care plan with goals and interventions to address the resident's refusal of medications. During a telephone interview conducted on 04/01/2021, at approximately 11:00 AM, Employee #2 (Director of Nursing) acknowledged the finding.	F 656	F656 MONITORING CORRECTIVE ACTION: ADON/ Designee will conduct random rounds to validate that all residents who are refusing medications have a person-centered care plans to include goals and approaches to address a resident's refusal of medication. IDT team will conduct random audits to ensure that all residents who are refusing medications have care plans to address the issue. All findings will be reported to the Quality Assurance Committee weekly x 4, then monthly x 3 until 4/21/21.	4/21/21

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F 656	Continued From page 10 Facility staff failed to develop a person-centered-care plan to include goals and approaches to address a resident's refusal of medications.	F 656	F684	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure 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 record review and staff interview, for two (2) of 11 sampled residents, facility staff failed to monitor residents' vital signs as ordered by the physician. Residents' #1 and #5. Findings included ... 1.Resident #1 was admitted to the facility on 03/19/2021, with diagnoses that included Pre-diabetes, Hypertension, Spinal Stenosis, Pyelonephritis, Hydro-nephrosis, and Chronic Lower Back Pain. Review of the treatment administration record (TAR) showed the following: "Start Date 03/19/2021 at 2300 (11:00 PM) Vital signs every shift x 3 days. (Document in PCC [Point Click Care]) every shift for 3 Days"	F 684	CORRECTIVE ACTIONS FOR RESIDENTS AFFECTED: Resident # 1 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. Resident #5 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. ADON/Designee conducted house wide audit to identify residents that the facility staff did not ensure that their vital signs are monitored per doctor's orders by 4/21/21. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the Potential to be affected. MEASURES TO PREVENT RECURRANCE: In service to be provided to all clinical team on the importance to monitor a resident's vital signs per the doctor's order by 4/21/21. Unit Managers/Designee will ensure nurses are taking residents' vital signs per the doctor's order and that there is proper documentation in place.by 4/21/21.	4/21/21

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	095019	A. BUILDING _____ B. WING _____	04/07/2021

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F 684	Continued From page 11 Review of Resident #1's TAR showed that on 03/20/2021, facility staff initialed in the space allotted indicating that vital signs for the day, evening, and night shift were done. However, the vital signs record revealed that only the resident's blood pressure and heart rate were documented that day, once at 9:48 AM. There were no other vital signs documented in any of the progress notes written on that day. During a telephone interview conducted on 03/26/2021, at 12:38 PM Employee #5 (Unit Manager) acknowledged the findings and stated, "Vital signs are done as instructed. If vital signs are not documented in the vitals section, it would be in the progress notes. I will talk to the staff about making sure they document properly." 2.Resident #5 was admitted to the facility on 03/19/2018, with multiple diagnoses including Hypertension, Cerebrovascular Disease, Cerebral Infarction, and Malaise. Review of the nursing progress note dated 03/18/2021, at 1940 (7:40 PM), documented, "Resident is placed on quarantine for 18 days as of today 3/18/2021, related to probable exposure to COVID-19 ..." Review of physician's order revealed the following order: "03/18/2021, "Vital signs Q (every) 4 hours for 14 days. [Every shift for COVID-19 exposure for 14 Days.]"	F 684	F684 MONITORING CORRECTIVE ACTIONS: ADON/Designee will conduct house audit to ensure all clinical team members are taking and monitoring vital signs according to the doctor's orders by 4/21/21. Random rounds will be conducted by the IDT Team members to ensure the clinical team is monitoring vital signs according to the doctor's order by 4/21/21. Unit managers/Designee will ensure nurses are documenting that the resident's vital signs are taken and monitored per the doctor's order by 4/21/21. Findings will be addressed and presented to the Quality Assurance Committee weekly x4, then monthly x 4 by 4/21/21.	4/21/21

