October 15, 2018

Veronica Longstreth RN, MSN

Program manager

Department of Health

899 North Capitol Street, NE, 2nd floor

Washington, DC 20002

Dear Ms.Longstreth,

Please find attached updated POC for the Federal tags, and State tags, and survey that were completed at our facility on August 15, 2018.

If there are questions, please contact me at 301-254-9250.

Sincerely,

Stephen Gbenle

Stephen Gbenle,RN,BSN,LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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F 000	INITIAL COMMENTS	F 000		

An unannounced Recertification Survey was conducted at Health Rehabilitation Center at Thomas Circle August 7, 2018, through August 15, 2018, and consisted of a review of 19 resident clinical records. Based on observations, record reviews, and staff interviews, an analysis of the findings determined the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
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
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Gbenle | TITLE: Administrator | (X6) DATE: 10/15/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 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 Sol- Solution TAR - Treatment Administration Record	F 000
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550

The following Plan of Correction, prepared and submitted by The Residences at Thomas Circle is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.
In this document, we have outlined specific actions in response to each allegation or finding.

1. Resident #18 has been discharged from the facility.

2. All current in-house residents have been interviewed by the Nursing home Administrator and/or designee to determine currently if they feel that they are being treated with respect and dignity by the direct care staff.

8/30/18

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F 550	Continued From page 2 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 19 sampled residents, the facility failed to honor Resident #18's	F 550	Residents currently in-house have been interviewed by the NHA and/or designee by and no issues with call-light response time has been noted. 3. The Nursing assistant involved in this incident was terminated. The direct care staff was in-serviced by the DON on resident Rights and the Provision of Care related to dignity and respect when briefs are being changed. Staff non-compliance will result in re-education and disciplinary action as indicated. All staff will be in-service by the DON on the expected response time to answering resident call lights. The D.O.N. and unit managers will be monitoring and following up as needed with re-education and/or disciplinary action as indicated to ensure timeliness of response and compliance. 4. NHA and/or designee will interview residents, document and report findings on a weekly basis x4, then monthly x3 related to the observance of resident rights by direct care staff. NHA and/or designee will review call light logs weekly x4, then monthly x3	8/30/18 8/30/18 10/15/18

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F 550	Continued From page 3 request/ preference to have her brief changed and did not treat the resident with dignity and respect, and failed to answer the resident's call for help in a timely manner (Resident #18). Findings included... Facility staff failed to honor the residents request/preference to have her brief changed and did not treat the resident with dignity and respect. Resident # 18 was admitted to the facility on July 3, 2018 with diagnoses, which included Joint pain, chronic embolism and thrombosis, and Hypothyroidism. According to the Admission Minimum Data Set (MDS) the Resident's Brief Interview for Mental Status (BIMS) score was 15 indicating she is cognitively intact. During a face-to-face interview with Resident #18 on August 7, 2018, at 4:00 PM, she stated. "Staff do not answer the call light. There have been times when it took an hour for staff to answer the light. I have urinated in my brief twice the Certified Nurse Aide (Employee #6) came to the room to check me and stated my diaper is not wet and she would not change me, I have filed a grievance ..." During a follow up interview with the Resident on August 13, 2018, at approximately 2:30 PM, she stated it was okay for the writer to discuss the concern with the facility. During a telephone interview with Employee # 6 on 8/14/18 at 1:59 PM, she stated, "The [Resident's] diaper was not wet it was dry. The	F 550	to ensure call lights are responded to within the expected time frame. The NHA and/or designee will report findings to the Quality Assurance Performance Improvement Committee for review and evaluation on a monthly basis. 5. Compliance date	10/15/18

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F 550	Continued From page 4 diaper did not have the blue line indicating it was wet. I touched the diaper it was dry. I told the resident to touch the diaper to see that it was dry. The resident was lying in bed at 45 degrees. I never removed the brief". There was no evidence that facility staff treated the resident with respect and dignity by asking the resident to touch the brief to determine if it was dry and when she failed to remove the resident's brief after the resident told her she was wet.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for one (1) of 19 sampled residents, the facility failed to honor Resident #18's request/preference to have her brief changed and did not treat the resident with dignity and respect, and failed to answer the resident's call for help in a timely manner (Resident #18). Findings included... Facility staff failed to honor the residents request/preference to have her brief changed and did not treat the resident with dignity and respect. Resident # 18 was admitted to the facility on July 3, 2018 with diagnoses, which included Joint	F 558	1. Resident #18has been discharged from the facility. 2. All current in-house residents have been interviewed by the Nursing home Administrator and/or designee to determine currently if they feel that they are being treated with respect and dignity by the direct care staff. Residents currently in-house have been interviewed by the NHA and/or designee by and no issues with call-light response time has been noted. 3. The Nursing assistant involved in this incident was terminated. The direct care staff was in-serviced by the Director of Nursing on resident Rights and the Provision of Care related to dignity and respect when briefs are being changed.	10/30/18

