STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095026	A. BUILDING _____ B. WING _____	06/28/2019

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F 000	INITIAL COMMENTS An unannounced staggered Long Term Care Survey was conducted at Knollwood Nursing Center from June 23, 2019 through June 28, 2019. Survey activities consisted of a review of 32 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 59. 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 AV- Arteriovenous 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	This plan of correction is prepared and/or executed solely because it is required by the Provisions of Federal and State law. The plan of correction is the Army Distaff Foundation and Knollwood's credible Allegation of Compliance.	

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

Administrator 7/24/19

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 HR- Hour 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 O2- Oxygen 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 ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 575	Required Postings	F 575		

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F 575 SS=C	Continued From page 2 CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility staff failed to ensure the contact information to include the names, mailing and email addresses for all pertinent State agencies and advocacy groups were posted and failed to ensure the posting included a statement that the resident may file a complaint with the State Survey Agency. The resident census was 59 on the first day of survey. Findings included ...	F 575	1. The posting was updated immediately to include the names, accurate phone numbers, or email addresses for aforementioned organizations and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. 2. A walk-through of the unit was conducted for other informational materials to verify correct contact information. 3. The Social Services Manager will review the contact information posted quarterly to verify that the contact information is current. 4. The Social Services Manager or designee will audit the required posting quarterly for compliance to be sure accurate information remains posted. Results will be shared at the QAPI meeting.	6/23/19 6/23/19 6/23/19 And on-going On-going

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F 575	Continued From page 3 During tour of the facility on 6/23/19 at 9:30 AM, the signage was observed posted on a bulletin board near the nurse's station. The signage contained a list of names of all pertinent State agencies and advocacy groups, adult protective services and the Office of the State Long-Term Care Ombudsman and the Medicaid Fraud Control. The signage did not show the names, accurate phone numbers, mailing or email address for aforementioned organizations. In addition, the posting did not include a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. During a face-to-face interview on 6/23/19, at 9:30 AM, Employee #2 was shown the required posting of contact information and acknowledged the finding.	F 575		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577	1. The posted sign of 14 font, highlighted in yellow was removed and replaced with one of 36 font. 2. No other signage with the deficient practice was posted. 3. The Social Services Manager has created a cover sheet for the electronic file of the signage to indicate the signage should remain in the 36 font for future copies of the signage that may be printed. 4. The Social Services Manager or designee will audit the posting quarterly to verify the new posting is still posted in the larger size. Results of the audit will be reported to the QAPI committee.	6/23/19 6/23/19 7/23/19 On-going

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F 577	Continued From page 4 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility staff failed to post notice of the availability of survey results in a format (font) readable by residents/resident representatives. The resident census was 59 on the first day of survey. Findings included... During tour of the facility on 6/23/19 at 9:30 AM the posted sign was found on the bulletin board on a blue card with yellow coloring in the middle of other postings which reads "results may be found on top of the fireplace in the HSC units' dinning/common area, directly below the large screen television." However, the posted signage was not in a format (font) readable by residents/resident representatives. During a face-to-face interview on 6/23/19 at 9:30 AM Employee #2 acknowledged the finding.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or	F 578		

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F 578	Continued From page 5 discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	F 578		

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F 578	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 32 sampled residents, the facility staff failed to ensure that Resident #38's advance directive was placed on her active clinical record. Findings included... Resident #38 was admitted to the facility on May 8, 2019, with diagnoses, which included Chronic Pain, Gastro-Esophageal Reflux Disease, Vascular Dementia with Behavioral Disturbance, Hypertension, and Spinal Stenosis. The "Advance Directive/Living Will and Durable Power of Attorney" Policy and Procedures signed March 27, 2018, stipulated, "Upon admission, the Social Services Department at Knollwood will inquire and document whether a resident has executed an Advance Directive, Living Will or Durable Power of Attorney ..." Review of the "End of-Life Program Planning" form dated May 18, 2019, (which serves the staff, residents, responsible parties, and family members in preparation for the time of a resident's passing), stipulated that the resident had Advance Directives, however, the Code Wishes/Preferences and Spiritual Needs sections were blank. Continued review of the Resident #38's active clinical record lacked evidence of the aforementioned Advance Directives. On June 25, 2019, Employee #8 provided the surveyor with a copy of Resident #38's advance	F 578	1.The family member of resident #38 was contacted to remind her that she had noted there were advanced directives and had not shared them yet with the facility. The family member then emailed the advanced directives, which were placed on the resident's clinical record. 2. An audit was conducted on advanced directives for all other residents; no other resident was found to lack advanced directives in the clinical record if the resident/resident representative said there were executed advanced directives. 3. An audit tool was developed for advanced directives tracking, and residents/resident representatives will be asked to confirm advanced directives at care plan conferences at a minimum quarterly. 4. Reports of the new audit tool will be shared with the QAPI Committee quarterly.	6/25/19 8/10/19 7/23/19 On-going

