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	HFD02-0011	A. BUILDING: _____ B. WING _____	09/03/2019

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SERENITY REHABILITATION AND HEALTH	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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L 000	Initial Comments An unannounced Licensure Survey was conducted at Serenity Rehabilitation and Health Center from August 26, 2019, through September 3, 2019. Survey activities consisted of a review of 70 sampled residents. The following deficiencies are based on observation, record review and staff interviews. 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 CPR- Cardiopulmonary Resuscitation 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 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team L - Liter	L 000	**SERENITY REHABILITATION AND HEALTH CENTER DISCLAIMER.** Facility submits this plan of correction under procedures established by the Department of Health In order to comply With the Department's directive to change Conditions which the Department alleges are deficient under state Regulations Relating to long term care. This should not be construed as either a waiver of the Facility's right to appeal and to challenge the accuracy or severity of the alleged Deficiencies or any Admission of any wrong doing.	11/22/19

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L 000	Continued From page 1 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 Trach- Tracheostomy	L 000		11/22/19
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of	L 051		

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L 051	Continued From page 2 physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for two (2) of 70 sampled residents, facility staff failed to develop comprehensive, person centered care plans for use of an antidepressant for one (1) resident, to address dental care t and the use of anticoagulant for one (1) resident. Residents' #54 and #95. Findings include . . . 1. Facility staff failed to develop comprehensive, a person centered care plan for use of an antidepressant for Resident #54. A review of Section I (Active Diagnoses) of Resident #54's annual Minimum Data Set dated 6/18/19 showed that the resident was coded for Depression. Review of Section N (Medications) of the same MDS was coded for use of an Antidepressant (Sertraline).	L 051	L051 **Corrective Action for the Residents Affected:** **1.**The affected Residents' #54 was re-assessed on 8/29/19 Care plan for use of an antidepressant was developed. Resident #54 suffered no negative outcome. **2A.** The affected Residents' #95 was re-assessed on 8/27/19 Care plan for the use of anticoagulant for Resident #95 was developed. **2B**.Care plan for dental care for Resident #95 was developed. Resident #95 suffered no negative Outcome. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to develop comprehensive, person centered care plans. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of developing comprehensive, person centered care plans for the residents.	11/22/19

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L 051	Continued From page 3 However, review of the resident care plans failed to reveal a care plan for the use of an Antidepressant. A face-to-face interview was conducted with Employee #17 on August 29, 2019, at approximately 3:00 PM. The employee reviewed the record and acknowledged that the care plan for use of an Antidepressant was never developed. 2A. Facility staff failed to develop plan of care for Resident #95's use of anticoagulant. Resident #95 was admitted to the facility on January 10, 2018, with diagnoses which included Human Immunodeficiency Virus Disease, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Anemia, Osteoarthritis, Neuropathic pain, Anxiety, and Major Depressive Disorder. A review of of the Quarterly Minimum Data Set (MDS) completed July 17, 2019, showed a Brief Interview for Mental Status (BIMS) score of "11" which is an indication that the resident has moderately impaired cognition and is not able to make decisions. Review of the Physician's order directed, 7/15/19 "Lovenox solution 80mg/0.8ml, Inject 80mg subcutaneously one time a day for DVT[deep vein thrombosis]"	L 051	**Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment /audit of residents to identify potential residents that facility staff failed to develop comprehensive, person centered care plans weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

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L 051	Continued From page 4 A review of the physician's note dated 8/6/2019 showed " ... No rectal bleeding reported ... continue Lovenox 80 mg qd [every day], continue monitor s/s [signs and symptoms] of bleeding" A review of the medical record lacked a care plan with person-centered goals and approaches to reflect the resident's use of an anticoagulant. A face-to-face interview was conducted on August 27, 2019, at approximately 2:00 PM with Employee #18. The employee acknowledged the finding when asked about the care plan for Resident #95's use of anticoagulant. 2B. Facility staff failed to develop plan of care for Resident #95's dental care. Resident #95 was admitted to the facility on January 10, 2018, with diagnoses which included Human Immunodeficiency Virus Disease, Gastroesophageal Reflux Disease, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Anemia, Osteoarthritis, Neuropathic pain, Anxiety, and Major Depressive Disorder. A review of of the Quarterly Minimum Data Set (MDS) completed July 17, 2019, showed a Brief Interview for Mental Status (BIMS) score of "11" which is an indication that the resident is moderately cognitively impaired and not able to make decisions.	L 051		11/22/19

