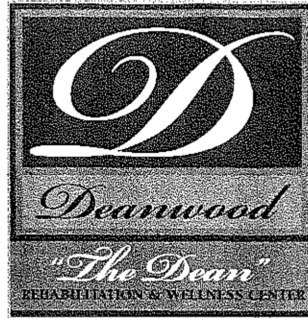


February 7, 2017 Sent via email: February 7, 2017

Veronica Longstreth, RN, MSN
Program Manager
Government of the District of Columbia
Department of Health
899 North Capitol St., N.E 2nd Floor
Washington, D.C. 20002

Dear Ms. Longstreth:

Enclosed you will find the Plan of Correction for a Recertification (Health) Quality Indicator Survey (QIS) survey conducted by surveyors from the Department of Health (DOH),Health regulation and Licensing Administration on January 17, 2017 at Deanwood Rehabilitation and Wellness Center.

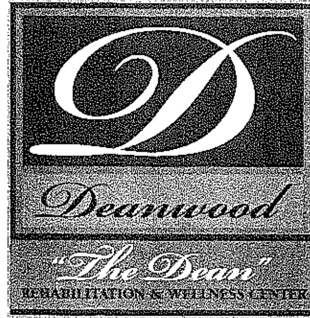
Please accept this letter, Plan of Correction and credible evidences as our allegation of compliance. If you have any questions or need additional information please feel free to contact me at (202) 399-7504 ext. 535.

Sincerely,

Amilia Alcema Dual BS, MBA, LNHA
Administrator

5000 Nannie Helen Burroughs Avenue N.E., Washington, DC 20019
TEL 202-399-7504 | FAX 202-399-0881

RapidRecovery AT



February 7, 2017

Sent via email: February 7, 2017

Cassandra Kingsberry
Supervisory Nurse Consultant
Government of the District of Columbia
Department of Health
899 North Capitol St., N.E 2nd Floor
Washington, D.C. 20002

Dear Ms. Kingsberry:

Enclosed you will find the Plan of Correction for a Recertification (Health) Quality Indicator Survey (QIS) survey conducted by surveyors from the Department of Health (DOH),Health regulation and Licensing Administration on January 17, 2017 at Deanwood Rehabilitation and Wellness Center.

Please accept this letter, Plan of Correction and credible evidences as our allegation of compliance. If you have any questions or need additional information please feel free to contact me at (202) 399-7504 ext. 535.

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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) COMPLETE DATE
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that facility staff failed to accurately code the Admission MDS (Minimum Data Set) under Section A, Identification Information; Preadmission Screening and Resident Review (PASRR). Resident #35. The findings include: A review of the admission record for Resident #35 revealed that he/she was admitted to the facility on September 10, 2016. The history and physical signed and dated September 11, 2016 revealed the resident had diagnoses which included Bipolar Disorder. A review of Resident #35 ' s admission MDS [Minimum Data Set] with an ARD [Assessment Reference Date] of September 17, 2016 revealed: Section A1500 Preadmission Screening and Resident Review (PASRR) was coded " 0 " indicative of ' no ' for serious mental illness. Section I Active Diagnoses: Psychiatric/Mood	L 001	**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 wrongdoing. **L 001** **Corrective action for resident affected:** Resident # 35 was reassessed on 1/30/17. The MDS section was modified on 1/30/17. Section A1500, A1510 of the MDS 9/17/2016 for resident # 35 was modified on 1/30/17 to reflect the accurate coding Preadmission screening and Resident Review. (PASRR) Level II. 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' records will be audited for accurate coding per RAI instructions. Any issues found during the audit will be resolved and or modified. No residents were identified as affected	2-28-17

