STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	09/14/2016

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Sibley Memorial Hospital Renaissance from September 12, 2016 through September 14, 2016. Survey activities consisted of a review of 30 residents' clinical records during Stage 1; and review of 20 sampled residents during Stage 2. The following deficiencies are based on observation, record review 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 following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue DI - deciliter DMH - Department of Mental Health	F 000	Sibley Memorial Hospital Renaissance is filing the following plan of correction for purposes of regulatory compliance, in response to the Quality Indicator and licensure survey conducted on September 12, 2016 through September 14, 2016. The facility is submitting this plan of correction to comply with applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies herein. **The following comments are in response to F 253 #1: Exhaust Vents** 1. Corrective Action for Identified Patients: No known direct impact to patients from soiled exhaust vents. 2. Identification of Other Patients having the Potential to be affected: Other patients with the potential of being affected by the same deficient practice will be addressed by the following plan of correction: Environmental Rounds with attention to soiled exhaust vents. 3. Systemic Changes to Prevent Recurrence: Environmental Rounds performed by the Director of Plant Operations and Maintenance (Plant O&M) on a monthly basis and the Environment of Care (EOC) Committee semi-annually will include attention to soiled exhaust vents. Work orders should be submitted to Plant O&M for any repairs needed. 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Environmental rounds are aggregated and monitored for deficient trends on a quarterly basis and corrective measures are implemented as necessary. Plant O&M monitors the work order system for completion and satisfaction rates. This plan of correction is integrated into the quality assurance system through the quarterly report of deficient trends and review of completion and satisfaction rates on an annual basis by the EOC committee. 5. Date Corrective Action Completed: by 10/27/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
D. Elise Miller	Administrator	10/24/16

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

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F 000	Continued From page 1 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000	**The following comments are in response to F 253 #2: Loose Privacy Curtains** 1. Corrective Action for Identified Patients: No direct impact to patients from loose shower curtains/curtains. 2. Identification of Other Patients Having the Potential to be Affected: No direct impact to other patients from curtains loose. 3. Systemic Changes to Prevent Recurrence: Environmental Services management team and Environmental rounds performed by the Environment of Care Committee with attention to the replacement of all curtains when needed for rooms and showers. 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Environmental services monitors and inspects for replacing of curtains on an ongoing basis. 5. Date Corrective Action Completed: 10/24/16 **The following comments are in response to F 253 #3: Stained Privacy Curtains** 1. Corrective Action for Identified Patients: No direct impact to patients from shower curtains / curtains 2. Identification of Other Patients Having the Potential to be Affected: No direct impact to other patients from curtains stained with black markings. 3. Systemic Changes to Prevent Recurrence: Environmental Services management team and Environmental rounds performed by the Environment of Care Committee with attention to the replacement of all curtains when needed for rooms and showers.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 2 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made on September 13, 2016 at approximately 2:00 PM, it was determined that the facility failed to provide housekeeping services necessary to maintain a sanitary environment as evidenced by soiled exhaust vents in 10 of 15 residents' rooms, loose privacy curtains in five (5) of 15 residents' rooms, stained privacy curtains in three (3) of 15 residents' rooms and low water temperatures in two (2) of 15 residents' rooms. The findings include: 1. Exhaust vents were soiled in 10 of 15 residents' bathrooms including rooms #301, 302, 303, 305, 308, 310, 311, 315, 318 and #320. 2. Privacy curtains were hanging loose and off the hooks in five (5) of 15 residents' rooms. (#301B, 303A and B, 305A, 310A, 311). 3. Privacy curtains were stained with black markings in three (3) of 15 residents' rooms including rooms #303B, 305A, and 310B. 4. Water temperatures were measured at less than 95 degrees Fahrenheit in two (2) of 15 residents' rooms (#308 and #315). These observations were made in the presence of Employee #9 who acknowledged the findings.	F 253	**The following comments are in response to F 253 #3: Stained Privacy Curtains (continued)** 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Environmental rounds are aggregated and monitored for deficient trends and correction measures are implemented as necessary. Environmental services monitors and inspects for replacing of curtains on an ongoing basis. 5. Date Corrective Action Completed: 10/24/2016 **The following comments are in response to F 253 #4: Water Temperature** 1. Corrective Action for Identified Patients: No known direct impact to patients from hot water temperatures less than 95 degrees at faucets. Plant Operations and Maintenance (PO&M) manually adjusted the water temperatures and brought the temperatures to meet the requirements for hot water on 9/13/2016 during the survey. 2. Identification of Other Patients Having the Potential to be Affected: Although the hot water mixing valve appears to be working at this time, PO&M will continue to monitor and manually adjust the temperature as needed to stay in compliance with the required temperature. 3. Systemic Changes to Prevent Recurrence: Environmental Rounds performed by the Director of Plant Operations and Maintenance (Plant O&M) on a monthly basis and the Environment of Care (EOC) Committee semi-annually will include attention to hot water temperatures at faucets. Work orders should be submitted to Plant O&M for any repairs needed.	
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 3 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that facility staff failed to develop a care plan with goals and approaches for the potential adverse reactions from the use of nine (9) or more medications for Resident #76. The findings include: A review of the Physician ' s Orders signed on August 16, 2016 revealed the following medication orders: "Tylenol, Amiodarone,	F 279	**The following comments are in response to F 253 #4: Water Temp (continued)** 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Environmental rounds are aggregated and monitored for deficient trends on a quarterly basis and corrective measures are implemented as necessary. Plant O&M monitors the work order system for completion and satisfaction rates. This plan of correction is integrated into the quality assurance system through the quarterly report of deficient trends and review of completion and review of completion and satisfaction rates on an annual basis by the EOC Committee. 5. Date Corrective Action Completed: 9/13/16 **The following comments are in response to F 279: Develop Comprehensive Care Plans** 1. Corrective Action for Identified Patients: a. There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. b. Care plans for all residents with 9 or more medications will be initiated on admission by the admitting RN c. The Director of Nursing will counsel the individual identified as responsible for the deficiency 2. Identification of Other Patients Having the Potential to be Affected: Quality and Compliance RN will perform chart audits on new admissions within 24 hours 3. Systemic Changes to Prevent Recurrence: a. Nurses will identify patients with 9 or more medications every Monday and Thursday and report to the charge nurse b. The charge nurse will review the information and update the respective care plan c. Provide care plan education to the nursing staff within 30 days	