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L 051	Continued From page 5 A review of the physician's note dated 3/5/2019 showed " Mouth multiple impacted roots on lower gum and upper gum. No gum bleeding, No oral ulcers. Oral pain due to missing teeth and impacted roots, ...dental evaluation as scheduled." Review of the Physician's order directed, 4/18/19 "Follow up with [dental office] for extraction of all remaining teeth post medical clearance" A review of the medical record lacked person-centered goals and approaches to reflect the resident's dental care. A face-to-face interview was conducted on August 27, 2019, at approximately 2:00 PM with Employee #18. She acknowledged the findings when asked about the care plan for Resident #95's dental care and stated "[resident's name] refuses the dental appointments." B. Based on medical record review and staff interview for one (1) of 70 sampled residents, facility staff failed to update care plan with goals and approaches for resident-centered care for one (1) resident's gastrostomy tube (GT). Resident #53. Findings included... Facility staff failed to update resident-centered care plan to reflect the changes in treatment for Resident #53's gastrostomy tube site care.	L 051		11/22/19

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L 051	Continued From page 6 A review of Resident #53's admission record shows that he was admitted to the facility on June 19, 2015, with diagnoses which included Hypertension, Anemia, Type 2 Diabetes Mellitus, Systemic Lupus Erythematosus, Hyperlipidemia, Gastroesophageal Reflux Disease, Cerebrovascular Disease, Cardiomegaly, Dementia, and Major Depressive Disorder. A review of the Quarterly Minimum Data Set [MDS] dated 6/15/19 showed, Section K 0510 Nutritional Approaches: B Feeding tube -nasogastric or abdominal (PEG), while a resident. A review of Physician Health Status note dated August 7, 2019, showed " .... GT [gastrostomy tube] with no hyper granular tissue, mild irritation and moderate serous drainage + minimal erythema around" add Calmoseptine ointment use for peri GT site care." A review of the care plan Focus showed "Resident has skin irritation on GT area initiated 3/26/19. On 8/7/2019 the aforementioned changes made to GT site care was not updated on the care plan. Facility staff failed to show evidence of an updated resident-centered care plan that reflects the changes mentioned on 8/7/2019 for Resident #53's GT site care. A face-to-face interview was conducted with Employee #18 [Nurse Manager] on August 30, 2019, at approximately 9:55 AM. She acknowledged the findings.	L 051		11/22/19

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L 051	Continued From page 7 C. Based on medical record review and staff interview for two (1) of 70 sampled residents, the facility staff failed to develop a care plan with individualized, person-centered approaches to address one (1) resident with a diagnosis of Dementia (Resident #120). Findings included... Resident #120 was admitted to the facility on 7/30/19 with diagnoses to include Dementia, Hypertension, Arthritis, and Diabetes Mellitus. Review of the Annual Minimum Data Set (MDS) dated 8/6/19 , showed Section C (Cognitive Patterns) C0500 Brief Interview for Mental Status coded as "12", which indicates moderate cognitive impairment. Review of discharge summary from [hospital name] dated 7/22/19 showed "patients' mental status was attributed to underlying dementia with frontal lobe component. Hospital course: Altered Mental Status, Dementia with Agitation. Review of physicians order dated 8/12/19 showed "psychiatric consultation for resident with Dementia and Behavioral Disturbance ..." Further review showed "monitor resident behavior every 4 hours for Dementia with behavioral disturbance." Review of the care plan showed, "Focus: Resident has a history of Dementia, Interventions: monitor weight, PO (by mouth) intake, skin integrity, labs, provide mechanical soft diet with chopped meats, thin liquids	L 051		11/22/19