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LNHA	2-7/17

Health Regulation & Licensing Administration

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L 001	Continued From page 1 Disorder revealed I5900 Manic Depression (Bipolar Disease) was coded as an Active Diagnosis. The clinical record revealed that a PASRR screen was conducted on Resident #35 on September 1, 2016. The screen was coded as " yes " under Section B, " Does the beneficiary have a diagnoses or evidence of a major mental illness ...that may lead to chronic disability. " A review of the clinical record revealed that a Level II Screen was completed and returned to the facility on September 8, 2016 which determined that the resident was "Appropriate for Nursing Facility." A face-to-face interview was conducted on January 13, 2016 at approximately 1:00 PM with Employee #21. After review of the above aforementioned he/she acknowledged the findings. The record was reviewed on January 12, 2016.	L 001	**L 001** **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. All residents' records will be audited for accurate coding per RAI instructions. Any issues found during the audit will be resolved and or modified. No residents were identified as affected. **Measure to prevent recurrence:** MDS coordinators will receive formal education on the accurate coding of section A preadmission screening and Resident Review of section A1500 per RAI guidelines. MDS coordinators, will review all new admissions records and perform residents interview prior to coding. Any discrepancies will be discussed with the social workers daily in the clinical meetings , to determine the need for further evaluation and a PASRR level II screen. **Monitoring Corrective action:** MDS coordinators will complete audits to include all OBRA assessments weekly x4 then monthly times 3. The findings will be completed and reported to the Quality Assurance performance improvement Committee monthly for the next 3 months.	2-28-17
L 012	3203.2 Nursing Facilities A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on records review on January 11, 2017 at approximately 2:30 PM, it was determined that the facility failed to obtain required District of Columbia issued Food Protection Manager certificates for three (3) of five (5) persons in charge.	L 012		

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L 012	Continued From page 2 The findings include: A review of the Food Protection Manager certificates on January 11, 2017 at approximately 2:30 PM revealed that the designated persons in charge did not have a District of Columbia issued Food Protection Manager Identification Card as required by the 2012 District of Columbia Food Code, section 203 of chapter 2 which states the following: 203 CERTIFICATION AND DISTRICT-ISSUED ID REQUIREMENTS - FOOD PROTECTION MANAGER, PERSON IN CHARGE 203.1 Each person in charge shall be certified by a food protection manager certification program that is accredited by the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs. Such certified food protection managers shall be deemed in compliance with §201.2(b). 203.2 A person in charge who is a certified food protection manager as required... §203.1 shall be re-certified every three (3) years. 203.3 A person in charge who is a certified food protection manager as required... §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. These observations were made in the presence of Employee #25 who acknowledged the findings.	L 012	L012 **Identification of others with the potential to be affected:** **Corrective action for resident affected:** No resident was identified in this F tag. All required staff will obtain the required District of Columbia issued Food Protection Manager Certificate. **Identification of others with the potential to be affected:** At risk residents were all residents in the the time of this survey. **Measure to prevent recurrence:** Education was provided to all required staff. They understand the importance of obtaining the required District of Columbia issued Food Protection Manager Certificate. Director of Human Resources and lead dietician will be responsible to audit and for assure compliance with this requirement. **Monitoring Corrective action:** Director of Human Resources and lead dietician will be conducting random audit to ensure all required staff will obtain the required District of Columbia issued Food Protection Manager Certificate. The findings will be compiled and reported to the Quality Assurance performance Improvement Committee monthly for the next 3 months.	2-28-17

Health Regulation & Licensing Administration

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L 051 Continued From page 3

L 051 3210.4 Nursing Facilities

A charge nurse shall be responsible for the following:

(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;

(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;

(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;

(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;

(e)Supervising and evaluating each nursing employee on the unit; and

(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:

A. Based on record review and staff interview for one (1) of 35 sampled residents, it was determined that facility staff failed to clarify physician orders regarding notification requirements for oxygen saturation levels for Resident #58.

The findings include:

A review of a physician ' s orders dated January 03, 2017 revealed the following:

L 051

L 051

Corrective action for resident affected:
A. Resident #58 was reassessed on 1/15/17.
Attending physician was notified on 1/15/17.
Clarification order obtained on 1/12/17.
Resident suffered no negative outcome.
B. Resident #302 was reassessed on 1/11/17.
Attending physician and RP made aware.
New orders obtained on 1/11/17.
Resident was reassessed again on 2/2/2017.
Attending physician and RP were informed. Nutrition care plan was modified on 1/11/17.
Resident suffered no negative outcome.