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F 279	Continued From page 4 Ammonium Lac-Hydrin, Dulcolax, Wellbutrin, Lanoxin, Colace, Flonase, Lactinex (probiotic-aiding digestion), Lidoderm 5% patch, Mycostatin, Protonix, Miralax, and Gas-X. There was no evidence that a care plan was initiated with goals and approaches to address the potential adverse drug interactions associated with the use of nine (9) or more medications found in Resident's #76's chart. A face-to-face interview was conducted with Employee #2 at approximately 2:00 PM on September 14, 2016. After review of the care plans, he/she acknowledged that the record lacked evidence of a care plan for the potential adverse interaction of the use of nine (9) or more medications. The record was reviewed on September 14, 2016.	F 279	**The following comments are in response to F 279: Develop Comprehensive Care Plans (cont.)** 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: The Quality and Compliance RN will perform 5 random chart audits every week. Audit results will be reported at the quarterly Renaissance Compliance and Quality Assurance Committee Meeting. 5. Date Corrective Action Completed: 10/17/16 **The following comments are in response to F 323: Free of Accidents / Hazards / Supervision / Devices** 1. Corrective Action for Identified Patients: No direct impact identified to patients from the deficient practices of standing water located by the dish-machine. 2. Identification of Other Patients Having the Potential to be Affected: Daily monitoring and preventive maintenance walk thru of area will be conducted by management during every shift. 3. Systemic Changes to Prevent Recurrence: We have placed a slip resistant mat in the area where the standing water is settling. The Food and Nutrition Services Management Team and Food Service Team will meet with all team members to discuss this new practice to ensure safety to all employees. 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: The Food and Nutrition Team will monitor this safety risk area daily until a complete renovation of the floor is completed. The opening /closing manager will log any hazards that are found daily. 5. Date Corrective Action Completed: 10/27/2016	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations made on September 13, 2016 at approximately 2:00 PM, it was determined that the facility failed to maintain an	F 323		

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F 323	Continued From page 5 environment free of potential accident hazards as evidenced by a wet floor in the dishwashing machine room. The findings include; 2. The floor in the area where the dishwashing machine is located was constantly covered with approximately an inch of water and presented a slipping hazard to staff. The observations were made in the presence of Employee #9 who acknowledged the findings.	F 323	**The following comments are in response to F 325: Maintain Nutrition Status unless Unavoidable** 1. Corrective Action for Identified Patients: a. The resident found to have been affected by the deficient practice of not having a re-weigh had no adverse outcome. b. The Quality and Compliance RN will provide staff education regarding the Renaissance weight policy c. The Director of Nursing Services will counsel the staff involved in the deficiency 2. Identification of Other Patients Having the Potential to be Affected: a. Weekly chart audits performed by the Quality and Compliance RN b. Weekly review of weight discrepancies with follow-up with the staff assigned to the resident to ensure accuracy of documentation 3. Systemic Changes to Prevent Recurrence: Identify residents with Length of Stay (LOS) of 30 days during weekly Care plan meetings 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Continue weekly chart audits performed for all residents by the Quality and Compliance RN. Audit results will be reported at the quarterly Renaissance Compliance and Quality Assurance Committee Meeting. 5. Date Corrective Action Completed: 10/17/16	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that facility staff failed to re-weigh Resident #61. The findings include:	F 325		