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L 051	Continued From page 8 consistency." The facility failed to develop a care plan with individualized, person-centered, interventions/ approaches to address a resident with a diagnosis of Dementia. During a face-to-face interview on 9/3/19 at 12:30 PM, Employee #17 acknowledged the finding and added, "I will review and update the care plan."	L 051		11/22/19
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that facility failed to provide a minimum daily average of six tenths (0.6) hours of advanced practice registered nurse or registered nurse per resident per day for two (2) of twenty-six (26) days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels.	L 056	**L056** **Corrective Action for the Resident Affected:** The facility cannot retroactively correct this deficiency. Education will be provided Human Resources and Staffing Coordinator to ensure that the facility has adequate staffing by regulatory requirement. The facility is actively recruiting nursing staff and new hire orientation monthly and as needed. The facility will initiate a staff retention program including incentive and sign on bonuses for licensed nursing staff. The affected Resident suffered no negative outcome. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. Human Resources and Staffing Coordinator will complete house wide	

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L 056	Continued From page 9 The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of Nurse Staffing was conducted on September 3, 2019, at approximately 1:00 PM. Of the twenty-six (26) days reviewed, Two (2) of the twenty-six (26) days failed to provide a minimum daily average of six tenths (0.6) hours of advanced practice registered nurse or registered nurse per resident per day as follows: Hours of advanced practice registered nurse or registered nurse per resident per day Saturday, August 31, 2019, showed that the facility provided advanced practice registered nurse or registered nurse per resident at a rate of 0.5 hours. Sunday, September 1, 2019, showed that the facility provided advanced practice registered nurse or registered nurse per resident at a rate of 0.5 hours. A face-to-face interview conducted with the Staffing Coordinator at the time of the staffing review and she acknowledged the findings.	L 056	audit of staffing needs. Any issue found during the audit will be addressed, **Measures to prevent recurrence** The facility is actively recruiting nursing staff and new hire orientation monthly and as needed. The facility will initiate a staff retention program including incentive and sign on bonuses for licensed nursing staff. Education will be provided to Human Resources and Staffing Coordinator to ensure that the facility has adequate staffing by regulatory requirement. **Monitoring Corrective Action** Human Resources and Staffing Coordinator will complete full house audit for staffing needs weekly times 4, then monthly. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

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L 067	Continued From page 10 3214.1 Nursing Facilities A comprehensive on-going in-service education program shall be provided by the facility and shall include training on the provision of resident care. This Statute is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure annual in-services sheets failed to record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training in four (4) of four (4) in-service(s) reviewed. Findings included ... Record review of the staff annual/mandatory in-service records on 09/03/19 at 1:00 PM showed the facility provided education on four (4) topics, as listed below: Abuse Training - 01/26/19, 01/27/19, 01/30/19, 01/31/19, 02/02/19, and 02/03/19; Dementia/Alzheimer's - 02/04/19 and 05/09/19; Podiatry/Geriatric Foot Care - 04/17/19 and 04/19/19; and Elder Justice, Abuse, and Neglect - 05/09/19. Continued review of the previously mentioned training documents revealed twenty-seven (27) "In-Service Training Sign-in Sheets" that showed the following: 1.Twenty (27) of 27 sign-in sheets lacked documented evidence of the amount of in-service hours employees received from the previously mentioned in-service training. 2. Two (2) of the 27 sign-in sheets lacked documented evidence of the subject, the date,	L 067	L067 **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The staff development was educated on importance of ensuring that annual in-services sheets record the mandatory 12 hours of training, the subject the date, the time/duration, the purpose, and/or who Conducted the training. Health Care Academy was contacted to correct the error on their competencies from credits to contact hours for CNA competencies/Training The affected Residents suffered no negative outcome. **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. .The Director of Staff Development/ Designee will complete house wide Assessment/ Audit to identify potential annual in-services sheets that failed to record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** The Director of Nursing/Designee will	11/22/19