2-28-17

Identification of others with the potential to be affected:
All residents residing in the facility have the potential to be affected.
A. All assistant director of nursing/Designee will complete an audit to ensure facility staff are obtaining physician clarification orders regarding notification requirements for oxygen saturation levels.
B. The interdisciplinary team will review and revise care plans to assure nutrition care plans are modified in a timely manner.
Any issues found during the audits/review will be resolved and or corrected.
No residents were identified as affected.

Measure to prevent recurrence:
A. Staff development coordinators will be providing in-services to license staff on the importance of obtaining physician clarification orders regarding notification requirements for oxygen saturation levels.
B. Interdisciplinary team and all staff involve in the care planning process will be in-serviced on assuring nutrition care plan modification in a timely manner.

Health Regulation & Licensing Administration

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L 051	Continued From page 4 " Do vital signs every shift. ... Notify physician Respiratory Rate less than 20 per minute. Notify physician oxygen saturation (O2 sat.) greater than 90%. Notify physician when less than 89% every shift for CHF (Congestive Heart Failure). " A review of Section I, Diagnoses of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of December 13, 2016 revealed that the resident's diagnoses included CHF. A face- to- face interview was conducted with Employee #24 at approximately 10:00 AM on January 12, 2017. Employee #24 stated that the parameters for the Oxygen saturation levels are taken from the facility's CHF Clinical Pathway. A review of the facility ' s CHF Clinical Pathway revealed the following: " Notify physician for any parameter out of range such as unrelieved shortness of breath, new or worsening shortness of breath/chest tightness, inability to sleep without sitting up/needing 2 pillows/head of bed up, deterioration in mental status and anxiety. ... Notify physician. Keep Oxygen Saturation greater than 90%. Notify physician O2 sat. less than 89%. " A review of the facility ' s CHF clinical pathway as compared to the physician ' s order lacked consistency. A face- to - face interview was conducted with Employees #4 and 24 at approximately 11:00 AM on January 12, 2017. Both employees were queried regarding the physician ' s order which specified that the physician should be notified if the resident ' s oxygen saturation level was below	L 051	**L 051** **Monitoring Corrective action:** A. Assistant Director of Nursing/Designee Will complete random audits of residents' medical records to ensure facility staff are obtaining physician clarification orders regarding notification requirements or oxygen saturation levels. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months. B. Lead Dietician/ Director of Rehab Services/Director of Nursing or designee will complete random audits of residents ' medical records to ensure the interdisciplinary team is reviewing/modifying nutrition care plans to reflect safe swallowing strategies as ordered in a timely manner. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next **L 099** **Corrective action for resident affected:** No resident was identified in this F tag. 1.The pack of bologna was discarded same me day on 1/9/17. 2.Two (2) of two (2) six pound ten ounces cans of cheddar cheese sauce were stored open and uncovered on the countertop located across from the deep fryer was discarded. 3All cooking grills were cleaned by the cooks on 1/9/17. 4.All cooking grills were cleaned by the cooks on 1/9/17. 5.The food warmer was emptied and cleaned during the same day 1/9/17 6. All food trays inside the food warmer were removed, washed and sanitized on 1/9/17.	2-28-17

