STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095030		08/18/2017

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

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Sibley Memorial Hospital Renaissance from August 14, 2017 through August 18, 2017. Survey activities consisted of a review of 30 residents' clinical records during Stage 1; and review of 26 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 Dl - 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 August 14, 2017 through August 18, 2017. 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 F156 – Failure to provide a resident with Notice of Medicare Non-Coverage within 48 hours/no later than two days before the discontinuation of rehabilitation services:** 1. Corrective Action for Identified residents: There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident was discharged without objection. 2. Identification of Other residents having the Potential of be Affected: Other residents having the potential to be affected by the same deficient practice will be identified by the healthcare team and will be given the Notice of Medicare Non-Coverage within 48 hours/no later than two (2) days before the discontinuation of rehabilitation services. 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 healthcare team will identify residents for prospective discharges during the care plan meetings on Mondays and Thursdays. b. The Case Coordinators will give residents the Notice of Medicare Non-Coverage within 48 hours/ no later than two (2) days before the discontinuation of services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Elise Miller
TITLE: Administrator
(X6) DATE: 10/9/17

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	c. The Case Coordinator who failed to provide the resident with a non-coverage notice two (2) days before the discontinuation of services was re-educated on August 18, 2017 on the issuing requirements for the Notice of Medicare Non-Coverage within 48 hours/ no later than two (2) days before the discontinuation of services. d. All Case Coordinators who cover the Renaissance Nursing Facility were re-educated on August 21, 2017 on the issuing requirements for the Notice of Medicare Non-Coverage within 48 hours/no later than two (2) days before the discontinuation of services. 4. Monitoring and Integration into the Quality Assurance System: In order to monitor performance on an ongoing basis, weekly audits will be performed by the Data Analyst staff and any discrepancies of appropriate notice (without a statement of the resident's waiver of the two days prior notice or a statement of the resident's agreement with the discharge date) will be provided to the Case Coordination Manager and Administrator in order to identify and counsel Case Coordinators who are non-compliant, with a goal of 90% or above compliance. The audit report will be reported to the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on August 25, 2017.	
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident	F 156	**The following comments are in response F157 – Failure to notify the physician that one medication was not administered as ordered:** 1. Corrective Action for Identified Residents: There are no further corrective actions for the resident found to have been affected	

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F 156	Continued From page 2 remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact	F 156	by this deficient practice as the resident was discharged. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified by the healthcare team through audit of medication administration record and documentation that the physician was notified when medication was not administered as ordered. 3. Systemic Changes to Prevent Recurrence: The following systemic changes wereput in place to ensure the deficient practice will not recur: a. Re-education at Daily Safety huddles and staff meeting on medication administration and documentation of physician notification when medication was not delivered as ordered. Re-education to staff was provided by the Director of Nursing, Quality Compliance Nurse, and Nursing Informatics Representative. b. Any nurse found to be non-compliant will receive one-on-one re-education and will be monitored for compliance. c. The Quality Compliance RN will perform random audits of five Medication Administration Record (MAR) for proper medication administration and note documentation. 4. Monitoring and Integration into the Quality Assurance System: Monthly audits of five MARs for three months with a compliance rate of 100%. Audit results will be reported to the Director of Nursing and at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017.	

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F 156	Continued From page 3 agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning	F 156	**The following comments are in response F167 – Failure to post signage that identified survey results location without directing residents and visitors to ask the facility:** 1. Corrective Action for Identified Residents: No direct impact identified to the residents from the deficient practice of not posting the most recent survey results in a readily accessible area. The Inspection Report Book was moved and the signage replaced while the QIS surveyors were still onsite. 2. Identification of Other Residents Having the Potential of Being Affected: All Residents will be educated on admission on the locations of the Inspection Report Books in the facility. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not recur: a. Signage was replaced with clear instruction of location of Inspection Report Books. b. Two new locations were added for the Inspection Report Books, namely in the 3 South hallway near the nurses station and in the Activity Area. c. The Quality Compliance Coordinator will maintain and monitor the books weekly. 4. Monitoring and Integration into the Quality Assurance System: Weekly monitoring of the Inspection Report Books in the correct locations will be completed by the Quality Compliance Coordinator and will be reported to the Director of Nursing, the Administrator and at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on September 17, 2017.	