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F 578	Continued From page 7 directive. Facility staff failed to ensure that Resident #38's advance directive was placed on the active clinical record. During a face-to-face interview on June 28, 2019 at 10:43 AM Employee #8 acknowledged the finding.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 three (3) of 32 sampled residents, the facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident death, for one (1) resident receiving hospice care and for one (1) resident diagnosis of Macular Degeneration. Residents' #1, #9 and #29 Findings included... 1. Facility staff failed to complete and submit a Discharge Tracking Minimum Data Set (MDS) assessment at the time of the Resident #1's death. Review of the resident's clinical record on June 25, 2019, showed significant change MDS dated February 14, 2019 when the resident entered the Hospice Program. Further review of the record failed to show	F 641	1A. The MDS of Resident #1 was modified to reflect the death of the resident on the discharge tracking MDS assessment. 2A. An audit of residents who have died since December 2018 was conducted. The audit showed that the other deceased residents had a MDS death record. 3A. MDS nurses will be reminded to complete a discharge tracking MDS following a resident's death. 4A. The MDS Coordinator or designee will audit records of deceased residents monthly X 3 then quarterly X 3 to monitor that a discharge tracking MDS assessment was completed following the death of a resident for a 90% compliance rate.	6/25/19 6/25/19 8/10/19 On-going

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F 641	Continued From page 8 evidence that an MDS was completed when the resident expired on February 21, 2019. A face-to-face interview was conducted with Employee #9 at approximately 3:30 PM on June 25, 2019. During the interview, the employee acknowledged that an MDS was not completed at the time of the resident's death. 2. Facility staff failed to accurately code the Minimum Data Set (MDS) for one (1) resident receiving hospice care. Resident #9 Resident #9 was admitted to the facility on 2/23/17 with diagnoses which include: Unspecified Atrial Fibrillation, Retinal Edema, Primary Open-Angle Glaucoma Right Eye and Essential Hypertension. On 6/27/19 at 10:00 AM a review of the physician's order dated 3/5/19 at 2:00 PM showed "Admit to Capital Caring Hospice for hospice..." Review of the Quarterly Minimum Data Set (MDS) dated 3/25/19 showed under Section C [Cognition], Brief Interview for Mental Status [BIMS] Resident #9 was coded as "99" which indicate unable to complete the interview. Under Section O [Special Treatments, Procedures and Programs] Hospice care was left blank which indicates resident is not receiving hospice care. During a face-to-face interview on 6/27/19 at 11:00 AM with Employee #9 she stated "yes, Resident #9 is receiving hospice services I will make the change now". Employee #9	F 641	1B. The MDS of Resident #9 of 3/25/19 was corrected to indicate that Resident #9 is receiving hospice services. 2B. An audit of residents receiving hospice services was conducted to verify that section "O" of those residents' MDS was checked to indicate that they are receiving hospice services. No other deficient practice was found. 3B. MDS nurses will be reminded to code Section "O" of the MDS when a resident is receiving hospice services. 4B. The MDS Coordinator or designee will audit the MDS records for residents who are receiving hospice services to verify that Section "O" of the MDS is checked. This audit will be conducted monthly X 3 then quarterly X 3 and the result of this audit will be presented to the QAPI Committee for further recommendations.	6/25/19 6/26/19 8/10/19 8/10/19 And On-going