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L 067	Continued From page 11 the time, the purpose, and who conducted the training. The only information on the two (2) sing-in sheets were 41 employee signatures. 3. One (1) of the 27 sign-in sheets lacked documented evidence of the subject, the date, the time, the purpose, and who conducted the training. The one (1) sign-in sheet, however, did have the name of the person who conducted the training and twenty-five employee signatures. 4. Sixteen (16) of the 27 sign-in sheets lacked documented evidence of the time the training was provided. During a face-to-face interview on 09/02/19, at 2:45 PM, the Employee # _ Staff Educator acknowledged the findings.	L 067	provide education to the Staff Development on importance of ensuring that annual in-services sheets record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training. **Monitoring Corrective Action:** The Director of Staff Development/ Designee will complete house wide Assessment/ Audit to identify potential annual in-services sheets that failed to record the mandatory 12 hours of training, the subject, the date, the time/duration, the purpose, and/or who conducted the training weekly times 4 then, monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months	11/22/19
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection;	L 088	L088 **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. Facility staff was in-serviced on importance of developing a system of surveillance to identify infections or communicable diseases and corrective action taken to minimize the spread of the infection. The affected Residents suffered no negative outcome **.Identification of others with the Potential to be Affected:** . All residents residing in the facility have the potential to be affected.	;

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L 088	Continued From page 12 (g)Recording incidents and corrective actions related to infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to develop a system of surveillance to identify infections or communicable diseases. The census on the first day of survey was 175. Findings included... 1. Facility failed to develop a system of surveillance to identify infections or communicable diseases. Review of the facility's Infection Control Surveillance logs showed the following: May 2019 there were 25 facility-acquired infections to include chin abscess, vaginitis, boil at right chest, conjunctivitis, urinary tract infections related to E. Coli, resident on isolation for urinary tract infection, skin dermatitis, MRSA of the eyelid, fungal irritation, related to incontinence, and pneumonia. June 2019 there were 23 facility-acquired infections to include vaginitis, boil at right chest, conjunctivitis, urinary tract infections, and fungal irritation - no locations listed. July 2019 there were 21 facility-acquired infections to include Urinary tract Infections and	L 088	Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to develop a system of surveillance to identify infections or communicable diseases. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to show how corrective action is taken to help minimize the spread of the infection. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of developing a system of surveillance to identify infections or communicable diseases; and corrective action taken to minimize the spread of the infection. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to develop a system of surveillance to identify infections or communicable diseases weekly times 4 then, monthly times 3 months. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential resident that facility staff failed to show how corrective action is taken to help minimize the spread of the infection weekly times 4 then, monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: _____ B. WING _____	09/03/2019

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L 088	Continued From page 13 conjunctivitis. Based on the surveillance data, facility staff failed to show how corrective action taken to help minimize the spread of the infection (e.g., staff education and competency assessment). During a face-to-face interview on August 29, 2019 at approximately 11:30 AM, Employee # 27 acknowledged the findings.	L 088	**L091** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The soiled ice machine on One (1) of three (3) residents care units was cleaned on 9/27/19 The facility staff will be in-serviced on importance of maintaining a safe, sanitary environment. The affected Residents suffered no negative outcome.	11/22/19
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain a safe, sanitary environment as evidenced by a soiled ice machine on one (1) of three (3) resident care units. Findings included ... During an environmental walkthrough of the facility on August 27, 2019, between 10:30 AM and 3:00 PM, the access door to one (1) of one (1) ice machine located on the third floor pantry was soiled on the inside. This deficient practice could potentially contaminate beverages consumed by residents or staff. Employee #8 acknowledged the above findings	L 091	**Identification of others with the Potential to be Affected:** .All residents residing in the facility have the potential to be affected. Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential soiled Ice machine that facility staff failed to maintain in a safe sanitary condition. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** . Facility staff will be in-serviced on importance of maintaining a safe, sanitary environment. **Monitoring Corrective Action:** .Assistant Director of Nursing/ Designee will complete house wide assessment/ Audit to identify potential soiled Ice machine that facility staff failed to maintain in a safe sanitary condition weekly times 4 then, monthly times 3 months.	