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F 156	Continued From page 4 November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (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	F 156	**The following comments are in response F168 – Failure to post accurate contact information for agencies acting as client advocates:** 1. Corrective Action for Identified Residents: No direct impact identified to the residents from the deficient practice of incorrect information for agency acting as client advocates. The corrective action was completed while the QIS surveyors were still onsite. 2. Identification of Other Residents Having the Potential of Being Affected: All residents will be educated on admission on State Client Advocacy Group information and where it is located. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not recur: a. The State Client Advocacy Group Information was updated and placed in a glass wall display located in 3 North Hallway while the QIS surveyors were still onsite. b. The Facility Administrator will provide updated information for any changes in the list of State Client Advocacy Group. c. The Quality Compliance Coordinator will monitor and update the State Client Advocacy Group information as necessary. 4. Monitoring and Integration into the Quality Assurance System: Monthly monitoring of the State Client Advocacy Group information will be done by the Quality Compliance Coordinator and will be reported to the Director of Nursing, the Administrator and at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on September 17, 2017	

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F 156	Continued From page 5 facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 156	**The following comments are in response F226 – Failure to develop a comprehensive abuse policy and procedure that addresses protection:** 1. Corrective Action for Identified Residents: An investigation conducted upon notice of allegation. The Abuse allegation not substantiated. The Investigation shared with DOH and accepted. The residents have been discharged. 2. Identification of Other Residents Having the Potential of Being Affected: The following was added to the "Abuse and Neglect" policy # 10-28-01 and our process: 1. Protection of Residents from Retaliation: a. The facility, its managers, and other agents, shall protect the residents from harm during an investigation. This is accomplished by the following: i. Immediately remove the suspected employee from caring for the resident who made the report; ii. If agency personnel are involved in the allegation, remove from assignment and notify the agency; iii. Secure a copy of assignment sheet(s) for staff caring for the resident at the time of the alleged incident; iv. Suspend the suspected employee until the investigation is completed; v. Interview other residents who have been cared for by the suspected employee; vi. Review in safety huddles, the need to be sensitive to the affected resident's needs given his/her recent allegation of abuse; and	

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F 156	Continued From page 6 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's	F 156	ix. If the abuse allegation is substantiated, report the involved employee(s) to the appropriate District of Columbia professional disciplinary agency. b. The facility, its managers or other agents shall not, as a result of a nurse or other employee making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1) of the Social Security Act §1150B: i. Discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or ii. File a complaint or a report against a nurse or other employee with the appropriate District of Columbia professional disciplinary agency because of lawful acts done by the nurse or employee. 3. Systemic Changes to Prevent Recurrence: • Educate managers about changes to the revised policy • Include education tip on Abuse Awareness and Prevention at daily safety huddles • Incorporate the "Abuse Awareness and Prevention Education" for all staff with booklet distribution 4. Monitoring and Integration into the Quality Assurance System: Track completion of dissemination of booklet, inclusion of tips at huddles, and revised education of all staff; report to QAPI Committee.	

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F 156	Continued From page 7 per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on a clinical record review, the facility failed to provide a resident with the Notice of Medicare Non-Coverage within 48 hours /no later than two (2) days before the discontinuation of rehabilitation services for one (1) resident (Resident #3). The findings include: The Notice of Medicare Non-Coverage form stipulates that every Medicare resident in a facility has the right to appeal the decision of non-coverage to the Quality Improvement Organization (QIO) no later than two days after the effective date of the notice. Resident #3 was admitted to the facility on January 24, 2017, with a diagnosis of "Posterior Lumbar Decompressive Instrumented, Autologous 360 degree arthrodesis with iliac fixation T1-10-S1" [lumbar fusion], wherein	F 156	5. Dates Corrective Action Completed: • Dissemination of Education Booklet initiated September 2, 2017 • Safety Huddles inclusion of Abuse Awareness and Prevention tips initiated September 2, 2017 • Revised Policy September 2, 2017 **The following comments are in response F241 – Failure to respect resident's dignity by entering the resident's room without knocking on the door and awaiting a response to enter the room:** 1. Corrective Action for Identified Residents: No direct impact identified to the residents from the deficient practice of not knocking and waiting for a response before entering a resident room. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified through monitoring and Just-In-time education. 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 staff was identified and education provided by the Director Of Nursing (DON). b. All staff were re-educated on promoting care for residents in a manner and in an environment that maintains or enhances each resident dignity and respect. This will include a reminder that facility staff will not enter a resident's room without permission or acknowledgement from the resident. Re-education was done at Daily Safety huddles and staff meetings during the month of September. c. The Quality Compliance RN will conduct weekly random unannounced	