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L 051	Continued From page 5 89% or above 90%. Both employees indicated that the order was written incorrectly and that the error probably occurred while the order was being entered into the computer. The employees were queried whether anyone had called the physician to clarify the order. Both employees responded, " No." The record was reviewed on January 11, 2017. B. Based on record review and staff interview for one (1) of 35 Stage 2 sampled residents, it was determined that facility staff failed to amend the nutrition care plan to include safe swallowing approaches during meal consumption for Resident #302. The findings include: Facility staff failed to amend the nutrition care plan for Resident #302 once it was recommended that safe swallowing strategies be implemented to maintain effective swallowing. A review of the Resident #302 ' s clinical record revealed that the resident was admitted to the facility on February 25, 2016. The history and physical examination signed by the physician February 26, 2016 revealed the resident ' s diagnoses included, Diabetes Mellitus, Hypertension, Lung Cancer, Cerebral Vascular Accident, Gout, Hyperlipidemia and End Stage Renal Disease. A review of the nursing notes dated June 21, 2016 11:42 revealed "...Pt [patient] reports that [he/she] coughs/chokes while eating. [He/she reports the problem manifested a while ago but [he/she] never informed [the] nurse. "	L 051	L 099 **Corrective action for resident affected:** 7. The kitchen floor was scrubbed and cleaned the same day 1/9/17. 8.The facility cannot retroactively correct this deficiency. Education will be provided to dietary staff to ensure food temperature logs are always available for review. 9. Education will be provided to dietary staff to ensure they specify as to whether the temperatures were taken from the tray line in the kitchen or from the steam table in the dinning room. **Identification of others with the potential to be affected.** All residents have the potential to be affected. 2-28-17 1.A daily check list will be completed to ensure food items stored in refrigerators are labeled and dated. Any issue found will be addressed. 2. Cooks will be scheduled for Food Safety class to reinforce their knowledge of food Safety. Constant rounds will be conducted to ensure safety compliance. Any issue found during rounds will be addressed. 3. Steamers are scheduled to be deep clean once a week to ensure compliance with sanitation. Constant rounds will be conducted to ensure compliance. Any issue found during constant rounds will be addressed. 4. Audits of cleanliness of cooking grills will be completed by the Dietitians . and Food Service Director. Any issue found during the audit will be corrected appropriately. 5. Lead dietician conducted a full kitchen inspection to ensure the food warmer stays clean as required.	2-28-17

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NAME OF PROVIDER OR SUPPLIER: DEANWOOD REHABILITATION AND WELLNESS

STREET ADDRESS, CITY, STATE, ZIP CODE: 5000 BURROUGHS AVE. NE, WASHINGTON, DC 20019

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L 051	Continued From page 6 A review of the Physician's Order ' s dated " June 22, 2016 directed: ST [Speech Therapy] eval [evaluation] and tx [treat] as indicated. ST clarification order: Skilled ST for x [times] four days/week for x 2 weeks for dysphagia management to determine least restrictive diet and implement safe swallow strategies. " A review of the Speech Therapy (ST) Discharge Summary dated July 8, 2016 revealed: " Functional Outcomes: Swallowing Abilities = Min [Minimal]/Close Supervision; Solids: Diet Recs [recommendations] - Solids = Regular Texture; Liquids: Diet Recs - Liquids = Thin Liquids; Strategies: Comp Strategies/Positions: to facilitate safety and efficiency, it is recommended the Pt [patient] use the following strategies and/or maneuvers during oral intake: rate modification, bolus size modifications and hard throat clear/re swallow upright posture during meals. Supervision: Supervision for Oral Intake = Close Supervision." A review of the facility's in-service records revealed that direct care staff were trained on safe-swallow techniques for Resident #302 during the month of July 2016. A review of the comprehensive care plans for Resident #302, updated July, October and December 2016 revealed the interdisciplinary team identified "Nutritional Risk" as a problem. However, there was no evidence that the care plan was amended to include safe swallowing strategies as detailed by the Speech Therapist's evaluation of July 8, 2016. A face-to-face interview was conducted on January 12, 2017 at approximately 2:00 PM with Employee #19 who acknowledged the findings.	L 051	L 099 **Identification of others with the potential to be affected.** 6. Lead dietician conducted a full kitchen inspection to ensure soiled trays are not stored inside the food warmer. 7. A full kitchen inspection was conducted to assure the cleanliness of the kitchen floor. Any issue found during the inspection was addressed appropriately. 8. An audit of the temperature logs will be completed by Dietitian/Assistant Food Service Director to ensure compliance. Any issue found during the audit will be addressed. 9. An audit of the temperature logs will be completed by Dietitian/Assistant Food Service Director to ensure compliance. Any issue found during the audit will be addressed. **Measure to prevent recurrence:** Education was provided to Dietary staff to ensure they understand the importance of Storing and serving foods under sanitary Conditions. **Monitoring corrective action:** Random audits will be completed by the Dietitians/Assistant Food Service Director weekly times 3, then monthly times 3 to ensure dietary staff are storing and serving foods under sanitary conditions. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	2-28-17

