FOREST HILLS of DC

INCLUSIVE SENIOR LIVING

August 2, 2016

Veronica Longstreth. RN. MS
Interim Program Manager, Health Facilities Division
Department of Health
899 North Capitol Street, NE
Washington. DC 20002

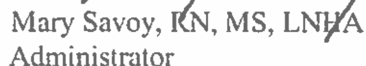
Dear Ms. Longstreth:

Enclosed please find the Plan of Correction for the Federal QIS Survey, conducted June 27 through July 1, 2016 at Forest Hills of DC. The Statement of Deficiencies (2567) associated with this Plan was received today. Although you have advised that our date for submission of this Plan is not until August 12, we are responding immediately to avoid any concerns about denial of payment. This Plan of Correction is separate and in addition to our August 1 submission, which responded to the Statement of Deficiencies identified during our licensure survey and which was provided to Forest Hills on July 22, 2016.

This Plan of Correction is submitted for purposes of regulatory compliance and as part of Forest Hills of DC's ongoing efforts to continuously maintain the high quality of care and services provided. As such, it does not constitute an admission of the facts or conclusions cited in the survey report for any purpose whatsoever.

Ifyou have any questions, feel free to contact me directly at 202-777-3320, or by e-mail at msavoy@foresthillsdc.org. Thank you.

Sincerely,



Mary Savoy, RN, MS, LNHA
Administrator

Enclosure (CMS-2567)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Recertification Survey was conducted at Forest Hills of DC from June 27 through July 01, 2016. Survey activities consisted of a review of 30 residents' clinical records during Stage 1 and a review of 20 clinical records during Stage 2. The following deficiencies are based on facilityobservations of staff practices; review of the facility's operating procedures and interviews with residents, families and facility staff. After analysis of the fiudings, it was determined that the facility was 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 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	Please start typing your responses here.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Savoy RN
TITLE: LNHA
(X6) DATE: 8/2/16

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 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 Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center S/he she/he Sol- Solution SIC - quote transcribed as written TAR - Treatment Administration Record	F 000		
F 162	483.10(c)(8) LIMITATION ON CHARGES TO	F 162		

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F 162 SS=D	Continued From page 2	F 162		

PERSONAL FUNDS

The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter.

(This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services:
Nursing services as required at §483.30 of this subpart.
Dietary services as required at §483.35 of this subpart.
An activities program as required at §483.15(f) of this subpart.
Room/bed maintenance services.
Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss,

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F 162	Continued From page 3 moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.	F 162		

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F 162	Continued From page 4 The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview for one (1) of 20 sampled Stage 2 residents, it was determined that facility staff failed to ensure that one (1) resident ' s representative was given a list of services and a list of items that the resident would and would not be charged for if his/her relative was a Medicaid Resident. Resident #36. The findings include: A family interview was conducted on June 28, 2016 at approximately 3:19 PM. A query was made regarding if the resident is on Medicaid, did the staff give him/her (or you) a list of services and items that you would and would not be charged for. The family member responded " No " . A review of the facilities Admissions Agreement package signed by the Responsible Party on October 12, 2015 revealed on " page 16, List of typical additional charges which are payable by	F 162	**Failure to Ensure that 1 Resident's Representative Was Given a List of Services and a List of Items that the Resident Would and Would Not be Charged for if His/her Relative Was A Medicaid Resident.** **1. Corrective Action for Resident With Deficient Practice.** A list of items and services was provided to the resident's daughter that detailed each item/service available to the resident and the charges for each, if any. **2. How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** A listing available from the Accounting Office that identified Medicaid residents was obtained. These residents and /or responsible parties were provided the list of items and services available to the resident and the charges for each, if any **3. Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** An Appendix to the Admissions Agreement has been developed to include a list of items and services available to residents and the charges for each, if any. This list will be provided to all newly admitted residents as part of the Admissions Agreement. **4. Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Accounting will audit Admissions Agreements of residents admitted on or after 8/1/16 and report findings to the QAPI Committee quarterly.	7/5/16 7/15/16 7/15/16 7/28/16

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F 162	Continued From page 5 resident either to the Methodist Home or directly to providers/vendors. " However, the sheet did not contain the cost of the items listed on the sheet. A face-to-face interview was conducted with Employee #11 on July 1, 2016 at approximately 11:30 AM, who acknowledged that during the admissions process, items that the resident would and would not be charged for were discussed, however there is not a list containing the cost of the items. A face-to-face interview was conducted with Employee #12 on July 1, 2016 at approximately 11:00 AM who acknowledged the findings.	F 162		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for three (3) of 20 sampled residents, it was determined that facility staff failed to: monitor blood pressure in accordance with physician ' s orders for one (1) resident, consistently conduct evaluation and reassessment of pain for one (1)	F 309		