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F 156	Continued From page 8 physical and occupational therapies were rendered. Resident #3 discharged from the facility on February 25, 2017. Physical therapy discharge notes dated February 24, 2017, at 3:55 PM showed Physical Therapy plan to "discontinue skilled therapy. Recommend home health therapy ...communicated/Interdisciplinary meeting with the patient regarding discharge plan". Clinical record review indicated that a Notice of Medicare Non-Coverage was given and signed by Resident #3 on February 24, 2017, with the termination of services effective February 25, 2017. The facility failed to provide the Notice of Medicare Non-Coverage no later than two (2) days which would allow Resident #3 to appeal the notice if needed. During a face-to-face interview on August 18, 2017, at 8:55 AM, Employee #16 acknowledged the findings.	F 156	observations of staff in maintaining resident's dignity and the rights to be treated with respect. 4. Monitoring and Integration into the Quality Assurance System: The Quality Compliance RN will conduct five random unannounced observations each week for three months to ensure staff is maintaining residents dignity by knocking and wait for a response before entering the residents' rooms. The observation results will be reported to the Director of Nursing and the Administrator. The observation results will also be reported at the Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017. **The following comments are in response F246 -- Failure to place call light within the resident's reach:** 1. Corrective Action for Identified Residents: There are no further corrective actions for the resident found to have affected by this deficient practice. The deficient practice was corrected while the QIS surveyor was still in the resident's room. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified by Nursing Leadership through monitoring of the residents' environment. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not occur: During September, the staff were re-educated at Daily Safety huddles on the importance of purposeful rounding and making sure the call light and telephone are accessible to the residents.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		

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F 157	Continued From page 9 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 26 sampled residents, the facility staff failed to notify the physician one (1)	F 157	4. Monitoring and Integration into the Quality Assurance System: Weekly monitoring of five resident's rooms for three months to ensure call lights and telephone are accessible to residents by the leadership team during leadership rounds. The monitoring results will be reported to the Quality Assurance Committee meeting by the Unit Manager. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017. **The following comments are in response F253 – Failure to maintain resident's environment, in a sanitary manner:** **Soiled Exhaust Vents** 1. Corrective Action for Identified Residents: No known direct impact to residents from soiled exhaust vents. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents 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: Work orders will be submitted to EVS for any soiled exhaust vents. Environmental Rounds will be performed by the Environmental Services Management Team on a monthly basis and the Environment of Care (EOC) Committee semi-annually with attention to soiled exhaust vents. 4. Monitoring and Integration into the Quality Assurance System: Environmental rounds are aggregated and monitored for deficient trends and	

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F 157	Continued From page 10 medication (Tylenol) was not administered as ordered (Resident # 252). Findings include: A review of the medical record revealed a physician order form dated August 14, 2017, directed the following: "acetaminophen [Tylenol] 650 mg oral (route), give once prior to transfusion, start 8/14/17 at 1530." A review of the transfusion information form reveal "transfusion of Leukoreduced RBC (red blood cells) Unit W2032 17 662324 B-E0 382V00 was started on 8/14/17 at 2129 and the transfusion was completed on 8/15/17 at 0119 [volume 368.33 ml]." At the time of the review, there is no documented evidence of an adverse reaction to the transfused (1) unit of blood. On August 17, 2017, at approximately 10:30 AM a review of the medication administration record (MAR) dated August 14, 2017, revealed "not given" for Tylenol 650 mg oral (1530). A further review of the record lacked documented evidence the physician was notified the medication [Tylenol 650 mg PO] was not administered as ordered. A face-to-face meeting conducted with Employee# 8 on August 17, 2017, at approximately 2:00 PM after a review of the record, Employee# 8 acknowledged the findings.	F 157	corrective measures are implemented as necessary. Environmental services monitors and inspects for the cleaning of exhaust vents on an ongoing basis. 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: October 2, 2017. **Torn / Loose Privacy Curtains** 1. Corrective Action for Identified Residents: No known direct impact to residents from torn, loose, or off the hooks privacy curtains. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents 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 torn, loose, or off the hooks privacy curtains. 3. Systemic Changes to Prevent Recurrence: Work orders will be submitted to EVS for any torn, loose, or off the hooks privacy curtains. Environmental Rounds will be performed by the Environmental Services Management Team on a monthly basis and the Environment of Care (EOC) Committee semi-annually with attention to the replacement of all curtains when needed for rooms and showers. 4. Monitoring and Integration into the Quality Assurance System: 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. This plan of correction is integrated into the quality assurance	
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (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	F 167		