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L 091	Continued From page 14 during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	L 091	Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months	11/22/19
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to prepare and serve foods under sanitary conditions as evidenced by 12 of 12 baffles from the kitchen hood system that were soiled with grease deposits and hot foods that tested at less than 140 degrees Fahrenheit (F) during a test tray assessment. Findings included ... 1. Twelve (12) of twelve (12) baffles from the exhaust hood system were soiled with grease. 2. Hot food temperatures tested at less than 140 degrees Fahrenheit (F) during a test tray assessment on August 27, 2019, at approximately 1:10 PM. A serving of chicken breast was at 123.6 degrees F, a serving of broccoli and cauliflower mix tested at 112.4 degrees F and sweet potatoes were at 138.8 degrees F. Employee #19 acknowledged the above findings during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	L 099	**L099** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **A.**The Twelve (12) of twelve (12) baffles from the kitchen exhaust hood system were soiled with grease were cleaned on 8/27/19 **B.**Hot food temperatures tested on 8/28/19 Degrees were within the required temperature range. The affected Residents suffered no any negative outcome. **Identification of others with the Potential to be Affected:** . All residents residing in the facility have the potential to be affected. **A.** The Director of Food and Nutrition Services/Designee will complete house wide audit to identify potential baffles from the kitchen exhaust hood system are soiled with grease **B.** The Director of Food and Nutrition Services/Designee will complete a random test tray of Hot food temperatures to identify potential Hot food temperatures that is less than 135 degrees Fahrenheit Any issues found during the audit will be addressed. **Measures to prevent recurrence:** **1.**Staff Development will provide education to the Food and Nutrition Services staff on the importance of preparing and serving	

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L 109	Continued From page 15	L 109	**L099**	11/22/19
L 109	3220.3 Nursing Facilities If a resident refuses food, appropriate substitutions of comparable nutritive value shall be offered at the same mealtime. This Statute is not met as evidenced by: Based on record review and staff interview for 1 (one) of 54 sampled residents the charge nurse failed to provide evidence of monitoring or modifying interventions consistent with resident needs, goals to maintain acceptable parameters of nutritional status. Resident #120. Findings included ... Resident #132 was admitted to the facility on 10/1/18 with diagnoses to include Hypertension, Hyperlipidemia, Peripheral Vascular Disease and Chronic Kidney Disease. Review of the Annual Minimum Data Set (MDS) dated 8/2/19 , showed Section C (Cognitive Patterns) C0500 Brief Interview for Mental Status is coded as "15", which indicates cognition intact. Section G Functional Status showed resident is coded as "0" which indicates independent with eating. Section K (Swallowing/Nutritional Status); nutrition approach is coded as "therapeutic diet." Reviews of the medical record showed resident weights are recorded as follows: 2/13/19 -132# 3/4/29- 130# 4/3/19- 136# 5/2/19- 135# 6/3/19-136# 7/1/19- 136# 8/1/19- 128 # During an interview on 8/28/19 at 10:00 AM	L 109	foods under sanitary conditions. **Monitoring Corrective Action:** The Director of Food and Nutrition Services/Designee will complete house wide audit to identify potential baffles from the kitchen exhaust hood system are soiled with grease weekly times 4, then monthly times 3 months. The Director of Food and Nutrition Services/Designee will complete a random test tray of Hot food temperatures to identify potential Hot food temperatures that is less than 135 degrees Fahrenheit (F) weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months **L109** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The affected Resident #132 was reassessed on 8/29/19. The Dietitian was reeducated on clinical assessment and Monitoring/ modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status Resident #132 suffered no negative outcome. **Identification of others with the Potential to be Affected:** .All residents residing in the facility have the potential to be affected. The Dietitian/Designee will complete house wide assessment/audit of residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 109	Continued From page 16 resident was asked have you lost weight. The resident responded "yes, I don't like the food here." Review of the meal log showed resident refused one or more meals for the month of August and or consumed 51-75% of meals. Further review of the medical record showed the following entries: Nurse practitioner noted dated 7/31/19 "resident wanted to change his diet to regular, resident stated I want to have corn meat and hot dog." Nurse practitioner note dated 8/2/19: "resident wanted to talk to again for changing his diet, resident agreed to continue his cardiac diet again." Review of the medical record showed an interdisciplinary team meeting was held on 8/6/19 and the resident's documented weight loss of 8 lbs. nutritional issues were not addressed. Dietary note dated 8/7/19: "pt. does not like the food and has been complaining of diet, registered dietician explained to patient that preference for fried foods can be detrimental to his health and that the patient can have fried foods no more than once a week due to complaints of possible weight loss, continue current diet and Boost BID supplement." Nurse supervisor note dated 8/22/19 "resident lost 8 lbs within a month, he had a reweigh and the reweigh remain the same." Significant weight change note by registered dietician dates 8/21/19 "PO intake is 50-100 %	L 109	to identify potential residents that facility staff failed to provide evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status. Any issued found during the assessment /audit will be corrected. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of Providing evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status. **Monitoring Corrective Action:** The Dietitian/ Designee will complete house wide assessment /audit of residents to identify potential residents that the facility staff failed to provide evidence of monitoring or modifying interventions consistent with resident needs and goals to maintain acceptable parameters of nutritional status weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