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F 641	Continued From page 9 acknowledged the finding at the time of the review. 3. Facility staff failed to accurately code the [Minimum Data Set] MDS for a diagnosis of Macular Degeneration for one (1) resident. Resident #29. Resident #29 was admitted to the facility on May 18, 2015, with diagnoses that included Anemia, Chronic Kidney Disease, Chronic Respiratory Failure, Hypertension, Heart failure, and Myestinea Gravis. A review of the Ophthalmologist Report of Consultation for an appointment dated December 18, 2018, at 9:30 AM showed, "Findings: Pt reports stable vision since last year, no current issues VA (visual Acuity) 20/100 both eyes stable clinical exam ... Diagnosis: nonexudative AMD (Aged-related Macular Degeneration) OU (both eye) Recommendation: 1. Continue AREDS (eye multivitamin) (1 caps (capsules)) daily 2. Annual FU (follow up) advised." A review of the Physician Order sheets from January 2019, to June 2019, showed "Ocuvite Eye + Multi Tab, Give 2 tablets by mouth twice daily for eye health. A review of the Quarterly Minimum Data Set (MDS) dated April 28, 2019, showed Resident #29 scored 12 on the Brief Interview for Mental Status in Section C (Cognitive Patterns) indicating "moderately impaired" cognitive skills for daily decision making. Section B (Hearing, Speech, and Vision) B1000 ability to see in adequate light	F 641	1C. An MDS assessment was opened and the diagnosis for macular degeneration was added to the assessment. 2C. An audit of residents with an active diagnosis of macular degeneration will be completed by the MDS Coordinator or designee to ensure that the diagnosis is part of the annual MDS. 3C. MDS nurses will be inserviced to add active diagnoses to the current MDS assessment. 4C. The MDS Coordinator or designee will audit the MDS records monthly X6 then quarterly X 2 to verify that active diagnoses are entered into the MDS. The result of this audit will be presented to the QAPI Committee for further recommendations.	7/22/19 8/10/19 8/10/19 On-going

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F 641	Continued From page 10 (with glasses or other visual appliances) coded as 0 indicating Adequate- sees fine detail, such as regular print in the newspapers/books. Section I (Active Diagnoses) showed the space allotted for coding Macular Degeneration was left blank indicating not coded. The medical record lacked evidence that the MDS was coded to accurately reflect the resident's diagnosis of Macular Degeneration. A face-to-face interview was conducted with Employee #9, [MDS Coordinator] on June 27, 2019, at approximately 11:30 AM. Employee #9 reviewed the MDS information and acknowledged the findings.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		

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F 655	Continued From page 11 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 32 sampled residents, facility staff failed to develop baseline care plans with goals and approaches to properly care for four (4) newly admitted residents. Residents' # 38,53, 62 and 160. Findings included... 1. Facility staff failed to ensure that Resident # 38 had a baseline care plan completed within 48 hours of admission. Resident #38 was admitted to the facility on May	F 655	1.The baseline care plans of Residents #38, #53, #62, and #160 could not be reissued. 2. The form used to complete baseline care plans was modified to indicate that the baseline care plan will be developed within 48 hours of admission instead of being developed within seven days of a resident's admission. 3. The Interdisciplinary Team will be inserviced on developing baseline care plans within 48 hours of a resident's admission. 4. An audit of baseline care plans will be conducted weekly X4, then monthly X 3, then quarterly X 2 to verify that baseline care plans are being developed within 48 hours of a resident's admission with a threshold of 95%. The results of this audit will be presented to the QAPI Committee for further recommendations.	6/28/19 6/25/19 8/10/19 On-going

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F 655	Continued From page 12	F 655		

8, 2019, with diagnoses, which included Chronic Pain, Gastro-Esophageal Reflux Disease, Vascular Dementia with Behavioral Disturbance, Hypertension, and Spinal Stenosis.

Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility on May 14, 2019 (seven days after admission).

There was no evidence that facility staff ensured that Resident # 38 had a Baseline Care Plan completed within 48 hours of admission.

The findings were acknowledged during a face-to-face interview with Employee #2 on June 27, 2019 at approximately 2:45 PM.

2. Facility staff failed to ensure that Resident #53 had a baseline care plan completed within 48 hours of admission.

Resident #53 was admitted to the facility on 5/31/19, with diagnoses to include Essential Hypertension, Unspecified Atrial Fibrillation, Heart Failure and Cerebral Infarction.

Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility staff on 6/5/19 (five days after admission).

There was no evidence that facility staff ensured that Resident # 53 had a baseline care plan completed within 48 hours of admission.

During a face-to-face interview conducted on 6/26/19 at approximately 10:00 AM Employee #2

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F 655	Continued From page 13	F 655		

acknowledged the findings.

3. Facility staff failed to ensure that Resident # 62 had a baseline care plan completed within 48 hours of admission.

Resident #62 was admitted to the facility on March 27, 2019, with diagnoses to include Congestive Heart Failure, Pulmonary Edema, Muscle Weakness and Hypoxemia.