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F 167	Continued From page 11 surveyors and any plan of correction in effect with respect to the facility; and (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. (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 observations and staff interview, the facility failed to post signage that identified survey results location without directing residents and visitors to ask the facility. The census during the survey was 38 residents. The findings include: On August 14, 2017, at 12:15 PM, signage related to the location of survey inspection reports was observed. The signage posted on the wall, in the hallway of the facility read as follows: "Inspection reports of the skilled nursing unit are	F 167	system through quarterly reports with annual report to the EOC Committee. 5. Date Corrective Action Completed: October 2, 2017. **The following comments are in response F279 – Failure to initiate a care plan for resident's use of an indwelling Foley catheter:** 1. Corrective Action for Identified Residents: No direct impact identified to the residents from the deficient practice. Foley catheter care plan was initiated immediately after the deficiency was identified. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified by the healthcare team through audit of care plans. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not recur: a. The Director of Nursing counseled the Nursing staff that was identified as responsible for the deficiency. b. Care plans for all residents who have lines, drainage and indwelling catheters will be initiated by the admitting nurse. c. The Quality Compliance RN will review care plans during the Mondays' Care Plan Meetings. d. The Quality Compliance RN will perform monthly chart audit for required documentation to include care plan for indwelling catheter on new admission within 24 hours of admission. e. The Nursing Leadership Team provided care plan re-education to the nursing staff at Daily Safety	

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F 167	Continued From page 12 available in a notebook located between the 3 North glass wall displays and upon request in the office of the Chief Executive Officer of the hospital. The Chief Executive Officer's office is located on the First Floor of Building C near the entrance to the visitors parking area". Residents and visitors must request the survey results from the Chief Executive Officer's office, which prevents accessibility to survey results without assistance from the facility. Employee #1, present at the time of the observation, acknowledged the findings.	F 167	huddles and at staff meetings during the month of September. f. Re-education was provided to Charge Nurses on shift-to-shift communication regarding patients with lines and indwelling catheters and on the completion of Charge Nurse Report Form. 4. Monitoring and Integration into the Quality Assurance System: The Quality Compliance RN will perform ten random audit of care plans for three months for a compliance rate of 100%. Audit results will be reported to the Director of Nursing and at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017.	
F 168 SS=D	483.10(g)(10)(ii)(k) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES (g)(10) The resident has the right to- (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. (k) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to	F 168	**The following comments are in response F309 – Failure to hold doses of vancomycin after notification the vancomycin trough level was greater than the toxic range of 20 mcg/ml and failed to administer insulin in accordance with the physician's order:** 1. Corrective Action for Identified Residents: There are no further corrective actions as the resident has been discharge home. 2. Identification of Other Residents Having the Potential of Being Affected: All residents have the potential to be affected by the deficient practice. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice does not recur: a. Failure to hold Vancomycin doses with elevated trough level: i. Nursing Leaders re-educated staff on standard monitoring and hold orders for Vancomycin Therapy. Lab results	

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F 168	Continued From page 13 arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post accurate contact information for agencies acting as client advocates, to provide residents the opportunity to contact these agencies. The census during the survey was 38 residents. The findings include: On August 14, 2017, at 12:20 PM, signage related to contact information for agencies acting as client advocates was observed posted on the wall, in the hallway of the facility. The signage posted did not reveal the correct name of the Senior Deputy Director of the Department of Health and the Ombudsman. There was no evidence that facility staff provided the residents with the correct contact information necessary for the agencies acting as client advocates. Employee #1 present, at the time of the observation, acknowledged the findings.	F 168	are be reviewed by the RN and verified to the physician and pharmacist prior to administering vancomycin therapy. ii. The Laboratory Results will be reviewed and audited for patients with Intravenous Vancomycin Therapy by the Nurse Practitioner weekly to verify proper administration of therapy. iii. The Nurse Practitioner will report deficient practice and non-compliance by nurses to the Quality and Compliance Nurses and to the Director of Nursing on a weekly basis. iv. The Director of Nursing will conduct one-on-one counseling to nurses that are not in compliance. b. Failure to administer insulin as per physician's order: i. Staff re-education on Medication Administration and Documentation ii. 2 RN (Quality and Compliance Nurses) will perform random audit of 5 Medication Administration Record for proper administration and review documentation. iii. Nurses found to be out of compliance will be counsel on a one-on-one basis by the Director of Nursing.	
F 226 SS=C	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 226	4. Monitoring and Integration into the Quality Assurance System: a. The two RNs (Quality and Compliance Nurses) will monitor performance through weekly audits of Laboratory Results for patients receiving Vancomycin Therapy and report to the Director Of Nursing on a weekly basis. b. The two RNs (Quality and Compliance Nurses) will monitor performance	