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L 051	Continued From page 7 The record was reviewed on January 12, 2017.	L 051		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations on January 9, 2017 at approximately 8:00 AM and/or on January 11, 2017 at approximately 2:30 PM, it was determined that the facility failed to store and serve foods under sanitary conditions as evidenced by one (1) f one (1) open and undated pack of bologna in the walk-in refrigerator, two (2) of two (2) open and uncovered cans of cheddar cheese sauce stored for use on a countertop, one (1) of two (2) soiled steamer, one (1) of one (1) soiled cooking grill, one (1) of one (1) soiled food warmer, seven (7) of seven (7) soiled food trays, a soiled kitchen floor and inconsistent food temperature logs for the month of December 2016. The findings include: 1. One (1) of one (1) pack of bologna was stored in the walk-in refrigerator open and undated. 2. Two (2) of two (2) six-pound ten ounces cans of cheddar cheese sauce were stored open and uncovered on the countertop located across from the deep fryer. 3. One (1) of two (2) steamers, the one located on the bottom was soiled.	L 099	L 108 **Corrective action for resident affected:** No resident was identified in this L tag. Maintenance staff checked Pallet heater on 1/12/17 to ensure it remains plugged in. Dome was checked by Director of maintenance to ensure it is fitted tightly to retain the heat on 1/12/17. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. Lead dietician, Assistant Food Service Director, Director of maintenance Will complete a full kitchen inspection Dieticians will audits test trays to ensure compliance with required temperature at the point of delivery to the residents. Any issue found during the audit will be addressed. No residents were identified as affected.	2-28-17

Health Regulation & Licensing Administration

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L 099	Continued From page 8 4. One (1) of one (1) cooking grill was soiled with food residue. 5. One (1) of one (1) food warmer was soiled on the inside. 6. Seven (7) of seven (7) food trays stored inside the food warmer were soiled. 7. The kitchen floor was soiled with dark spots throughout. 8. Food temperature logs were unavailable for review for 11 of 31 days during the month of December 2016 including December 1, 2, 5, 7, 10, 16, 19, 20, 21, 23 and 24. Food temperature logs were not obtained on every meal (breakfast; lunch and/or dinner) for 18 of the remaining 20 days (including the aforementioned 11 days) in December 2016. 9. Food temperature logs in December 2016 were not specific as to whether the temperatures were taken from the tray line in the kitchen or from the steam table in the dining room. These observations were made in the presence of Employee #25 and/or #26 who acknowledged the findings. These observations were made in the presence of Employee #25 and Employee #26 who acknowledged the findings.	L 099	**L 108** **Measure to prevent recurrence:** In-service will be provided to dietary, maintenance and nursing staff regarding the importance of ensuring the facility serves hot food at a minimum temperature of 140 degrees Farenheight at the point of delivery to the resident. **Monitoring corrective action:** Lead dietician, Assistant Food Service Director, Director of maintenance /Designee will complete random kitchen inspections. Dieticians will complete random audits test trays to ensure compliance with required temperature at the point of delivery to the residents. Any issue found during the audit will be addressed. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	2-28-17
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot	L 108		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	01/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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) COMPLETE DATE
L 108	Continued From page 9 foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations on January 12, 2017 at approximately 2:00 PM, it was determined that the facility failed to serve hot foods at a minimum temperature of 140 degrees Fahrenheit (F) as evidenced by hot foods that tested below the required temperature. The findings include: Hot foods such as puree mashed potatoes (120 degrees F), puree vegetables (118 degrees F), puree beef (110 degrees F), regular diet vegetables (133 degrees F) tested at less than the required minimum of 140 degrees Fahrenheit (F). These observations were made in the presence of Employee #25 who acknowledged the findings.	L 108		
L 170	3228.2 Nursing Facilities Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that the podiatry service failed to conduct in-service training for nursing employees. The findings include: A review of the facility in-services revealed that no in-service training for nursing employees was conducted by the podiatry service. According to 22DCMR 3228.2, "The podiatry services shall include direct services to residents,	L 170	**L 170** **Corrective action for resident affected:** The facility cannot retroactively correct this deficiency. Education team contacted vendors for podiatry services to ensure they conduct in-service training for nursing employees. Podiatry team will provide in-service Training to nursing employees. **Identification of others with the potential to be affected.** All residents residing in the facility have the potential to be affected. **Measure to prevent recurrence:** Education team will conduct an audit to Podiatry team provide in-service to nursing staff. Education will be provided to the podiatry Team on the importance of providing in-service to the nursing team. **Monitoring corrective action:** Random audits will be completed by the Staff development Coordinators/Designee to ensure nursing staff are receiving in in-service training from podiatry services. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	2-28-17