Review of the facility's "48-hour baseline care plan" showed the care plan was signed by the resident and the facility on April 2, 2019 (seven days after admission).

There was no evidence that facility staff ensured that Resident # 62 had a baseline care plan completed within 48 hours of admission.

During a face-to-face interview on June 27, 2019 at approximately 4:45 PM, Employee #2 acknowledged the findings.

4. Facility staff failed to ensure that Resident #160 baseline care plan was developed within 48 hours of admission.

A review of the medical record showed Resident # 160 was admitted to the facility on June 13, 2019, with diagnoses to include: Malignant Pleural Effusion, Chronic Kidney Disease, Age-related Osteoporosis, Anemia, and Hypertension.

A review of Resident #160's 48-hour baseline care plan showed the care plan was signed by the resident and designated staff on June 18,

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F 655	Continued From page 14 2019 (five days after admission). The evidence showed that the resident baseline care plan was not developed within 48 hours of the resident's admission to the facility. During a face-to-face interview on June 26, 2019, at approximately 10:45 AM, Employee #14 acknowledged the findings.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 32 sampled residents facility's staff failed to ensure the resident received treatment and care in accordance with professional standards of practice as evidenced by failing to provide evidence of collaboration with the hospice team for one (1) resident and to develop one (1) residents care plan and to accurately assess a residents neurological status after a fall. Residents' #9 and #32. Findings included ... 1.Facility staff failed to devlop a care plan in collaboration with the hospice team.	F 684		

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F 684	Continued From page 15 Record review of the facility's undated policy titled "Hospice Procedures" showed "resident's care plan of care is in collaboration with hospice to attain and maintain the resident's highest practical physical, mental and psychological well-being". Resident #9 was admitted to the facility on 2/23/17 with diagnoses which include: Unspecified Atrial Fibrillation, Retinal Edema, Primary Open-Angle Glaucoma Right Eye and Essential Hypertension. On 6/27/19 at 10:00 AM a review of the physician's order dated 3/5/19 at 2:00 PM showed "Admit to Capital Caring Hospice for hospice..." Review of the Hospice care plan showed "Hospice care-resident has terminal condition and will maintain a quality of life, dignity and comfort with limitations of disease process." Approach: "administer pain meds, oxygen as ordered, coordinate residents care with Hospice as appropriate, honor food preferences, assist with meal intake as needed encourage fluids, provide pressure relieving devices, provide support to resident as needed ..." Facility staff failed to show evidence of collaboration with hospice to develop goals and approaches to care for a resident receiving hospice services. During an interview on 6/27/19 at 12:30 PM with Employee #8, stated this is not a collaborative care plan, but I have hospice coming in to make changes to the care plan." Employee #8	F 684	1A. The Hospice's plan of care for Resident #9 was integrated with the Facility's care plan to show evidence of collaboration with hospice. 1B. The care plans of all other residents on hospice services were audited; all other Hospice plans for care were found to be integrated with the Facility's care plans for those residents. 1C.The care plan that had not been integrated for Resident #9 was with a provider different than the provider for all the other residents on hospice services. The licensed nurses and the hospice care team for Resident #9 will be inserviced to document their interventions in the integrated care plan in the Facility's electronic medical record. 1D. Hospice care plans will be audited by the MDS Coordinator or designee monthly X 3, then quarterly X 3 to verify that there is integration of services. The results of this audit will be reported to the QAPI Committee for further recommendations.	7/22/19 7/22/19 8/10/19 On-going

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F 684	Continued From page 16 acknowledged the finding at the time of the review. Facility staff failed to accurately assess a resident's pupil response after a fall. 2. The facility staff failed to accurately assess the resident's neurological status (pupil response to light) after a fall, as evidenced below: Resident #32 was admitted to the facility on 10/24/17 with diagnoses, which included Repeated Falls, Muscle Weakness, Parkinson's Disease, Contracture of Right Elbow, and Alzheimer's Disease. The nursing note dated 05/16/19 at 10:00 AM, documented, "Found resident sitting on the floor with his back to the lower side of the bed". Continued review of the active clinical record revealed a physician's order dated 05/16/19 at 10:00 AM, that directed "[neurological] checks for 72 hours". Review of the "Neurological Assessment Flow Sheet" dated 05/16/19, instructed ...for Pupil Response - staff was to "Check PERL (pupil equal and reactive light) if applicable or enter appropriate code for each eye" in the pupil response column. Additionally, for Motor Functions - staff was to "Enter the appropriate code" in the hand grasp column. The key listed at the bottom of the form indicated that the equal sign should be documented if the resident's hand grasp are equal.	F 684	2A. The neurological assessment for Resident #32 with the pupil response that was not consistent with the instructions given on the form could not be corrected. 2B. Neurological Assessment flow sheets completed between June 23, 2019 and July 19, 2019, will be audited for accurate assessment of pupil response to light. 2C.An inservice will be conducted for licensed nurses reviewing each area of the neurological flow sheet, the appropriate code to use, and the reason why the codes are used. 2D.An audit of neurological assessments will be completed every week X 4, then monthly X 3, then quarterly X 3 to verify compliance. The result of this audit will be presented to the QAPI Committee for further recommendations.	6/25/19 8/10/19 8/10/19

