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 _____	09/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Quality Indicator Recertification Survey was conducted at Forest Hills of DC from September 20, 2017 through September 22, 2017. Survey activities consisted of a review of 19 residents' clinical records during Stage 1 and a review of 22 clinical records during Stage 2.
The following deficiencies are based on facility observations of staff practices; review of the facility's operating procedures and interviews with residents, families, and facility staff. After analysis of the findings, 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
cc - cubic centimeters
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Savoy
TITLE: Administrator
(X6) DATE: October 21, 2017

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 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) LE- Lower Extremity 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 Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review PO- by mouth PO2- Pulse oximetry POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party Sol- Solution S/P- Status Post TAR - Treatment Administration Record Tx- Treatment UE- Upper Extremity	F 000		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		

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F 278	Continued From page 2 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview of three (3) of 22 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) as follows: 1.) the active diagnoses for two (2) residents with visual	F 278	**F 278 – Failure to Accurately Code MDS:** **A. <u>Three Residents With Vision Diagnoses</u>** **1. Corrective Action for Deficient Practice:** MDS coding errors were corrected for three residents involved. **2. Other Residents Potentially Affected by Deficient Practice:** External consultant has been contracted to complete retrospective audits of MDSs to determine if additional coding errors exist. Corrections will be made as necessary. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) DON to complete weekly validation audits of MDS coding using EHR software; b) MDS Coordinator in-serviced on methodology for validating MDS codes prior to submission; c) policy updated to incorporate changes; d) semi-annual review of MDSs by external consultants **4. Performance Monitoring to Ensure Sustainability:** Audit results to be reported to QAPI quarterly.	10/23/17 10/23/17 10/23/17 10/26/17

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F 278	Continued From page 3	F 278		

diagnoses, and 2.) the functional status for one (1) resident (Residents #6, 37, and 48).

The findings include:

1. The facility staff failed to code visual diagnosis on the MDS.

A. A review of the medical record for Resident# 6 revealed Resident was admitted to the facility on November 3, 2014, with admitting diagnoses of Essential (Primary) Hypertension, Muscle Weakness, Neuropathy, and Osteoarthritis.

A further review of the medical record revealed a Report of Consultation [Ophthalmology] form dated March 7, 2017, findings "1. Macular Degeneration and 2. Dry Eyes, recommendations: 1. No treatment necessary 2. Artificial Tears 1 gtt (drop) both eyes, Lacri-lube ophthalmic ointment left eye only thin ribbon at night".

On September 21, 2017, at approximately 2:45 PM, a review of the medical record Minimum Data Set Assessments dated June 14, 2017, revealed the facility staff failed to code Section I [Active Diagnoses] under Section I18000 [Additional Active Diagnoses] Resident #6 Visual Diagnosis.

The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis.

During a face-to-face interview with Employee# 15 on September 21, 2017, at approximately 3:15 PM, the Employee acknowledged the findings.