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L 109	Continued From page 17 varied appetite, patient has history of non-compliance with diet states he does not like the food." During an interview on 8/29/19 at 11:30 AM with Employee #19 states "I am not aware the resident has refused any meals and the dietician would email us if there are any changes or alternatives, this was never discussed in the care plan meeting." During an interview on 8/29/19 at 12:30 PM, Employee #21 was asked was the resident offered food alternatives, between-meals snacks or nourishments, and if she was aware the resident was refusing meals. Employee #21 stated "I did not discuss alternatives and I did not know he was refusing his meals." Employee #21 was unable to provide evidence of monitoring or modifying interventions (as appropriate) consistent with resident needs, goals to maintain acceptable parameters of nutritional status. During a face-to-face meeting on 8/29/19 at 12:30 PM, Employee #21 acknowledged the finding.	L 109		11/22/19
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;	L 128	L128 **Corrective Action for the Residents Affected:** The affected Resident #66 was Re-assessed on 9/3/19.The Consultant Pharmacist was educated on the importance of identifying and making recommendations to correct the insulin dosage. .The affected Resident suffered no negative outcome.	

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L 128	Continued From page 18 (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 70 sampled residents, the consultant pharmacist failed to identify and make recommendations to correct the Insulin dosage for one resident. Resident #66. Findings include . . . A review of the Humalog Insulin order for Resident #66 for May 2019 showed that the dosage of the Insulin was documented as 3 ml instead of 3 units. A review of Insulin order for June, July and August were also documented incorrectly as 3 ml instead of 3 units.	L 128	**Identification of others with the Potential to be Affected:** .All residents residing in the facility have the potential to be affected. . Assistant Director of Nursing/ Designee will complete house wide assessment/audit of residents to identify potential residents the consultant pharmacist failed to identify and make recommendations to correct the Insulin dosage. Any issues found during the audit will be addressed. **Measures to prevent recurrence:** Staff Development will provide education to the Consultant Pharmacist on the importance of identifying and make recommendations to correct the Insulin dosage. **Monitoring Corrective Action:** . Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential residents that the Consultant Pharmacist failed to identify and make recommendations to correct the Insulin dosage weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