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F 684	Continued From page 12 Review of the care plan with a revision date of 03/18/2021, revealed the following: Focus Area - [Resident's Name] is at risk to transmitting infection r/t (related to) COVID-19 Pandemic. [Possible COVID-19 exposure 3/18/2021.] Interventions - Monitor vital signs every 4 hours X 14 days ... Review of the March 2021 TAR showed an order for staff to monitor Resident #5's vital signs every four hours and every shift (every 8 hours) for 14 days starting on 03/18/2021. Review of the TAR lacked documented evidence the facility's staff monitored Resident #5's vital signs every 4 hours as ordered. Instead, the record showed facility staff monitored the resident's vital signs every 8 hours (every shift) from 03/19/2021, to 03/25/2021. Review of vital signs sheets and nursing progress notes dated from 03/19/2021, to 03/29/2021, lacked documented evidence that facility staff monitored Resident #5's vital signs every 4 hours. During a telephone interview conducted on 04/01/2021, at approximately 11:00 AM, Employee #2 (Director of Nursing) acknowledged the finding and stated that the March 2021 TAR was written in error and staff was to monitor Resident #5's vital signs every 4 hours. Facility staff failed to monitor Resident #5's vital signs as ordered by the physician.	F 684		4/21/21
F 842 SS=E	Resident Records - Identifiable Information	F 842		

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F 842	Continued From page 13 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert staff on the importance to accurately state	F 842	F842 CORERECTIVE ACTUON FOR RESIDENTS AFFECTED: Resident #2 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. Resident #3 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. Resident # 6 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. Resident #7 was assessed 4/8/21, resident suffered no negative outcome. MD made aware. ADON/Designee conducted house wide audit to ensure facility staff are taking blood pressure on the correct arm for residents on dialysis by 4/21/21. IDENTIFICATION OF RESIDENTS WITH THE POTENTIAL TO BE AFFECTED: All dialysis residents residing in the facility have The potential to be affected. MEASURES TO PREVENT RECURRANCE: In service will be provided to all clinical team	4/21/21

were

blood pressure is taken on all dialysis residents by 4/21/21.

Unit Managers/Designee will monitor documentation from clinical staff to ensure they clearly document where blood pressure were obtained from all dialysis residents by

4/21/21

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	095019	A. BUILDING _____ B. WING _____	04/07/2021

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F 842	Continued From page 14 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for four (4) of 11 sampled residents, facility staff failed to accurately maintain and document resident's medical records in accordance with the professional standards and practices. Residents' #2, #3, #6 and #7. Findings included ...	F 842	F842 IDT team members will conduct random rounds During grand rounds to ensure the clinical team Members are accurately stating in their documentation where the residents blood pressure was taken pre and post dialysis by 4/21/21. MONITORING CORRECTIVE ACTIONS: ADON/ Designee will conduct house wide audit To validate that the clinical team is accurately Documenting where blood pressure is obtained On dialysis residents by 4/21/21. Findings will be addressed and presented to the Quality Assurance Committee weekly x4, then monthly x 3 by 4/21/21.	4/21/21

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F 842	Continued From page 15 Facility staff failed to accurately state where blood pressure was being taken. 1.Resident #2 was admitted to the facility on 03/17/2021, with diagnoses that included End Stage Renal Disease (ESRD), Multiple Strokes, Atrial Fibrillation, Peripheral Vascular Disease, and Chronic Leg Pain. Review of the physician's orders showed the following: "3/18/2021 07:00 Assess dialysis AV [arteriovenous] graft site on right upper arm for bleeding, redness, tenderness, and swelling every shift, [No b/p [blood pressure] and no blood draws on this arm] ..." Review of the vital signs record showed that three (3) different facility staff documented 14 times that the blood pressure was taken on the right arm from 3/17/2021, to 3/26/2021. During a telephone interview conducted on 03/26/2021, at 4:43 PM, Employee #7 (Registered Nurse) stated, "It's a documentation error. We don't take blood pressures on that arm. The resident is alert and oriented and doesn't let anyone go near that arm." At the time of the interview, Employee #7 acknowledged the findings. 2.Resident #3 was admitted to the facility on 03/17/2021, with diagnoses that included ESRD and Atrial Fibrillation.	F 842		4/21/21