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F 309	Continued From page 6 resident and apply adaptive devices for the management of edema for one (1) resident. Residents #17, 22 and 23 The findings include: 1. Facility staff failed to follow physician orders for application of adaptive devices for the treatment edema of Resident #17 ' s left upper extremity. According to the History and Physical examination signed by the physician on September 29, 2015 revealed that Resident #17 ' s diagnoses included: HTN (Hypertension), HLD (Hyperlipidemia), Depression, and Edema. Physician ' s orders dated June 16, 2016 [original order dated 4/7/14] directed: Patient to wear cone splint on left hand when in bed. Remove when out of bed. Check skin on left hand for any redness or irritation; Elevate left arm on pillow when in bed and OOB [out of bed] for edema. " Resident #17 was observed lying in bed on June 29, 2016 at approximately 4:30 PM in the company of Employee ' s #5 and #13. There was no evidence that the cone hand splint was applied and the left hand/arm was not elevated on pillows. Employee #13 stated, he/she was not aware that the resident required a cone or elevation of the left arm. Employee #5 was unsuccessful in locating the cone for the resident. Facility staff failed to follow physician's orders for the use of adaptive devices for the treatment of edema for Resident #17.	F 309	**Failure to follow physician orders for application of adaptive devices for treatment of edema of Resident #17 ' s left upper extremity.** 1. **Corrective Action for Resident With Deficient Practice.** A thorough search for resident's adaptive device was conducted to include the resident's room, laundry facilities, and the Therapy Department. Adaptive device was not located. Therapy provided replacement device for the resident. 2. **How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** Residents who have adaptive devices of any type have been identified by Therapy. All have been assessed to have assistive devices, as ordered. Staff have been informed of the devices that are to be in place and the wearing/usage schedule ordered. 3. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Charge Nurses will ensure adaptive devices required for each resident are indicated on the CNAs' Daily Assignment Sheet. Use of adaptive devices will be included in the CNAs' documentation (e.g., Care Tracker) and on the TAR completed by nurses. 4. **Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Care Tracker and TARs will be audited monthly by the Medical Records Secretary for compliance. Results will be reported quarterly to the QAPI Committee.	6/29/16 7/5/16 7/27/16 7/28/16

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

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F 309	Continued From page 7 2. Facility staff failed to monitor Resident #22 ' s blood pressure in accordance to physician ' s orders. According to the facility ' s policy " Protocol for Blood Pressure Monitoring, " revised date: 04/30/15 stipulates, " II. Policy Implementation: A. Monitoring Protocol for Hypertensive Residents- 2. If the resident ' s systolic blood pressure is greater than 160mmHg (millimeters of Mercury) or less than 100mmHg and the diastolic blood pressure is greater than 100mmHg or less than 60mmHg the reading will be considered abnormal. The resident must be monitored and two additional reading obtained at intervals not longer than 2 hours apart ...3. The resident ' s physician will be notified if the blood pressure is abnormal for three (3) consecutive readings ... " The physician's order dated May 26, 2016 [no time indicated], directed: " Monitor blood pressure 2 [times] a day on Tuesdays, Thursdays, and Saturdays to determine the effectiveness of blood pressure medications. Notify M.D. (Medical Doctor) if SBP (Systolic Blood Pressure) > [greater than] 160 or < [less than] 100mmHg or DBP (Diastolic Blood Pressure) [greater than] 100 or [less than] 60mmHg [times] 3 (three) consecutive readings ... " The June 2016 MAR (Medication Administration Record) revealed Resident #22 ' s blood pressure on June 21, 2016 at 10 AM was 164/78 and on June 28, 2016 at 10:00AM it was 174/70. A review of the nurses notes for June 21, 2016 and June 28, 2016 lacked documented evidence	F 309	**Failure to monitor Resident #22's Blood Pressure in Accord with Physician's Order.** **2. Corrective Action for Resident With Deficient Practice.** Employee involved in the deficient practice was educated on the Blood Pressure policy. The meaning of the word "consecutive" was also clarified with this employee. **5. How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** Medical charts and MARs of residents receiving B/P medications were reviewed. Based on this documentation review, no other residents experienced the deficient practice. Documentation was consistent with the Physician's Order. **6. Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Staff received Training/Education on the Policy and Procedure for abnormal Blood Pressure values. Special emphasis was placed on employees' comprehension of terminology included in the policy. **7. Plan to Monitor Performance to Make Sure Solutions Are Sustained.** MARs will be audited by Nurse Manager for compliance. Results will be reported quarterly to the QAPI Committee	7/1/16 7/12/16 7/18/16 7/28/16