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F 278	Continued From page 4 B. A review of the medical record for Resident# 48, revealed Resident was admitted to the facility on January 11, 2016, with admitting diagnoses of Chronic Obstructive Pulmonary Disease with (acute) exacerbation, Heart Failure, Pleural Effusion, and Hyperlipidemia. A further medical record review reveals a Report of Consultation [Ophthalmology] form dated August 7, 2017, findings "Macular Degeneration possible wet OD (right eye) continue with Ocuvite, recommended to come to the office for OCT, patient will decide whether to proceed with possible treatment..." On September 21, 2017, at approximately 2:45 PM a medical record review reveals Minimum Data Set Assessments dated July 11, 2017. The assessment reveals the facility staff failed to code Section I [Active Diagnoses] under Section I18000 [Additional Active Diagnoses] Resident# 48 Visual Diagnosis. The medical record lacked documented evidence the MDS coding reflects the Resident's visual diagnosis. During a face-to-face interview conducted with Employee# 15 on September 21, 2017, at approximately 3:15 PM. Employee #15 acknowledged the findings. 2. The facility staff failed to accurately code the bed mobility on the MDS. Medical record review of Resident #37 was admitted to the facility on 1/19/17 with diagnoses to include Dementia, Hyperlipidemia, Essential	F 278	**F 278 – Failure to Accurately Code MDS:** **B. <u>Resident's Bed Mobility</u>** **1. Corrective Action for Deficient Practice:** MDS coding error was corrected for resident involved. **2. Other Residents Potentially Affected by Deficient Practice:** External consultant has been contracted to complete retrospective audits of MDSs to determine if additional coding errors exist. Corrections will be made as necessary. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) Form used to monitor residents during ARD assessment period (which includes functional status) will be modified to require signatures of both the MDS nurse and the rehab director to ensure consistency in assessments. b) Administrator, DON, MDS Coordinator, and rehab director will participate in monthly Triple Check meetings to avoid coding errors prior to MDS submissions. Errors identified will be corrected contemporaneously at the meetings. c) DON will generate monthly findings from Triple Check meetings to monitor frequency and type of errors identified. d) semi-annual reviews of MDSs by external consultants. **4. Performance Monitoring to Ensure Sustainability:** Audit results to be reported to QAPI quarterly.	10/23/17 10/23/17 10/23/17 10/26/17

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F 278	Continued From page 5 Hypertension, Chronic Atrial Fibrillation, and Cerebral Infarct. On September 20, 2017, at approximately 10:00 AM, Resident #37 was observed actively participating in a range of motion ball toss game. On September 21, 2017, at 11:39 AM, a clinical record review showed Minimum Data Set (MDS) dated April 24, 2017. The facility staff code Section G Functional Status subsections for bed mobility as limited assistance (resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance) on April 24, 2017. Review of the nursing assistant's "Documentation Survey Report" for April 18- 24, 2017, which corresponds to the Assessment Reference Date (ARD) of April 24, 2017, showed the Resident required extensive assistance to total dependence for five (5) of 19 documented shits for bed mobility. The medical record lacked documented evidence the facility staff accurately coded bed mobility to reflect the resident's status during the assessment reference period. During a face-to-face interview conducted with Employee# 15 on September 21, 2017, at approximately 3:15 PM. Employee #15 acknowledged the findings.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 6 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 1. (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	F 279	**F 279 – Failure to develop a hospice care plan with goals and approaches to address the coordination of the resident's care and services.** 1. **Corrective Action for Deficient Practice:** Hospice nurse was in-serviced by hospice administrator on how to clearly identify and develop a plan of care with the LTC team. Plan must contain common palliative interventions & palliative outcomes. 2. **Other Residents Potentially Affected by Deficient Practice:** Facility staff met with the contracted hospice provider and reviewed the current care plan integration process for all hospice residents to ensure that collaboration was addressed. An audit of all hospice records was conducted by the facility and shared with the contracted hospice provider. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) Facility staff and hospice staff will receive in-service training regarding communication processes and care plan integration that includes timely documentation of interventions (i.e., immediately after hospice visit and/or care plan participation). All documentation by hospice staff will be given to the MDS Coordinator immediately to scan into the EHR. b) Monthly compliance audits of hospice records will be completed by both hospice and facility personnel to ensure compliance. Any deficiencies will be identified and corrected on the spot. c) Hospice general manager will participate in quarterly QAPI meetings. **Performance Monitoring to Ensure Sustainability:** Audit results will be reported quarterly to QAPI Committee.	10/2/17 10/9/17 10/9/17 10/15/17 10/26/17

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F 279	Continued From page 7 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 22 Stage 2 sampled residents,the facility staff failed to develop a hospice care plan with goals and approaches to address the coordination of care and services for Resident's #52. The findings include: A review of the admission information in the clinical record on September 22, 2017, at approximately 10:00 AM revealed that Resident #52 was admitted to the facility on January 24,	F 279		