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F 558	Continued From page 5 pain, chronic embolism and thrombosis, and Hypothyroidism. According to the Admission Minimum Data Set (MDS) the Resident's Brief Interview for Mental Status (BIMS) score was 15 indicating she is cognitively intact. During a face-to-face interview with Resident #18 on August 7, 2018, at 4:00 PM, she stated. "Staff do not answer the call light. There have been times when it took an hour for staff to answer the light..." During a follow up interview with the Resident on August 13, 2018, at approximately 2:30 PM, she stated it was okay for the writer to discuss the concern with the facility. Review of the "Alarm Average Response Time" Report [call light record] from August 1 to 11, 2018, showed that on August 5, 2018, it took staff 16 minutes to answer the resident's call light. During a face-to-face interview with Employee # 1 on 8/15/18 at 11:30 AM, she reviewed the "Alarm Average Response Time" report and acknowledged the findings.	F 558	Staff non-compliance will result in re-education and disciplinary action as indicated. All staff will be in-serviced by the DON on the expected response time to answering resident call lights. The D.O.N. and unit managers will be monitoring and following up as needed with re-education and/or disciplinary action as indicated to ensure timeliness of response and compliance. 4. NHA and/or designee will interview residents, document and report findings on a weekly basis x4, then monthly x3 related to the observance of resident rights by direct care staff. NHA and/or designee will review call light logs weekly x4, then monthly x3 to ensure call lights are responded to within the expected time frame. The NHA and/or designee will report findings to the Quality Assurance Performance Improvement Committee for review and evaluation on a monthly basis. 5. Compliance date	10/15/18
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.			10/15/18

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F 561	Continued From page 6 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview for two (2) of 19 sampled residents, facility staff failed to conduct an assessment of the residents likes and dislikes/food to ensure foods served accommodated the resident's preferences. Residents' # 20 and #27. Findings included... 1. Resident #20 was admitted on May 27, 2018, with diagnoses to include Cerebrovascular with Left Hemiplegia and Hemiparesis and Hypotension.	F 561	1. Resident's #20 and $27 food likes/dislikes, and preferences have been reviewed and documented by the dietician. 2. Dietician has assessed and documented all current residents in-house to their likes/dislikes of food preferences. 3. The Registered Dietician, Nursing Home Administrator and Director of Nursing had an education review. The RD and/or designee will assess and document likes/dislikes of food preferences within 48 hours of admission and at a minimum quarterly thereafter. 4. The Registered Dietician and/or designee will interview residents for compliance with food preferences weekly x4, then monthly x3. This report will be presented to the QAPI Committee monthly for review, evaluation, and further recommendations as indicated. 5. Compliance date	9/30/18 8/30/18 10/30/18

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F 561	Continued From page 7 During a resident interview on August 8, 2018, at 3:10 PM, the resident stated "for the last three to four week's items have been missing from food trays, 70% missing food item, 30%-40% out of stock food items, one whole week out of regular food items, there are no alternatives, and no lemons for one month. I had started to write notes daily to food services and no one has asked about food preference." A review of Resident #20's medical record showed a section reserved for "Resident Preference" in the chart. The section contained a question which stated "Is there food/drink that you prefer? Soft drink was the documented response to the question. The section reserved for the documentation of "food" was left blank. The medical record lacked documentation the facility staff obtained the resident's food preferences to facilitate provision of alternate food items during mealtime. During a face-to-face interview on August 15, 2018, at 3:15 PM with Employee #5, she reviewed the care plan and Nutritional Initial Review and could not provide any further insight. Employee #5 acknowledged the findings. 2. Resident #27 was admitted to the facility on July 20, 2018, with diagnoses that include joint pain, insomnia, anxiety disorder, major depressive disorder, Hypertension and constipation.	F 561		

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F 561	Continued From page 8 During a face-to-face interview with Resident #27 on 8/09/18, at 1:29 PM, she stated, they [facility staff] have not ask me my food preferences. During a follow-up interview with Resident #27 on 8/10/18, at 12:40 PM she stated, "I am not allergic to tomatoes or onions I don't like them, but the list me as having an allergy to them. I don't like any seafood I can't stand it." The resident's "Nutritional Initial Review" dated 7/23/18, showed the Resident's Food likes, dislikes and allergies as "nkfa [no known food allergy], select menu available". During a face-to-face interview with the Employee #5 (Dietitian) on August 9, 2018 at 5:55 PM she stated, I did not ask residents their food preference.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565	1. No resident was harmed by this deficient practice. 2. Grievances including resident council grievances brought up during the month of June, and July, August have been addressed and presented at the Resident Council meeting.	9/28/18