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F 325	Continued From page 6 A review of Resident #61's weight history for the period of April 2016 through September 2016 revealed the following: "April, 2016- 179.9 lbs. (pounds) May 5, 2016- 171.3 lbs. May 5, 2016- 183.4 lbs. (re-weigh) June, 2016- 184.5 lbs. July, 2016 - 179.8 lbs. August, 2016- 181.2 lbs. September 8, 2016 - 170.9lbs/171lbs " A comparison of the August and September weights revealed that the resident sustained a loss of 10 pounds which was indicative of a 5% weight loss within 30 days. According to the Centers for Medicare & Medicaid Services' MDS (Minimum Data Set) 3.0 User ' s Manual: October 2013 the Resident Assessnent Instrument (RAI) Section K, Page K-4, " Weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment. " According to the documentation in the clinical record the resident was weighed on September 8, 2016 and the weight was recorded as 171lbs. This weight when compared with the previous month ' s (August) weight of 181lbs indicated a significant weight loss of 5%/10lbs. A dietician ' s note dated September 8, 2016 in the clinical record revealed the following: " Resident experienced unintentional/significant weight loss of 5%. Suspect measurement error. Reweight requested. " Further review of the resident ' s documented	F 325		

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F 325	Continued From page 7 weights failed to reveal any evidence that the facility staff reweighed the resident to determine whether the 5%/10 lb weight loss was accurate. A face-to-face interview was conducted on September 12, 2016 at approximately 11:30 AM with Employee #3. A query was made whether the resident was reweighed. He/she responded, " No. " A face-to-face interview was conducted with Employee #2 at approximately 10:30 AM on September 13, 2016. The employee acknowledged the finding during the interview. The record was reviewed on September 12, 2016.	F 325	**The following comments are in response to F 329: Drug Regimen is Free from Unnecessary Drugs** 1. Corrective Action for Identified Patients: There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. 2. Identification of Other Patients Having the Potential to be Affected: Other residents having the potential to be affected by the same deficient practice will be identified through staff audits. The corrective action will include a letter from the Chief Medical Officer (CMO) to the physician cited for this deficiency with physician re-education on the completeness of orders. 3. Systemic Changes to Prevent Recurrence: The following systemic changes will be put in place to ensure the deficient practice will not recur: a. The pharmacist will perform medication order checks for completion. When an order is found to be incomplete, e.g., lack of a relevant indication for an ordered medication, the pharmacist will call the physician and clarify the order prior to carrying the order out. Pharmacy will provide a monthly report of incomplete orders by physician to the Director of Nursing, Administrator and the Medical Director in order to identify and counsel physicians who are non-compliant. b. The physicians who failed to write complete orders will be sent a letter from the CMO and will be re-educated on completeness of orders.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		

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F 329	Continued From page 8 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 20 Stage 2 sampled residents, it was determined that the physician failed to include an indication for the use of Resident #224 ' s medications. The findings include: The electronic Physician ' s Order Sheet dated August 31, 2016 directed: " Allopurinol (Zyloprim) tablet 100mg, daily, [by mouth]; Cyanocobalamin (Vitamin B-12) tablet 1,000 mcg [by mouth] daily; Duloxetine (Cymbalta) DR [delayed release] capsule 30 mg [by mouth] daily; Vitron C 65 mg - Iron-125mg per tablet 1 tablet [by mouth] daily; Enoxaparin (Lovenox) syringe 40 mg [Subcutaneous] daily; Fluticasone-salmeterol (Advair) 500-50mcg/dose diskus inhaler 1 puff two times daily; Folic Acid (Folvite) tablet 800mcg [by mouth] daily; Gabapentin (Neurontin) capsule 300mg [by mouth] two times daily; Gabapentin (Neurontin) capsule 600mg [by mouth] nightly, Hydrocodone-acetaminophen (Vicodin) 5-300mg per tablet [by mouth] as needed every 6 hours; Megestrol (Megace) 40 mg/mL suspension 400mg [by mouth] daily; Ondansetron (Zofran ODT) disintegrating tablet 4 mg [by mouth every six hours as needed]; Pazopanib (Votrent) tablet	F 329	**The following comments are in response to F 329: Drug Regimen is Free from Unnecessary Drugs (continued)** 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: In order to monitor performance on an ongoing basis, weekly audits will be performed by the MDS Coordinator and found discrepancies of medication indications will be provided to the Director of Nursing, Administrator and the Medical Director in order to identify and counsel physicians who are non-compliant, with a goal of 90% or above compliance. The plan of correction will be integrated into the quality assurance system. 5. Date Corrective Action Completed: on or by 10/24/16.	