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F 279	Continued From page 8 2017, with diagnoses which included Alzheimer's Disease and Hypertension, The resident was also coded for Hospice Care under Section O of the Comprehensive MDS (Minimum Data Set) dated February 1, 2017. A review of the care plan dated August 2, 2017, lacked evidence of collaborative goals and approaches to manage the prescribed hospice care for Resident #52. During a face- to- face interview with Employee # 2 on September 22, 2017, at 2:00 PM he/she acknowledged the findings after reviewing the clinical record.	F 279		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323	**F 323 – Portable Heater in Resident's Room** **1. Corrective Action for Deficient Practice:** heater was immediately removed from room. 2. **Residents Affected by Deficient Practice:** No resident was affected by deficient practice. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) Safety Rounds Checklist has been updated to include observation for portable heaters and other equipment in resident rooms that may pose safety hazards. . b) Education was provided to all private duty caregivers regarding equipment safety and other safety measures to be maintained while caring for a resident. Emphasis included use of portable heaters. **4. Performance Monitoring to Ensure Sustainability:** Results of bi-weekly safety rounds will be reported quarterly to QAPI	9/20/17 9/20/17 9/27/17 10/26/17

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F 323	Continued From page 9 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations made on September 20, 2017 at approximately 10:00 AM, the facility failed to maintain resident's environment free of accident hazards as evidenced by a portable heater that was in use in one (1) of 21 resident's rooms. The findings include: A portable heater was plugged in and in use in resident room #140, one (1) of 21 resident's rooms surveyed. This observation made in the presence of Employees #11 and #12 was acknowledged.	F 323		
F 329	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		

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F 329	Continued From page 10 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview of one (1) of 22 sampled residents, the facility staff failed to include indications for the use of Klonopin (treatment of anti-anxiety) on the POS (physician order form) for Resident # 35. The findings include: A review of the history and physical revealed	F 329	**F 329 – Failure to include indications for the use of Klonopin (treatment of anti-anxiety) on the Physician Order Sheet** **1. Corrective Action for Deficient Practice:** clarification order for medication in question was immediately obtained. 2. **Residents Affected by Deficient Practice:** Chat audits were conducted to identify other residents who may have experienced deficient practice. Based on audit, no other resident was affected. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) Nurses were trained on policy which requires indication for use for each medication ordered. b) Charge nurses are required to conduct chart checks daily. c) Supervisors audit physician orders monthly to ensure indication for each medication is included as part of the order. **4. Performance Monitoring to Ensure Sustainability:** Results of nursing audits will be reported quarterly to QAPI Committee.	9/25/17 9/25/17 9/27/17 10/26/17

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F 329	Continued From page 11 Resident # 53 was admitted to the facility on April 30, 2014, with a diagnosis which included Depression and Hypertension. The clinical record for Resident #35 revealed a physician's order originated April 5, 2017, directed "Klonopin 0.25mg by mouth 2 times a day for anxiety". A review of the current physician's orders signed September 12, 2017, stated: "Klonopin 0.25mg by mouth 2 times a day". There was no evidence of indications for use on the physician order form. During a face-to-face interview with Employee #2 on September 22, 2017, at 10:00 AM, the Employee acknowledged the findings.	F 329		
F 371	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		