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F 565	Continued From page 9 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to act promptly upon the June 27, 2018, grievances of the Resident Council concerning issues related to resident care and life in the facility. The resident census was 24 on the first day of the survey. Findings included... Grievance Policy Last revised 12/22/17 "Policy: The community will provide and adhere to a procedure for receiving, responding to, and resolving grievances of residents or their representatives. Procedure: 3. Upon receipt of a grievance, the Executive Director, Administrator, or a designee will schedule a formal meeting to discuss the problem	F 565	3. Activities manager or designee will document resident council grievances on the grievance form, provide original to Social Worker who will copy to the appropriate discipline for resolution. Social worker will review progress of resolution weekly by the appropriate department manager with accompanying documentation during Grievance Performance Improvement Project meetings. NHA or designee will in-service all department managers as to the new process. 4. Social worker or designee will audit and document findings related to timely and appropriate resolution of reported grievances weekly x4, then monthly x3. This will be reported to the QAPI Committee monthly for review, evaluation, and further recommendations as indicated. 5. Compliance date	10/10/18 10/15/18

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F 565	Continued From page 10	F 565		

and attempt to reach a solution satisfactory to all.
4. A written summary of the grievance and remediation/correction plan will be documented in the community's grievance log within 30 days of receiving the formal grievance form ..."

Review of the resident council meeting minutes for June 27, 2018 conveyed resident concerns surrounding areas such as the laundry not returning their clothing, having to wait for long periods of time for toilet tissue, soap and etc..; trash not being taken out every day the room not being properly cleaned and missing laundry. Food and beverage- meat is tough, not enough snacks for people who are diabetics, food is not seasoned well, vegetables were hard to eat, what is on the menu is never available, needing hydration station on the neighborhood, being offered bread and more leafy vegetables during meals. Nursing: waiting long periods of time for assistance at night, feeling ignored by the staff when they request items or help, need staff diversity training, staff being impatient and not knowing what to do ..."

A review of the July 31, 2018, and August 9, 2018, Resident Council Meeting minutes showed the residents continued the same concerns.

Review of the facilities grievance log showed that resident concerns from the June 27, 2018, meeting were not addressed by the grievance official or department directors within 30 days.

During a face-to-face interview on 8/9/18 at 5:55 PM with Employees #1 and #2, it was stated that the Resident Council Meeting minute concerns go to the all managers and the managers are expected to respond to the concerns. Employee

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F 565 F 584 SS=D	Continued From page 11 #1 further Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584	1. No resident was harmed by this deficient practice. Room #202, the broken closet door noted at the time of the survey was repaired. Room #214 the warped carpet in the resident's room at the time of the survey was replaced. A damaged wall in room #214 noted at the time of the survey was repaired. 2. All closet doors, carpet and walls were inspected by Plant operations Director and corrections were made as required. 3. In-service was done with the maintenance staff by Plant operations Director regarding the process for inspection and replacement of closet doors, carpet and wall integrity on a routine basis to ensure their proper repair. The results of these inspections will be forwarded to the Director of Maintenance for task completion by maintenance staff.	8/13/18 8/15/18

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	095021	A. BUILDING _____ B. WING _____	08/15/2018

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F 584	Continued From page 12 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced a broken closet door in one (1) of 17 resident rooms, a warped carpet in one (1) of 17 resident rooms, and a damaged wall in one (1) of 17 resident rooms. Findings included... During an environmental tour of the facility on August 10, 2018, between 9:30 AM and 11:00 AM, the following were observed: 1. The closet door in resident room #202 was hanging off its hinges, one (1) of 17 resident room surveyed. 2. The carpet in resident room #214 was buckled and frayed and there was a hole in the wall, one (1) of 17 resident's room. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	F 584	4. The Director of Maintenance will audit his repair logs for task completion weekly x4 and then monthly x3. The Director of Maintenance will present his findings of these routine inspections to the NHA at a minimum weekly for further assistance as indicated. Results of these audits will be present to the QAPI Committee monthly for review and/or further recommendations as indicated. 5. Compliance date 1. No resident was harmed by this deficient practice. 2. Grievances including resident council grievances brought up during the month of June, and July, August have been addressed and presented at the Resident Council meeting.	10/15/18
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		