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F 226	Continued From page 14 resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive abuse policy and procedure that addresses protection, one (1) of the seven (7) components of abuse. The findings include: A review of the facility's policy entitled: "Abuse and Neglect Policy, Policy number 01-28-01, which stipulates: It is the policy of the [Facility Name] that mistreatment, neglect, verbal, mental, or sexual abuse of any resident will not be	F 226	through weekly audits of Medication Administration Record for proper administration and documentation and report to the Director of Nursing on a weekly basis. c. Both weekly audits will continue for three month for a compliance rate of 100% and will reported to the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective actions were completed on October 2, 2017. **The following comments are in response F323 – Failure to ensure the resident's environment remains free of accident hazards:** 1. Corrective Action for Identified Residents: No direct impact identified to resident from the deficient practice of ensuring the resident's environment was free of accident hazards. The deficiency was corrected while the QIS surveyors were onsite. 2. Identification of Other Residents Having the Potential of Being Affected: Nursing Leadership will conduct environmental rounds to ensure that the residents' environment is free of accident hazards. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not occur: a. The Facility staff identified and re-education done by unit manager. b. During the month of September, the staff was re-educated in Daily Safety huddles and staff meeting on the importance of keeping the residents' environment clean and safe. c. Maintaining safety environment for the facility's residents will be the main topic of "Tip of the Week" for one month.	

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F 226	Continued From page 15 tolerated. In addition, the [Facility Name] will not tolerate any misappropriation of any resident's property. Effective date 11/28/16." Section E reads, "The [Facility Name] has in place, a proactive program to addresses the prevention of abuse and investigation of abuse allegations if reported to facility personnel as follows the screening, training, prevention, identification, reporting, and investigation." The policy lacked documented evidence that the facility included the written procedures for "Protection" in the policy that would provide residents with information on protection from harm during an investigation without the fear of retaliation. During a face-to-face interview with Employees #1 and 2 on August 16, 2017, at approximately 10:30 AM, the employees reviewed all aspects of the "Abuse and Neglect Policy". Consequently, the employees acknowledged that the written policy lack procedures for "Protection" as it relates to residents protection from harm during an investigation without the fear of retaliation were not documented in the policy.	F 226	d. The Quality Compliance RN will conduct random audits on safety of the resident's environment. 4. Monitoring and Integration into the Quality Assurance System: Weekly random audit of five resident's environment for three months to ensure that the resident's environment is free of accident hazards. The results will be reported to the Director of Nursing and the Administrator. The results will also be reported to the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017 **The following comments are in response F329 – Failure to ensure that all medication orders contained an indication for the use of the medication:** 1. Corrective Action for Identified Residents: 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 Residents Having the Potential of Being 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 were put in place to ensure the deficient practice does not recur: a. The pharmacist will review all medication order for completeness. When an order is found to be incomplete, e.g., lack of a relevant indication for an ordered medication,	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on an observation, the facility staff failed	F 241		