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	095019	A. BUILDING _____ B. WING _____	04/07/2021

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F 842	Continued From page 16 Review of the physician's order showed the following: "3/20/2021 15:00 (3:00 PM) Assess dialysis AV graft site on Left Upper Arm AV Graft Site for bleeding, redness, tenderness, and swelling every shift, [no b/p and no blood draws on this arm every shift]" Review of the vital signs record showed that facility staff documented one (1) time that the blood pressure was taken on the left arm from 3/17/2021, to 3/26/2021. During a telephone interview conducted on 03/26/2021, at approximately 4:00 PM, Employee #5 (Unit Manager) acknowledged the findings and stated that nursing staff is educated and trained not to use the arm with the AV graft to take blood pressures. 3. Resident #7 was admitted to the facility on 12/11/2013, with multiple diagnoses including ESRD, Dialysis Dependent, Hypertension, Diabetes Mellitus Type 2, and Hepatitis C. A.A review of the resident's quarterly Minimum Data Set dated 02/13/2021, documented in Section C (Cognitive Pattern) that the resident had a "Brief Interview for Mental Status" score of 13 indicating that the resident has an "Intact cognitive response." Review of the physician's order revealed an active order dated 12/28/2019, that documented the following, "Assess dialysis AV (arteriovenous) graft site on Left Arm ...no b/p (blood pressure)	F 842		4/21/21

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F 842	Continued From page 17 and no blood draws on this arm." Review of the "Blood Pressure Summary" record showed that 13 different staff members documented they had measured Resident #7's blood pressure in his left arm 41 times from 01/02/2021, to 03/26/2021. Review of the blood pressure summary record showed that Employee #11 (Registered Nurse) documented that she had measured the resident's blood pressure in his left arm on 15 different occasions from 01/24/2021, to 03/21/2021. During a telephone interview conducted on 03/26/2021, at approximately 3:30 PM, Employee #11 acknowledged the finding stated, "It was a typo. I never take the blood pressure in his left arm." B.Review of the physician's and nurse practitioner's progress notes dated from 01/11/2021, to 03/12/2021, showed they documented the resident had a "left chest permacath." Review of the TAR for March 2021 revealed an order with a start date of 05/19/2018, that instructed staff to, "Check dialysis Left upper chest permacath (dialysis access) upon return from dialysis center for bleeding, redness, swelling, and tenderness, every day shift, every Monday, Wednesday and Friday." Review of the resident's March 2021 active	F 842		4/21/21

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F 842	Continued From page 18 physician's order, with a start date of 12/30/2019 directed, Assess dialysis AV graft site on left arm..." It should be noted on 3/29/2021, (day shift 7:00 AM- 3:30 PM) a nurse initialed the March 2021 TAR indicating that Resident #7's permcath was assessed. During a telephone interview conducted on 03/29/2021, at approximately 10:00 AM, Employee #12 (Unit Manager) acknowledged the findings and stated that the resident did not have a left chest perm-a-catheter. The employee was then asked, what type of dialysis access did the resident have. She stated, "He has a left arm AV graft". When asked, did the resident have a left chest perm-a-catheter (dialysis access), Employee #12 stated, "No." At the time of the survey, the facility's staff failed to include accurate documentation for blood pressure monitoring and dialysis access in Resident #7's medical record. 4.Resident #11 was admitted to the facility on 01/13/2020, with diagnoses that included ESRD, Gastroesophageal Reflux Disease, Anemia, Osteoarthritis, and Atrial Fibrillation. Review of the physician's order dated 01/14/2020, showed the following care information: "Assess left forearm dialysis AV graft site for bruit & thrill every shift. (Notify MD [medical doctor]	F 842		4/21/21