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F 585	Continued From page 13 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585	3. Activities manager or designee will document resident council grievances on the grievance form, provide original to Social Worker who will copy to the appropriate discipline for resolution. Social worker will review progress of resolution weekly by the appropriate department manager with accompanying documentation during Grievance Performance Improvement Project meetings. NHA or designee will in-service all department managers as to the new process. 4. Social worker or designee will audit and document findings related to timely and appropriate resolution of reported grievances weekly x4, then monthly x3. This will be reported to the QAPI Committee monthly for review, evaluation, and further recommendations as indicated. 5. Compliance date	10/15/18

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F 585	Continued From page 14 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585		

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F 585	Continued From page 15 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to act promptly upon the June 27, 2018, grievances of the Resident Council concerning issues related to resident care and life in the facility. The resident census was 24 on the first day of the survey. Findings included... Grievance Policy Last revised 12/22/17 "Policy: The community will provide and adhere to a procedure for receiving, responding to, and resolving grievances of residents or their representatives. Procedure: 3. Upon receipt of a grievance, the Executive Director, Administrator, or a designee will schedule a formal meeting to discuss the problem and attempt to reach a solution satisfactory to all. 4. A written summary of the grievance and remediation/correction plan will be documented in the community's grievance log within 30 days of	F 585		

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F 585	Continued From page 16 receiving the formal grievance form ..." Review of the resident council meeting minutes for June 27, 2018 conveyed resident concerns surrounding areas such as the laundry not returning their clothing, having to wait for long periods of time for toilet tissue, soap and etc..; trash not being taken out every day the room not being properly cleaned and missing laundry. Food and beverage- meat is tough, not enough snacks for people who are diabetics, food is not seasoned well, vegetables were hard to eat, what is on the menu is never available, needing hydration station on the neighborhood, being offered bread and more leafy vegetables during meals. Nursing: waiting long periods of time for assistance at night, feeling ignored by the staff when they request items or help, need staff diversity training, staff being impatient and not knowing what to do ..." A review of the July 31, 2018, and August 9, 2018, Resident Council Meeting minutes showed the residents continued the same concerns. Review of the facilities grievance log showed that resident concerns from the June 27, 2018, meeting were not addressed by the grievance official or department directors within 30 days. During a face-to-face interview on 8/9/18 at 5:55 PM with Employees #1 and #2, it was stated that the Resident Council Meeting minute concerns go to the all managers and the managers are expected to respond to the concerns. Employee #1 further	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

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F 641	Continued From page 17 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 19 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) to reflect one (1) resident's diagnoses Depression, and oxygen therapy, and residents with Hallucinations and Insomnia. Resident #13. Findings included... A. Failed to accurately code the Minimum Data Set for Hallucinations and Insomnia. Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Acute and Chronic Respiratory Failure with Hypoxia and Shortness of Breath. A review of Resident #13's Admission MDS with a date of June 11, 2018, showed that in Section I Active Diagnosis, under Psychiatric /Mood Disorder the box next to the Disorder I5800 Depression, was blank indicating, "Not done." A review of the medical admission record dated June 11, 2018, review of system Psychiatric: showed Anxiety, Depression, and Irritability, but no Hallucinations and no Insomnia." A review of the Medication Review Report sheet showed that Resident has been receiving the	F 641	1. Resident #13 was discharged on 8/28/18 and the record cannot be amended retrospectively. 2. The Facility will audit by all current residents' MDS for timeliness and accurate coding. Any omitted areas identified will be corrected. 3. An educational review with the new MDS Coordinator, NHA and DON was completed. Resident records will be reviewed by (NHA) for accurate MDS coding to include resident diagnosis within 48 hours of admission. 4. Monitoring for accuracy and completion will be added for review during the daily stand-up meeting X3 months. 5. Compliance date	10/15/18 9/18/18 10/15/18

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F 641	Continued From page 18	F 641		

following medications:

"June 4, 2018, Bupropion Hydrochloride 75 mg give 2 tablets by mouth every 12hrs [hours] for Depression."
"June 6, 2018, Zoloft 25 mg give 1 tablet by mouth in the morning for Depression

During an interview on August 15, 2018, at approximately 1:00 PM with Employee #2. She was made aware that there are concerns with coding resident diagnoses. Employee #2 acknowledged the finding.

B. Failed to accurately code Minimum Data Set for Resident #13 who receives oxygen therapy.

A review of Resident #13's admission MDS with a date of June 11, 2018, Section O Special Treatments, Procedures, and programs Section C Oxygen Therapy was blank indicating, "Not done."

A review of the medical admission record dated June 11, 2018, review of system Respiratory: showed Dyspnea, Shortness of breath, but no cough."

A review of the Medication Review Report sheet showed that Resident has been receiving the following:

"Continuous O2 [oxygen] @ [at] 2 liters/min. Diagnosis for use SOB/COPD [shortness of breath/ Chronic Obstructive Pulmonary Disease]. Administer via NC [nasal cannula] every shift for