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F 371	Continued From page 12 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations made on September 20, 2017 at approximately 8:30 AM, the facility failed to serve foods under sanitary conditions as evidenced by one (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove that were soiled throughout and the kitchen floor soiled with debris. The findings include: 1. One (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove located in the main kitchen soiled. 2. The entire kitchen floor soiled with debris. The observations made in the presence of Employee #13 were acknowledged.	F 371	**F371 – Unsanitary Conditions** **A. Soiled Equipment** 1. **Corrective Action for Deficient Practice:** Equipment was cleaned thoroughly on September 21, 2017. 2. **Residents Affected by Deficient Practice:** There has been no indication to date that residents were affected by the deficient practice. 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) All Production and Utility staff were trained on the proper cleaning of equipment. b) The Master cleaning schedule was revised to increase weekly cleanings to bi-weekly for all kitchen equipment. 4. **Performance Monitoring to Ensure Sustainability:** The Executive Chef will monitor compliance with the schedule and report findings quarterly to the QAPI Committee. **B. Soiled Floor** 1. **Corrective Action for Deficient Practice:** Entire kitchen floor was deck scrubbed immediately. 2. **Residents Affected by Deficient Practice.** No resident was affected by deficient practice. **3. Systemic Changes to Ensure Deficient Practice Does Not Recur**. Floor cleaning policy was reviewed with all utility staff. Assignment sheet was revised to include name of employee responsible for sweeping & mopping floor each shift to ensure accountability. **4. Performance Monitoring to Ensure Sustainability** The Dining Services Manager on duty will monitor the cleanness of the floor daily by checking out each utility person after the shift. Findings will be reported to the Director of Dining services weekly and reported at the Quarterly QAPI meeting.	9/21/17 9/21/17 9/29/17 10/26/17 9/21/17 9/21/17 9/23/17 10/26/17
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F 456		

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 _____	09/22/2017

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 456	Continued From page 13 (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations made on September 20, 2017 between 8:30 AM and 9:45 AM, the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) food warmer with no temperature control knob, one (1) of one (1) tilt skillet which failed to power up when turned on, and one (1) of one (1) dishwashing machine which failed to reach 180 degrees Fahrenheit at final rinse. The findings include: 1. The temperature control knob for one (1) of one (1) food warmer was missing. 2. One (1) of one (1) tilt skillet failed to power up when the 'on' switch was activated. 3. The dishwashing machine in the main kitchen failed to reach a final rinse temperature of 180 degrees Fahrenheit during several consecutive rinse cycles. The dishwashing machine located in the dining room of the Healthcare 1 Unit was used to clean and disinfect all dishes. The observations made in the presence of Employee #13 and Employee #14 were acknowledged.	F 456	**L456 – Failure to Maintain Essential Equipment in Good Working Condition** **A. <u>Missing Temperature Control Knob</u>** **1. Corrective Action for Deficient Practice:** The knob was found and placed back on the warmer. 9/20/17 **2. Residents Affected by Deficient Practice:** No resident was affected by deficient practice. 9/20/17 **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** The monthly Safety and Sanitation Audit Checklist has been updated to include checking the working condition of all equipment. 9/27/17 **4. Performance Monitoring to Ensure Sustainability:** The Assistant Director and the Executive Chef will monitor results recorded on the Checklist. Concerns will be discussed with the Director at weekly Managers' meetings and presented to the QAPI Committee quarterly. 10/26/17 **B. <u>Tilt Skillet Failed to Power Up</u>** **1. Corrective Action for Deficient Practice:** Written notice placed on skillet stating that it was not working. 9/20/17 **2. Residents Affected by Deficient Practice:** No residents were affected. 9/20/17 3. **Systemic Changes to Ensure Deficient Practice Does Not Recur:** Purchase of new tilt skillet has been approved by Administrator. Upon arrival, tilt skillet will be added to Safety Rounds Checklist. 9/26/17 **Performance Monitoring to Ensure Sustainability:** Results from safety rounds will be reported quarterly to QAPI Committee. 10/26/17 **C. <u>Dishwashing Machine Failed to Reach Final Temperature of 180^0</u>** **1. Corrective Action for Deficient Practice:** Ecolab was called, responded immediately. Assessed dish machine and made recommendations regarding process flow changes to prevent depletion of hot water in booster heater before rinse cycle is complete. 9/20/17 **2. Residents Affected by Deficient Practice:** No residents were affected. 9/20/17 **3. Systemic Changes to Ensure Deficient Practice Does Not Recur:** a) New process that incorporates Ecolab's recommendations was developed, and all utility staff were in-serviced. b) Purchase of new dish machine has been approved by Administrator. c) Upon arrival, dish machine temperatures will be added to Safety Rounds Checklist. 9/23/17 9/26/17 **4. Performance Monitoring to Ensure Sustainability:** Results reported quarterly to QAPI. 10/26/17	