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F 309	Continued From page 8 of three consecutive blood pressure readings to determine the effectiveness of the blood pressure medications based on the parameters defined by the physician. A face-to-face interview was conducted with Employees # 3 and #7 on June 30, 2016 at approximately 2:00 PM regarding the aforementioned findings. Both acknowledged that consecutive blood pressure readings were not obtained. The clinical record was reviewed on June 30, 2016. 3. Facility staff failed to consistently conduct evaluation and reassessment of pain to include the intensity of pain for Resident #23. According to the facility ' s policy " Pain Assessment and Management, " revised dated 6/1/16 stipulates, " 1. Perform a pain assessment using the assessment form that is part of the protocol ....2. Review the resident ' s current pain medication regiment to determine the following: 2 C. degree of relief experienced from this medication ...." The " Pain Management Risk Assessment Tool " revealed .... " Pain Intensity: 0- No pain; 1- Mild (1-3 self-report on scale of 10), 2 Moderate (4-6 self-report on scale of 10), 3-Severe (7-10 self-report on scale of 10) ..." A review of the Physician ' s Order Form signed and dated June 9, 2016 (order originated February 24, 2015) directed, " Acetaminophen 500mg (RPL Tylenol Extra strength)- 2 (two) tabs (tablets)- (1000 mg) by mouth every 6 hours as needed for body pain .... " A review of the March 2016 through May 2016 MAR (Medication Administration Record)	F 309	**A (3): Failure to Consistently Conduct Evaluation and Reassessment of Pain to Include the Intensity of Pain for Resident #23.** 1. **Corrective Action for Resident With Deficient Practice.** Corrective action is not indicated, as pain medication had already been administered and documented as effective post administration. 2. **How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** Residents receiving pain medication (regularly scheduled and PRN) are identified based on physician orders. Corrective action taken to ensure pain assessments are conducted before and after administration of analgesic include a) updating the facility's current pain policy/protocol and assessment tool to address intensity, and 2) educate all staff on the correct interpretation of the policy and use of the tool. 3. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Monthly audits of the MARs by Medical Records will be conducted to determine compliance with the revised policy and implementation of the training provided. 4. **Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Results of the chart audits will be reported quarterly to the QAPI Committee.	6/30/16 7/15/16 7/18/16 7/28/16

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F 309	Continued From page 9 revealed that Resident #23 received Extra Strength Tylenol- 2 tablets on the following dates for body pain: March 4, 2016 - 12AM - result: effective March 13, 2016- 1:30 PM- result: helpful March 31, 2016- 1:00 PM- result: effective March 16, 2016- 1:10 AM - result: effective April 2, 2016- 2:00AM- result: effective April 19, 2016- 1:00 PM - result: helpful May 15, 2016 - 1:30 PM- result: effective There was no evidence that facility staff consistently conducted an assessment that included a description of the intensity of the pain (e.g. numeric scale) before and after the administration of Extra Strength Tylenol for Resident #23. A face-to-face interview was conducted with Employees # 3 and #7 on June 30, 2016 at approximately 2:30 PM. Both acknowledged the aforementioned findings. The clinical record was reviewed on June 30, 2016.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that facility staff failed to consistently assess and monitor Resident #17 ' s right heel to ensure that necessary treatment and services were provided. Subsequently, the resident developed an Unstageable Pressure Ulcer that was initially identified at an advanced stage. Resident #17. The findings include: Policy: Skin Impairment, Effective Date May 13, 2010, Revisions: May 16, 2016 stipulated: " Policy Statement: All residents will be assessed upon admission and then routinely for skin impairment. Skin impairment includes, but not restricted to: Skin tears, Pressure Ulcers, Vascular Ulcers ... Policy Interpretation and Implementation: 1. Prevention (b) For those residents who are at Risk (a score of 18 or below) the following intervention will be instituted: (2) Resident will be turned and repositioned every 2 hours while in bed ... (5) heels will be kept off mattress, (6) Skin will be moisturized at least twice a day ... (7) .... Incontinent residents must have pericare with skin barrier at least once per shift. Licensed staff will assess skin and document weekly .... " The History and Physical examination signed and dated by the physician on September 29, 2015 revealed that Resident #17 diagnoses included: HTN (Hypertension), HLD (Hyperlipidemia), Depression, and Edema.	F 314	**Failure to Consistently Assess and Monitor Resident #17's Right Heel to Ensure that Necessary Treatment and Services Were Provided. Subsequently, the Resident Developed an Unstageable Pressure Ulcer that was Initially Identified at an Advanced Stage.** **1. Corrective Action for Resident With Deficient Practice.** Total body assessment was completed for the resident and related documentation updated accordingly. **2. How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** Skin Sheets and other documentation (e.g., Braden Scale, Weekly Skin Checklist) were reviewed for all residents identified with pressure ulcers. Where necessary, these documents were updated and/or revised. **3. Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Policy will be revised to include: 1) Condition of each resident's skin is assessed weekly on shower days. 2) Assessment results are documented/signed by the licensed nurse on the Weekly Skin Assessment Sheet. 3) When there is a skin condition identified, the appropriate form (i.e., (Non- Pressure or Pressure Ulcer Record) will be instituted. 4) These documents will be updated weekly during wound rounds and audited for completion and accuracy on a monthly basis. **4. Plan to Monitor Performance to Make Sure Solutions Are Sustained.** The results of the Weekly Skin Rounds and an audit of the Skin Assessment sheets will be reported quarterly to the QAPI Committee.	7/5/16 7/5/16 7/18/16 7/28/16