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F 241	Continued From page 16 to respect one (1) of 26 sampled resident's dignity by entering the resident's room without knocking on the door and awaiting permission to enter the room. Resident #257. The findings include: On August 14, 2017, at approximately 12:20 PM Employee #12 opened the door to the Resident #257's room without first knocking on the door and awaiting a response to enter the room. The employee walked over to the resident's bed, greeted the resident and began speaking to the resident. During a telephone interview with Employee #12 on August 15, 2017, at approximately 11:00 AM, the employee acknowledged the failure to knock on the door and await the resident's response granting permission to enter.	F 241	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. 4. Monitoring and Integration into the Quality Assurance System: Weekly audits will be performed by the MDS Coordinator and any discrepancies of medication indications found will be provided to the Director of Nursing, Administrator and the Medical Director or CMO in order to identify and counsel physicians who are non-compliant. The weekly audits will continue for three months with a goal of 100% or above compliance. The report will be reported at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed October 2, 2017.	
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 26 Stage 2 sampled	F 246	**The following comments are in response F371 – Failure to prepare and distribute foods under sanitary conditions:** 1. Corrective Action for Identified Residents: No direct impact identified to residents from the deficient practice of a soiled refrigerator shelf and soiled muffin pans. 2. Identification of Other Residents Having the Potential of Being Affected: No additional residents were identified as being negatively impacted by the soiled	

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F 246	Continued From page 17 residents, the facility staff failed to place the call light within the resident's reach to ensure the facilitate a reasonable accommodation of individual needs and preferences. Resident #4. The findings include: Resident # 4 admitted to the facility on July 15, 2017, with diagnoses that included: Hypertension, Benign Prostatic Hyperplasia, Diabetes, Hyperlipidemia, and left knee joint infection. A review of the Minimum Data Set (MDS) admission assessment with an assessment reference date of July 22, 2017, was conducted. This assessment revealed that under Section C (Cognitive Patterns) the resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) Assessment. Under Section G (Functional Status) the resident was assessed as requiring limited assistance and one person assist for transfer and toilet use. On August 14, 2017, at approximately 4:20 PM Resident #4 was observed sitting in a recliner. The resident's call light cord for assistance was noted to be next to the wall beside the bed, approximately two (2) feet away from the recliner and out of reach from the resident. Employee #17 was made aware of the findings at the time of the observation. The observed practice failed to provide evidence to support that facility staff provided a measure for the resident to call for assistance while in the room.	F 246	refrigerator shelf or the soiled muffin pans 3. Systemic Changes to Prevent Recurrence: The Food and Nutrition Services Management Team and Sanitation Team have met with all employees and re-educated about the importance of cleaning any shelves that are soiled in the department. The sanitation team will meet monthly to discuss special cleaning assignments. 4. Monitoring and Integration into the Quality Assurance System: Daily monitoring by management will identify soiled shelving and muffin pans. The Food and Nutrition Services Management Team will review compliance on a monthly basis. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. Date Corrective Action Completed: October 2, 2017. **The following comments are in response F372 - Failure to properly dispose of refuse:** 1. Corrective Action for Identified Residents: No direct impact identified to residents from the deficient practice of spilled grease on the floor around the grease trap on the loading dock. 2. Identification of Other Residents Having the Potential of Being Affected: No additional residents were identified as being negatively impacted by spilled grease on the loading dock. 3. Systemic Changes to Prevent Recurrence: The Food and Nutrition Services Management Team and Sanitation Team have met with all employees and re-educated them on the importance of avoiding hazardous spills. The Food and Nutrition Services Management Team will provide ongoing education to avoid recurrence.	

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F 253	Continued From page 18	F 253	4. Monitoring and Integration into the Quality Assurance System: Daily monitoring of grease trap condition are currently in progress with daily report to the management team. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. Date Corrective Action Completed: August 25, 2017	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations made on August 17, 2017 at approximately 11:00 AM, the facility failed to maintain resident's environment, in a sanitary manner, as evidenced by soiled exhaust vents in eight (8) of 14 resident's rooms, torn privacy curtains in one (1) of 14 resident's room and loose privacy curtains in three (3) of 14 resident's rooms. The findings include: 1. Exhaust vents soiled in eight (8) of 14 resident's bathrooms including rooms #301, 303, 306, 308, 310, 314, 320 and 328. 2. Two (2) of two (2) privacy curtains in resident room #310 torn, one (1) of 14 resident's rooms surveyed. 3. Privacy curtains hanging loose and off the hooks in three (3) of 14 resident's rooms #303, 308, and 328. These observations made in the presence of Employee #6 who acknowledged the findings.	F 253	**The following comments are in response F386 – Failure of physician to include a review of the resident's laboratory values for vancomycin in his/her total program of care:** 1. Corrective Action for Identified Residents: 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 Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified by nursing. 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 review of the resident's total program of care, including medications, treatment and associated laboratory and other diagnostic or monitoring results. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put into place to ensure the deficient practice does not recur: a. The nurse will check a resident's Vancomycin trough level prior to administering Vancomycin. When the value is found above the therapeutic range, the nurse will call the physician prior to administering and document the conversation.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20	F 279		