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L 128	Continued From page 19 A review of the facility's policy titled "Pharmacy Recommendation Follow-Up /Review" Revised 07/2019 depicts the following: 1. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 2. This review must include a review of the resident's medical chart. 3. The pharmacist must report any irregularities to the attending physician and the facilities medical director and the director of nursing and these reports must be acted upon. Review of the Medication Regimen Review record for Resident #66 showed that the pharmacist reviewed the resident's medical records on May 15, June 17, July 18 and August 14, 2019. However, the consultant pharmacist failed to identify the incorrect order and or, make recommendations to the physician, and to the DON to correct the order. A telephone interview was conducted with the consultant pharmacist on September 03, 2019 at approximately 12:30 PM. After reviewing the orders in the computer he acknowledged the finding and stated that he would implement an audit system to ensure that this problem will not reoccur.	L 128		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 161	Continued From page 20 3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on review of medications stored on one (1) of three (3) medication carts on August 29, 2019 at approximately 12:30 PM the facility staff on the first floor failed to date the labels of seven (7) of 12 multi-dose vials/medication containers when they were first accessed; and to remove an expired medication for one (1) resident from a medication cart on the second floor. A. The following medications were opened. All of the containers lacked the dates on which they were initially accessed. Ferrous Sulfate 16 oz. bottle/8 oz. remained Expiration date 01/22 Ranitidine 300 ml bottle/140 ml remaining date of Expiration 4/1/20 Manantine 150ml bottle/30 ml left Expiration 3/30/20 Keppra 16 oz. bottle/12 oz. remaining Expiration date 03/22 Ferrous Sulfate 16 oz. bottle/12 oz. left Expiration date 01/20 Chlorhexidine Gluc. (Peridex) 0.2 % solution 16 oz. bottle/4 oz. left Expiration date Feb. 2022	L 161 L 161	L161 **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. **A.**.All medications in the medication carts without date on the labels of vials/medication containers when they were first accessed were removed from the medication cart. Reordered and dated when first accessed. **B.**The expired medication was removed immediately from the cart on 8/29/19. The affected Resident suffered no negative outcome. **Identification of others with the Potential to be Affected:** .All residents residing in the facility have the potential to be affected. **A.** Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential medications that the facility staff failed to date the labels of vials/medication containers when they were first accessed. **B** .Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential expired medications that the facility staff failed to remove from the medication cart. Any issues found during the audit will be addressed.	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 161	Continued From page 21 Docusate Sodium 16 oz. bottle/15 oz. left Expiration date 1/21. B. Facility staff failed to remove one (1) expired medication from the medication care. Labetelol 100mg six (6) tablets with a "Use by date " of 6/01/19 was observed on the medication cart during review of medication storage on August 29, 2019 at approximately 1:00 PM. Review of the resident's medication orders revealed that the Labetelol was prescribed for the resident on June 27, 2018. The prescriber wrote "Labetalol HCL Tablet 100mg give 1 tablet orally two times a day for HTN [Hypertension] hold if SBP [Systolic Blood Pressure <110 [less than] or HR [Heart Rate] <60 [less than]. The medication was discontinued on July 31, 2018. Further review of the Physician's order and the MAR failed to reveal a current order for the Labetelol. A face-to-face interview was conducted with Employee #17 at approximately 3:00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication and acknowledged that the expired medication should have been removed from the medication cart. A face-to-face interview was conducted with Employee # Manager at approximately 3:00 PM on August 29, 2019. During the interview the employee stated that the resident was no longer taking the medication and acknowledged that the expired medication should have been removed from the medication cart.	L 161	**Measures to prevent recurrence:** A. Staff Development will provide education to the facility licensed nurses on importance of labeling of vials/medication containers when they are first accessed. B. Staff Development will provide education to the facility licensed nurses on importance of removing expired medications from the medication cart. **Monitoring Corrective Action:** **A**. Assistant Director of Nursing/ Designee will complete house wide assessment / audit of residents to identify potential medications that the facility staff failed to date the labels of vials/medication containers when they were first accessed. weekly times 4, then monthly times 3 months. **B**..Assistant Director of Nursing/ Designee will complete house wide assessment/ audit of medications to identify potential expired medications that the facility staff failed to remove from the medication cart weekly times 4, then monthly times 3 months.. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19

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L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in three (3) of 38 resident's rooms that did not emit an audio or visual alarm when tested. Findings included... During an environmental walkthrough of the facility on August 27, 2019, between 10:30 AM and 3:00 PM, call bells in resident rooms #209B, #241A and #309A did not alarm when tested , three (3) of 38 resident's rooms. This breakdown could prevent or delay care to residents in an emergency.	L 306	**L306** **Corrective Action for the Residents Affected:** The facility cannot retroactively correct this deficiency. The affected call bells in resident rooms' #209B, #241A and #309A were replaced on 8/27/19. The affected residents suffered no negative outcome **Identification of others with the Potential to be Affected:** All residents residing in the facility have the potential to be affected. The Director of Maintenance/ Designee will complete house wide Assessment/ Audit to identify potential resident room that facility staff failed to maintain the call bell system in good working condition. Any issue found during this audit will be corrected. **Measures to prevent recurrence:** Staff Development will provide education to the facility staff on importance of maintaining the call bell system in good working condition. **Monitoring Corrective Action:** The Director of Maintenance/ Designee will complete house wide Assessment/ Audit to identify potential resident rooms that facility staff failed to maintain the call bell system in good working condition weekly times 4 then, monthly times 3 months.	11/22/19

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L 306	Continued From page 23 Employee #8 acknowledged the above findings during a face-to-face interview on August 27, 2019 at approximately 3:00 PM.	L 306	.Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	11/22/19