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According to the quarterly Minimum Data Set (MDS) dated February 3, 2016, Resident #17 was coded in Section C (Cognitive Patterns) as severely impaired; Section G0110 and G0120 (Functional Status) the resident was coded as totally dependent, requiring assistance of one or two people for bed mobility, transfer, dressing, personal hygiene, bathing and wheelchair dependent for mobilization; Section H0300 (Urinary Continence) revealed resident was always incontinent. Section M (Skin Condition), the resident was coded as being at risk for developing pressure ulcers. In Section M 0210 (Current Number of Unhealed Pressure Ulcers) the resident was coded as " 0 " indicating that the resident did not have any unhealed pressure ulcer.

A review of the subsequent, Significant Change MDS dated May 3, 2016 revealed under Section M, Skin Conditions, Resident #17 was coded as having one (1) Unstageable pressure ulcer.

The " Pressure Ulcer " care plan updated February 9, 2016 revealed " Goal: Resident will remain free of skin breakdown through next review; Approach: ... Air alternating pad on mattress, Body/skin audit at least biweekly on bath days, Braden Scale assessment quarterly and PRN (as needed), Assess all skin during AM/PM care and prn, notify nurse/MD for any open or discolored areas .... "

A review of the clinical record revealed the facility ' s Pressure Ulcer Risk Assessment tool combined with the "Braden Scale - For Predicting Pressure Sore Risk " [a tool utilized by health professionals, especially nurses to assess a

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F 314	Continued From page 12 patient's risk of developing a pressure ulcer] signed and dated by the Registered Nurse on February 24, 2016, revealed Resident #17 was assessed as "High Risk " for pressure ulcer development. A review of the Dietary Progress Notes dated February 2, 2016 revealed that Resident #17 ' s " skin integrity was intact " and that the resident was at " risk for pressure ulcer(s) [secondary] to immobility. " A review of nurse ' s notes revealed the following: March 20, 2016 -11:00 PM- .... Turned and repositioned q 2 [every 2 hours] as as needed ... March 21, 2016- 6:52 AM- ... skin warm and dry to touch. ADL [Activities of daily living] provided, turned and positioned as needed ... March 21, 2016- 3:35 PM- ... Turning and positioning per protocol. No skin breakdown noted. Skin warm and intact ... March 21, 2016- 11:18 PM- ... incontinent care done ... March 22, 2016- 7AM- ... Turned and repositioned [every] 2 hours, also other needed ADL ' s and nursing care were attended to ... March 22, 2016- 11:20 PM- ... incontinent care done ... March 23, 2016- 7:02 AM- ... incontinent care done ... March 23, 2016- 11:00 PM- ... incontinent care	F 314		

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done ...

The clinical record lacked evidence of nurse ' s progress notes for the period of March 23, 2016 through March 27, 2016.