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F 684	Continued From page 17 Staff assessment on the form showed the following: On 05/16/19 Employee #17(the assigned Licensed Nurse) documented the "equal sign" eleven times from 9:00 AM to 3:00 PM under the pupil response column; and the hand grasp column was blank the aforementioned times. 05/16/19 at 4:00 PM pupil response was documented as equal and reactive to light and hand grasp were equal; 05/16/19 at 8:00 PM pupil response was documented as equal and reactive to light and hand grasp were equal; 05/17/19 at 12:00 AM to 4:00 PM pupil response was documented as equal and reactive to light and hand grasp were equal; and 05/18/19 at 12:00 AM to 4:00 PM pupil response was documented as equal and reactive to light and hand grasp were equal. The was no evidence that facility staff accurately assessed Resident #32's pupil status for seven hours on May 16, 2019. According to the clinical record, Resident #32 had no untoward affects after the fall. During a face-to-face interview on 06/26/19 at approximately 11:30 AM, Employee #13 acknowledged the findings.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 18 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by frayed remote bed controller cords in 12 of 20 resident's rooms. Findings included ... During an environmental tour of the facility on June 25, 2019, at approximately 11:00 AM, remote bed controllers' cords in 12 of 20 resident's rooms were frayed. The uncovered, exposed electrical wires created a potential electrical shock hazard to residents, staff and the public. During a face-to-face interview on June 25, 2019, at approximately 12:30 PM, Employee #6 acknowledged the findings.	F 689	1.The 12 bed control cords were replaced. 2. All other bed control cords were examined and no others were found to be deficient. 3. The vendor for bed control cords was changed out in favor of a more durable product. Visual checks of the bed control cords were added to the bi-weekly bed inspection checklist. 4. The Director of Engineering or designee will audit the bi-weekly bed control checklists monthly X 12. The Director of Engineering or designee will also conduct monthly random inspections of bed control cords in 4 rooms. All audit results will be reported to the quarterly QAPI meeting for follow up.	6/28/19 6/28/19 8/1/19 On-going
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		

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F 755	Continued From page 19 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of (2) nursing units, the facility staff failed to ensure the system used for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed by staff. The census was 59 on the first day of the survey. Findings included... Review of the Controlled Drug Shift Change Audit	F 755	1.The controlled drug audit sheet for 6/20/19 was signed by the nurse who completed the reconciliation of the controlled medications. 2. An audit of the controlled drug sheet from 6/20/19 until 7/20/19 was completed; all drug sheets were fully reconciled. 3. Licensed nurses will be inserviced to make sure that they sign the controlled audit sheet after completing the reconciliation of controlled medications. 4. The Assistant Director of Nursing or designee will audit controlled drug sheets weekly X 4, then monthly X 4 then quarterly to verify that the controlled sheets were signed when the reconciliation of controlled medications was completed. The results of this audit will be presented to the QAPI Committee for further recommendations.	6/25/19 7/23/19 8/10/19 On-going

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F 755	Continued From page 20 Sheet instructions showed "controlled drugs (scheduled II to schedule V) must be counted by two nurses at the change of shift, the nurse going off duty and the nurse coming on." Review of the "Controlled Drug Shift Change Audit Sheet" showed the spaces allotted for nurse signature going off duty to reconcile the narcotic count for the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shift for 6/20/19 were left blank indicating the reconciliation of controlled medication was "Not Done". The evidence showed that the system use for acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was not followed by staff. A face-to-face interview was conducted with Employee #15 on 6/26/19, at 9:30 AM; she acknowledged the finding at the time of the review.	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 812	F812 1A. The thermometer was replaced immediately and food temperatures were taken as soon as the thermometer was replaced. 2A. An audit was done for food thermometers. No other food service areas were missing thermometers for taking food temperatures. 3A. The uniform for those dining services workers taking food temperatures has been modified to require a thermometer on the person. All dining services employees were inserviced on the importance of making sure all temperatures are taken for foods. 4A. Dining Services leadership will conduct monthly audits for compliance. Results of the monthly audits will be reported to the QAPI Committee.	6/23/19 6/23/19 6/26/19 On-going