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F 329	Continued From page 9 800mg [by mouth daily] and Polyethylene glycol (Miralax) packet 17g [by mouth] daily. " A review of the resident ' s August 2016 and September 2016 Medication Administration Records (MAR) revealed that the resident was receiving the prescribed medications as ordered. However, no indications were documented for the use of the medications. A face-to-face interview was conducted on September 14, 2016 with Employee #2 at approximately 1:00 pm. The employee reviewed the physician's order sheet and acknowledged that no reason was indicated for the use of the medications. The clinical record was reviewed on September 14, 2016.	F 329	**The following comments are in response to F 371: Food Procure, Store / Prepare / Serve - Sanitary** 1. Corrective Action for Identified Patients: No direct impact identified to patients from the deficient practice of five of seven convection ovens that were soiled with burnt food deposits. 2. Identification of Other Patients Having the Potential to be Affected: Daily monitoring by management will identify other patients having the potential to be affected by the same deficient practice. 3. Systemic Changes to Prevent Recurrence: The Food and Nutrition Services Management Team and Sanitation Team will meet with all sanitation employees and have compressor fan cleaning added to master cleaning assignments. 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: The sanitation manager and supervisor will monitor regular cleaning of the convection ovens. The sanitation cleaning assignment log will become part of the quality assurance system for the Food and Nutrition Services Department and will be reviewed at the monthly managers meeting. 5. Date Corrective Action Completed: 10/24/16	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on September 13,	F 371		

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SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 2016 at approximately 9:45 AM, it was determined that the facility failed to prepare food under sanitary conditions as evidenced by five (5) of seven (7) convection ovens that were soiled with burnt food deposits. The findings include: Five (5) of seven (7) convection ovens were soiled with burnt food deposits. These observations were made in the presence of Employee #8 who acknowledged the findings.	F 371	**The following comments are in response to F 456: Essential Equipment, Safe Operating Condition** 1. Corrective Action for Identified Patients: No direct impact identified to patients from the deficient practices of three of seven fire control knobs from gas stove were missing 2. Identification of Other Patients Having the Potential to be Affected: Daily monitoring and preventive maintenance walk thru on equipment verification by management which will identify any other potential mechanical, electrical, and equipment. 3. Systemic Changes to Prevent Recurrence: The Food and Nutrition Services Management Team and Sanitation Team will meet with sanitation team members to reinforce proper cleaning and maintenance of carts, warmers, pots, pans and other equipment to include stoves. 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: The Operations Chef Manager will monitor all equipment in kitchen to ensure it is safe and functional. The opening manager log will become part of the quality assurance system for the Food and Nutrition Services Department and will be reviewed at the monthly managers meeting. 5. Date Corrective Action Completed: 10/24/16	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on September 13, 2016 at approximately 9:45 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by three (3) of seven (7) fire control knobs that were missing from the gas stove. The findings include: Three (3) of seven (7) fire control knobs from the gas stove were missing. These observations were made in the presence	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095030	A. BUILDING _____ B. WING _____	09/14/2016

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F 456	Continued From page 11 of Employee #8 who acknowledged the findings.	F 456	**The following comments are in response to F 463: Resident Call System – Rooms / Toilet / Bath**	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on September 13, 2016 at approximately 2:00 PM, it was determined that the facility failed to maintain the call bell system in good working condition as evidenced by a non-functioning call bell in one (1) of 15 resident ' s room. The findings include: The call bell in resident room #320 did not initiate an alarm when tested. This observation was made in the presence of Employee #9 who acknowledged the findings.	F 463	1. Corrective Action for Identified Patients: No known direct impact to patients from nonfunctioning call bell. Plant Operations and Maintenance staff repaired the call bell during the survey. 2. Identification of Other Patients Having the Potential to be Affected: Environmental Rounds with attention to nonfunctioning call bells 3. Systemic Changes to Prevent Recurrence: Environmental Rounds performed by the Director of Plant Operations and Maintenance (Plant O&M) on a monthly basis and the Environment of Care (EOC) Committee semi-annually will include attention nonfunctioning call bells. Work orders should be submitted to Plant O&M for any repairs needed 4. Monitoring and Incorporation into Quality Assurance / Performance Improvement Process Plan: Environmental rounds are aggregated and monitored for deficient trends on a quarterly basis and corrective measures are implemented as necessary. Plant O&M monitors the work order system for completion and satisfaction rates. This plan of correction is integrated into the quality assurance system through the quarterly report of deficient trends and review of completion and satisfaction rates on an annual basis by the EOC Committee. 5. Date Corrective Action Completed: 9/13/2016	