March 28, 2016 7:30 AM nurse ' s entry: CNA [Certified Nursing Assistant] reported black area noted on the right heel during care. On assessment area noted with grayish black discoloration with intact skin measuring 2.3cm [centimeters] x [by] 1.8 cm. Surrounding area noted with redness. No facial expression of pain noted on palpitation to the area and no warmness noted on the area. MD [Medical Doctor] updated, order in place to apply skin prep to the area twice daily, and float the heel with Prevalon boot [pressure relieving heel protector] on while in bed. Order in place to turn and reposition resident every two [2] hours. Resident remains alert and oriented to self. No change or deviation from [his/her] baseline noted ...skin prep applied to right heel as ordered. "

The clinical record lacked evidence that facility staff conducted body/skin assessments ' at least ' biweekly in accordance to the care plan. Through staff interview, it was determined that nursing staff were to utilize the facility ' s " Weekly Skin Checklist " form to record weekly skin assessments that were usually conducted on shower days. However, there was no evidence in Resident #17 ' s clinical records that Weekly Skin Checklist forms were completed.

A review of the " Pressure Ulcer Record " revealed nursing staff recorded the following characteristics of the resident ' s right heel ulcer:

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F 314	Continued From page 14 " Date First Observed: March 28, 2016, Stage: SDTI (Suspected Deep Tissue Injury), Color: grayish/black, Size: 2.3 cm x 1.8 cm, Granulation: No, Drainage: No, Odor: No ... " A face-to-face interview was conducted with Employee #5 on June 29, 2016 at approximately 3:00 PM. A query was made regarding the skin impairment of the resident ' s right heel. He/she stated " the wound was first found unstageable then once the scab came off, it was assessed as a Stage III pressure ulcer. " The employee further stated, the resident ' s shower days were Mondays and Thursdays. A telephone interview was conducted on July 1, 2016 with Employee #13 at approximately 4:15 PM. Employee #13 indicated that he/she works with the resident on the 7:00 AM to 3:00 PM shift and the day he/she saw the wound on the right heel [March 28, 2016] was the day he/she reported it. Employee #13 also reported that the right heel was not open, it was dark and was getting to be black. A telephone interview was conducted on July 1, 2016 with Employee #14 at approximately 4:30 PM. Employee #14 indicated that he/she works the evening shift from 3:00 PM to 11:00 PM and agreed that he/she was assigned to Resident #17 the evening of March 27, 2016. Employee #14 stated " on our shift we put the resident to bed ...we remove any clothes and wash the stockings for the morning. " In response to a query regarding whether or not the resident was observed with any abnormality in the skin of the right heel, he/she stated that no discoloration or abnormality was observed. The employee could not recall if the resident ' s heels were floated on	F 314		

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F 314	Continued From page 15 pillows. A face-to-face interview was conducted with Employee #1 on July 1, 2016 at approximately 3:00 PM. who stated " there are no shower/skin sheets [Weekly Skin Checklist] for the resident. " Resident #17 was assessed with a facility acquired, unstageable pressure ulcer of the right heel on March 28, 2016, characterized as " grayish black discoloration. " The resident was assessed as " high risk " for developing skin impairment according to the Braden Scale. There was no evidence that facility staff consistently assessed and/or monitored the resident ' s skin and subsequently, he/she was assessed with a facility acquired pressure ulcer of the right heel initially identified at an advanced stage [unstageable]. A face-to- face interview was conducted with the Employees #1 #2 and #3 on July 1, 2016 at approximately 5:00 PM. After review of the clinical record, all acknowledged the aforementioned findings. The clinical record was reviewed on July 1, 2016.	F 314		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations made on June 27, 2016 at approximately 9:05 AM it was determined that the facility failed to store foods under sanitary conditions as evidenced by two (2) of two (2) soiled food warmers in the main kitchen. The findings include: Two (2) of two (2) food warmers located in the main kitchen were soiled at the bottom. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 371	**A (1): Failure to Store Foods Under Sanitary Conditions as Evidenced by Two (2) of Two (2) Soiled Food Warmers in the Main Kitchen.** 1. **Corrective Action for Deficient Practice.** Two of two warmer units were cleaned June 28, 2016. 2. **How Potential for the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** No resident or equipment was affected by practice. 3. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not** Policy will be updated to include responsibility of Dining Services Management Team to inspect the warmer equipment, as part of the Safety and sanitation audit. The Master cleaning schedule has been updated and cleaning has been increased from bi-weekly to weekly or as needed. Weekly cleaning of the warmer has been placed on the production master cleaning schedule effective July 1, 2016. 4. **Plan to Monitor Performance to Make Sure Solutions Are Sustained. The director of dining services will monitor the** Results of the monthly Safety and sanitation Audit will be reported quarterly to the QAPI Committee.	6/28/16 6/28/16 7/1/16 7/28/1
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on June 27, 2016 at approximately 9:05 AM it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a minimum of 180 degrees Fahrenheit during five (5) consecutive final rinse cycles and a broken temperature gauge in one (1) of two (2) food warmers. The findings include:			