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F 842	Continued From page 19 immediately if no bruit is audible via stethoscope and thrill not palpable) every shift" "Assess left forearm dialysis AV graft site upon return from dialysis center for bleeding, redness, swelling, and tenderness every day shift every Tue, Thu, Sat" Review of Resident #11's progress notes on showed the following documentation of the Resident's dialysis access site: 3/16/2021 at 15:03 (3:03 PM) " ...Positive for bruit and thrill. Rt [right] arm AV [graft] intact..." Review of the Daily Skilled Notes showed the following: "3/9/21 at 13:03 (1:03 PM) "Rt. arm AV intact... Positive for bruit and thrill ..." "3/11/21 at 12:17 (PM) "Rt arm AV intact... Positive for bruit and thrill ..." "3/16/21 at 14:17 (2:17 PM) "Rt arm AV intact... Positive for bruit and thrill ..." Facility staff failed to maintain accurate documentation in the progress notes of the location of Resident #11's dialysis graft site. During a telephone interview conducted with Employee #2 (Director of Nursing) at approximately 2:00 PM on 04/08/2021, he acknowledged the findings.	F 842		4/21/21

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F 842	Continued From page 20 5.Facility staff failed to ensure Resident #6's medical record contained complete information. Review of the policy entitled, "Noncompliance- Testing for SARs-CoV-2 [severe acute respiratory syndrome coronavirus 2]" dated 01/2021, instructed staff to, "explore why the resident is refusing to be tested ...notify Primary Care Provider ... resident's Representative of the refusal ... licensed nurse will document the refusal in ...medical record." Resident #6 was admitted to the facility on 02/26/2021, with multiple diagnoses including Obesity, Asthma, Pulmonary Embolism and Malignant Neoplasm of Endometrium. Additionally, the record showed the resident had a recent diagnosis of COVID-19 on 03/18/2021. Review of the labs showed that on 03/13/2021, Resident #6 refused to be tested for SARS-COV-2. Review of the nursing progress notes dated from 03/13/2021, to 03/15/2021, failed to include documented evidence that the resident refused testing, the reason why she declined testing, and that the physician or responsible party were made aware of the resident's refusal. During a telephone interview conducted on 04/01/2021, at approximately 11:00 AM, Employee #2 (Director of Nursing) acknowledged the finding.	F 842		4/21/21

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F 842	Continued From page 21 At the time of the survey, Resident #6's medical record failed to include documented evidence that the resident refused testing, the reason why she declined testing, and that physician or responsible party were made aware of the resident's refusal.	F 842		
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	F 880	F880 CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS: No resident was directly affected. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents and employees in the facility have the potential to be affected. Employee #9: Progressive Coaching and Counselling provided. In-service provided to employee # 8 on were to place objects that are picked from the floor. Coaching and Counselling provided. Targeted in-service was done to employee #6 on doffing and donning of PPE'S. Coaching and Counselling provided.	4/21/21

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F 880	Continued From page 22 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(e)(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 observation, record review and staff interview, facility staff failed to maintain	F 880	F880 MEASURES TO PREVENT RECURRANCE: In service will be provided to all staff on hand Hygiene and proper ways of turning the faucet on and off by 4/21/21. In-service will be provided to all staff on donning and doffing PPE'S from quarantine rooms by 4/21/21. In-serv ice will be provided house wide on proper sanitation process when an object is picked from the floor by 4/21/21. In-service will be provided by staff educators/ designee on what to place in a clean/dirty PPE hampers by 4/21/21. Frequent rounds will be conducted by the IDT Team members to ensure all employees are maintaining infection control practices to minimize the potential spread of infection in the facility by 4/21/21. Department heads will monitor their employees daily to ensure everyone is donning and doffing their PPE's correctly daily by 4/21/21. Employee have been called upon to monitor their peers to ensure everyone is maintaining infection control practices to minimize the potential spread of infection in the facility. Employee who are not in compliance will be given coaching and counselling 4/21/21.	4/21/21