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L 170	Continued From page 10 as well as consultation and in - service training for nursing employees " A face-to-face interview was conducted with the Employee#10 and Employee#11 on January 17, 2017 at 10:45 AM. They acknowledged finding by confirming that the podiatrist did not conduct an in-service training for nursing employees.	L 170	L 410 **Corrective action for resident affected:** 1. Window blinds in resident room #207, #220, #323 and #330 were cleaned on 1/20/17. 2. Exhaust vents in resident room #229 and #334 will be replaced.	
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on January 12, 2017 between 9:20 AM and 12:30 PM, it was determined that the facility failed to provide necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior as evidenced by dusty window blinds in four (4) of 52 resident rooms, non-functioning exhaust vents in two (2) of 52 resident rooms and marred walls in four (4) of 52 resident rooms. The findings include: 1. Window blinds were dusty in four (4) of 52 resident rooms including rooms #207, #220, #323 and #330. 2. Exhaust vents were not functioning in two (2) of 52 resident rooms including room #229 and #334. 3. Walls were marred in four (4) of 52 resident	L 410	3. Walls marred in resident room #204, #409, #427 and #529 were fixed on 1/20/17. **Identification of others with the potential** **To be affected:** All residents residing in the facility have The e potential to be affected An audit of all window blinds was completed to assure any dusty blinds were cleaned, An audit of all exhaust vents was Conducted to assure they are functioning properly. A house wide inspection was conducted to assure compliance with marred walls. Any issues found during the inspection have been addressed properly to ensure the facility stays in compliance. No residents were identified as affected.. **Measure to prevent recurrence:** Housekeeping and maintenance staff have been in-serviced on the importance of providing necessary housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior.	2-28-17

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L 410	Continued From page 11 rooms including room #204, #409, #427 and #529. These observations were made in the presence of Employee #7 and Employee #17 who acknowledged the findings.	L 410	L 410 Monitoring Corrective action: Random Environmental audits will conducted by the Director of maintenance/ Director of housekeeping services weekly times 3 then monthly times 3. Findings will be reported to Performance Improvement Committee monthly for the next 3 months..	2-28-17
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations on January 9, 2017 at approximately 8:00 AM and on January 11, 2017 at approximately 2:30 PM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by exposed electrical wires from one (1) of one (1) plate warmer, a malfunctioning temperature display on one (1) of one (1) food warmer and a loose gasket from one (1) of one (1) refrigerator [identified by the facility staff as the milk box]. The findings include: 1.The electrical wires from the power cord attached to one (1) of one (1) plate warmer were exposed and presented a safety hazard to users. 2.The temperature display from one (1) of one (1) food warmer not functioning. 3.The gasket from the access door to one (1) of one (1) refrigerator [identified by the facility staff as the milk box] was loose. These observations were made in the presence of Employee # 25 who acknowledged the findings.	L 442		

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L 442		L 442	L442 **Corrective action for resident affected:** 1.The electrical wires from the power cord attached to one (1) of one (1) plate warmer Will be replaced by 2/18/17. 2.The temperature display from one (1) of one (1) food warmer will be replaced by 2/18/17. 3. 3.The gasket from the access door to one (1) of one (1) refrigerator [identified by the facility staff as the milk box] will be replaced by2/18/2017. **Identification of others with the potential To be affected.** All residents residing in the Facility have the potential to be affected. **Measure to prevent recurrence:** Maintenance and dietary staff will be In-serviced on the importance of ensuring the Facility maintains essential equipment in Safe operating condition. **Monitoring corrective action:** Random audits will be completed by the Director of maintenance to ensure facility Maintains essential equipment in safe operating conditions. Findings will be reported to Performance Improvement	2-28-17

Committee monthly for the next