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F 456	Continued From page 17 1. The dishwashing machine failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit in five (5) of five (5) consecutive wash cycles. 2. The built-in temperature gauge to one (1) of two (2) food warmers was stuck and needed to be replaced. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 456	**Failure to Maintain All Essential Mechanical, Electrical, and Patient Care Equipment in a Safe Operating Condition.** **(1) Dishwashing machine failed to reach a minimum final rinse temperature of 180 degrees F⁰ in five (5) of five (5) consecutive rinse cycles.** **1. Corrective Action for Resident With Deficient Practice.** Manual sanitation policy was put into place. Service company was called and came out immediately.	6/27/16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of five (5) sampled residents who received Hospice services, it was determined that facility staff failed to maintain an accurate clinical record as evidenced by the lack of complete documentation related to the provision of Hospice		**2. How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** No resident or equipment was affected by practice.	6/27/16
			3. Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur. The dish machine log will be reviewed by Management team before each meal. Manager will initial by each temp taken.	7/5/16
			4. Plan to Monitor Performance to Make Sure Solutions Are Sustained. Director of Dining Service will track any findings and report results to quarterly to the QAPI Committee.	7/28/16

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F 514	Continued From page 18 care and services. Resident #52. The findings include: Resident #52 was admitted to Hospice Care on December 28, 2015. A face-to-face interview was conducted with Employee #5 at approximately 2:30PM on June 30, 2016. During the interview the employee was queried regarding the frequency of visits by the Hospice Nursing staff. The employee responded, " Nursing Assistants visit several times each week [three to four days per week] and the nurse visits at least once a week; sometimes twice. " A review of the Hospice section of the clinical record revealed that the documentation did not reflect weekly visits by the Hospice Nurse. Review of documentation for the month of May revealed Hospice Nurse's notes dated May 06, 2016 and May 16, 2016. Review of the notes for June revealed documentation for June 6, June 10 and June 13. There was no note for the week of June 01, June 20, and/or June 27, 2016. A face-to-face interview was conducted with Employee #11 [Hospice nurse] at approximately 10:30AM on July 1, 2016. "I visit at least once a week; sometimes twice and more often if needed. I always write a summary of my visit and place a copy on the chart before I leave. I usually keep a copy for myself. I can show you my copy." The employee opened his/her bag and displayed copies of Hospice Nursing Notes that were dated June 20 and June 27, 2016. The employee concluded, " I don't know what happened to the notes but I left them in the chart. Another face-to-face interview was conducted	F 514	**Failure to Maintain an Accurate Clinical Record as Evidenced by the Lack of Complete Documentation Related to the Provision of Hospice Care and Services for Resident #52.** 1. **Corrective Action for Resident With Deficient Practice.** The hospice documentation in question was retrieved from the Hospice provider and placed in the resident's record. 2. **How Residents Potentially Affected by the Same Deficient Practice Will Be Identified, and What Corrective Action Will Be Taken.** All residents receiving hospice care will be identified. Their charts will be reviewed to ensure that documentation by hospice providers has been placed in the chart to reflect visit dates and services provided. 3. **Measures or Systemic Changes to be Made to Ensure Deficient Practice Does Not Recur.** Medical charts of residents receiving hospice care will be audited monthly by the Medical Records Secretary to determine presence of hospice documentation of visits made during the month. If documentation is found to be missing, the hospice provider will be contacted and requested to deliver the missing documentation. 4. **Plan to Monitor Performance to Make Sure Solutions Are Sustained.** Results of the monthly audits will be reported quarterly to the QAPI Committee.	7/5/16 7/15/16 7/25/16 7/28/16

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F 514	Continued From page 19 with Employees #1, 2 and 3 at approximately 12:00 PM on July 1, 2016. The employees acknowledged that the resident ' s clinical record lacked complete documentation of the provision of Hospice care and services. The record was reviewed on June 30, 2016.	F 514		