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F 812	Continued From page 21 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to store, serve and distribute foods under sanitary conditions as evidenced by staff who were observed serving breakfast foods to residents before food temperatures were completed, soiled equipment such as four (4) of four (4) convection ovens, one (1) of one (1) deep fryer, one (1) of one (1) grill and the interior of one (1) of one (1) oven, 20 of 20 six-inch, one-third steam pans that were stored wet, four (4) of 20 six-inch one-third pans that were dented throughout. Findings included ... The following observations were made during a walkthrough of the kitchen on the Special Care Center (SCC) on June 23, 2019, at approximately 8:15 AM. 1. Breakfast food temperatures from the Special Care Center (SCC) kitchen were not completed before foods were served to residents on June 23, 2019, at approximately 8:10 AM. Employee #4 was asked why food temperatures were not taken before residents were served and she explained that someone had removed the thermometer from the kitchen and she did not have one.	F 812	1B. The convection ovens, deep fryer, grill and oven were cleaned. 2B. No other convention ovens, deep fryers, grills, or ovens were found to be soiled. 3B. Convection ovens, deep fryers, grills and ovens have been upgraded for daily sanitation and weekly heavy duty cleaning. 4B. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review.	6/23/19 6/23/19 6/26/19 On-going

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F 812	Continued From page 22 Employee #4 was asked if she could get another thermometer and check food temperatures. Employee #4 left and came back in about five (5) minutes and proceeded to check the temperature of foods on the tray line. All food items tested above 135 degrees Fahrenheit. A review of the food temperature logs for the previous week confirmed that food temperatures were completed for breakfast, lunch and dinner throughout the week. Employee #4 acknowledged the findings during a face-to-face interview on June 23, 2019, at approximately 8:20 AM. During a walkthrough of the main kitchen on June 23, 2019, at approximately 8:30 AM: 2. Four (4) of four (4) convection ovens, one (1) of one (1) deep fryer, one (1) of one (1) grill and the interior of one (1) of one (1) oven were soiled. 3. 20 of 20 six-inch, one-third steam pans stored on a shelf in the clean, and ready-for-use area were stored wet, one on top of the other. 4. Four (4) of 20 six-inch one-third pans were dented throughout. Employee #4 acknowledged the findings during a face-to-face interview on June 23, 2019, at approximately 9:15 AM.	F 812	1C. The steam pans were re-washed immediately and properly stored. 2C. No other steam pans or other items drying were found to be wet nested. 3C. Utility employees were re-trained on properly storing wet items after washing. 4C. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review. 1D. The dented pans were disposed of immediately. 2D. An check was done for any other dented pans, no other pans were found to be dented. 3D. Utility employees were re-trained to discard dented pans when identified as such and advise the Chef of the need for replacement pan/s. 4D. Leadership will perform monthly compliance observations. Documentation of results of the observations will be reported to the quarterly QAPI Committee for review.	6/23/19 6/23/19 6/26/19 On-going 6/24/19 6/25/19 6/26/19 On-going
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		

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F 908	Continued From page 23 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to maintain electrical equipment in good condition as evidenced by frayed remote bed controller cords in 12 of 20 resident's rooms. Findings included ... During an environmental tour of the facility on June 25, 2019, at approximately 11:00 AM, remote bed controllers' cords in 12 of 20 resident's rooms were frayed. During a face-to-face interview on June 25, 2019, at approximately 12:30 PM, Employee #6 acknowledged the findings.	F 908	1.The 12 bed control cords were replaced. 2. All other bed control cords were examined and no others were found to be deficient. 3. The vendor for bed control cords was changed out in favor of a more durable product. Visual checks of the bed control cords were added to the bi-weekly bed inspection checklist. 4. 4. The Director of Engineering or designee will audit the bi-weekly bed control checklists monthly X 12. The Director of Engineering or designee will also conduct monthly random inspections of bed control cords in 4 rooms. All audit results will be reported to the quarterly QAPI meeting for follow up.	6/28/19 6/28/19 8/1/19 On-going