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	095019	A. BUILDING _____ B. WING _____	04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 appropriate infection control practices to minimize the potential spread of infections in three (3) occurrences. Findings included ... 1.Employee #9 failed to maintain appropriate infection control practices when turning off a faucet in a quarantine room, Resident #9. A physician's order dated 03/18/2021, for Resident #9 showed the following, "Place resident on Quarantine Q (every shift) for 14 days ..." During an observation of Resident #9's room on 03/24/2021, at approximately 11:30 AM, showed Employee #9 (Unit Manager) wearing a gown, gloves, a surgical mask and face shield helping Resident #9 with hand hygiene. After helping the resident, Employee #9 removed her gown and gloves. The employee then balled the used gown into her hands, turned off the faucet using the gown, and then placed the gown on the vanity area near the sink. During a face-to-face interview conducted on 03/24/2021, at 11:32 AM, Employee #9 acknowledged the finding. At the time of the survey, Employee #9 failed to maintain appropriate infection control practices while turning off a faucet in Resident #9's room.	F 880	F880 MONITORING CORRECTIVE ACTIONS: ADON/ Designee will conduct random rounds to ensure all employees are maintaining infection control practices to minimize the potential spread of infection in the facility by b4/21/21. Unit Mangers/Designee are responsible of ensuring that all employees are maintaining infection control practices to minimize the potential spread of infections in the facility. Unit Mangers will be held accountable if an employee is not in compliance by 4/21/21. Departmental heads will also be held accountable if someone in their department is not in compliance in maintaining infection control practices to minimize the potential spread of infection in the facility by 4/21/21. IIDT team will conduct random rounds in the facility to ensure employees are maintaining infection control practices to minimize the potential spread of infection in the facility. Findings will be addressed and presented to the Quality Assurance Committee weekly x 4, then monthly x3 by 4/21/21.	4/21/21

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F 880	Continued From page 24 2.Employee #8 (Registered Nurse) failed to maintain infection control practices by placing a dirty object [bottle of hand sanitizer] with clean items. During an observation on unit 4 North on 03/24/2021, at approximately 12:00 PM, Employee #8 was observed picking a bottle of hand sanitizer off the floor and placing it in the clean personal protective equipment (PPE) storage unit located on the wall between the resident room. During a face-to-face interview conducted on 03/24/2021, at approximately 12:10 PM, Employee #8 acknowledged the finding and left the hand sanitizer in the storage unit with the other clean items. At the time of the survey, Employee #8 failed to maintain infection control practices when she placed a dirty item in a clean PPE storage unit. 3.Facility staff failed to follow standards of practice for disposal of used PPE and performing hand hygiene. Review of the facility's policy entitled, "Infection Control (Personal Pretective [Protective] Equipment- PPE) dated 01/2021, instructed staff to:" Remove gown ... dispose in [room] trash receptacle... Employee may now exit patient room. Perform hand hygiene ... wash hands with soap and water or use Alcohol Based Hand sanitizer ..."	F 880		4/21/21

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F 880	Continued From page 25 During a tour of unit 3 north on 03/24/2021, at approximately 10:50 AM, Employee #6 (Maintenance worker) was observed taking off his isolation gown as he walked out of a resident's room. It should be noted that the resident's room had signage that showed, "Quarantine Droplet/ Contact Precautions". After removing the gown, Employee #6 walked down the hallway holding the used gown with his hands, then placing the used gown in a trash receptacle by the nurse's station. Additionally, Employee #6 failed to perform hand hygiene after placing the used gown in the trash receptacle. It should be noted that the employee walked by two working hand sanitizing stations. Review of the education sign in sheets dated 03/15/2021, on "Hand Hygiene", "Infection Control" and "Safely Remove and Don PPE" showed Employee #6 signed an attendance sheet, indicating he received the previously mentioned trainings. During a face-to-face interview conducted on 03/24/2021, with Employee #6 at approximately 10:50 AM, when asked why he did not discard the used gown before leaving the resident's room, he stated, "I didn't know I had to put it in the trash can inside the room." When asked if he knows when to perform hand hygiene, Employee #6 stated, "Yes, I was going to do it, it just slipped my mind." At the time of the interview, the employee acknowledged the findings. At the time of the survey, Employees' #8, #9, and #10 failed to follow standards of practice to	F 880		4/21/21

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F 880	Continued From page 26 minimize the potential spread of infections.	F 880		4/21/21