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F 279	Continued From page 19 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 279	The physician will either order to withhold the Vancomycin or document the rationale for administering the Vancomycin with the current trough level. b. The physicians who failed to document in the resident's medical record evidence that he reviewed and addressed the Vancomycin trough level will be sent a letter from the CMO and will be re-educated on review of the resident's total program of care, including medications, treatment and associated laboratory and other diagnostic or monitoring results. 4. Monitoring and Integration into the Quality Assurance System: Weekly audits of resident's receiving Vancomycin will be performed and any nontherapeutic trough levels without a change in order or a documented rationale will be reported to the Director of Nursing, Administrator and the Medical Director or CMO in order to identify and counsel physicians who are non-compliant. The weekly audits will continue for three months with a goal of 100% compliance. The audit results will be reported at the Quality Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed October 2, 2017. **The following comments are in response F456 – Failure to maintain essential equipment in good working condition:** 1. Corrective Action for Identified Residents: No direct impact identified to residents from the deficient practice of water pooled around the dish machine and fire extinguisher stored on top of an electrical box. 2. Identification of Other Residents Having the Potential of Being Affected: No	

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F 279	Continued From page 20 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled residents, the facility staff failed to initiate a care plan for one (1) resident's use of an indwelling Foley catheter. Resident #54. The findings include: Resident #54 admitted to the facility on June 16, 2017, with documented use of the Foley was coded on the Minimum Data Set (MDS) dated June 30, 2017. A physician's order dated July 18, 2017, recommended, "Replace catheter every 30 days." Review of the resident's care plans showed no care plan initiated with goals and interventions for the care of the resident's Foley catheter.	F 279	additional residents were identified as being negatively impacted by water pooled around the dish machine and fire extinguisher stored on top of an electrical box. 3. Systemic Changes to Prevent Recurrence: a. Temporarily – We have also placed a slip resistant mat in the area where the standing water is settling. b. Long-term – A replacement dish machine is being built by the manufacturer and will be installed once construction of the dish machine is completed. c. The fire extinguisher has been relocated to a place that was approved by Plant Operations. d. Staff have been educated on the important of safety hazards and the use of the slip resistant mat as well as the new location of the fire extinguisher. 4. Monitoring and Integration into the Quality Assurance System: Daily monitoring and preventive maintenance walk-through of the area will be conducted by management during every shift to make sure staff are safe from slip hazards. Monthly monitoring of the fire extinguisher will be completed to ensure compliance. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. Date Corrective Action Completed: The slip resistant mat was placed around the dish machine on October 2, 2017. A new dish machine is scheduled to be installed on November 15, 2017. The Fire Extinguisher was relocated on October 2, 2017.	

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F 279	Continued From page 21 During a face-to-face interview with Employee #8 at approximately 3:00 PM on August 16, 2017, the employee reviewed the care plans and acknowledged that the facility did not initiate a care plan for the use of the resident's Foley catheter.	F 279	**The following comments are in response F514 – Failure to accurately record clinical information for resident's wound and to accurately record resident's gender in a clinical note:** 1. Corrective Action for Identified Residents: No direct impact identified to the residents from the deficient practice of not accurately recording the resident's wound location or gender. The anatomical location of the wound was corrected for Resident #252 on August 17, 2017. The gender of the Resident #245 was corrected on August 17, 2017. 2. Identification of Other Residents Having the Potential of Being Affected: All residents have the potential to be affected. 3. Systemic Changes to Prevent Recurrence: a. Staff re-education on proper and accurate documentation of the anatomical location on admission assessments and change of conditions by the Wound Ostomy and Continence Nurses. b. Re-education of staff on skin assessments must be conducted by two RNs upon admission. c. Staff re-education for proper and accurate documentation of gender and wound location. d. One-on-one counseling will be provide to nurses that are not in compliance. 4. Monitoring and Integration into the Quality Assurance System: The Quality and Compliance Nurses will audit five charts each week for accurate wound and gender documentation. The audit will continue for three months with a compliance rate of 100%. The results will be reported to the Director of Nursing. Inaccuracies by Case Coordinator in gender documentation will be reported to the Case Coordination Manager. The results will also be reported at the Quality	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 22 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 26 Stage two sampled residents, the facility staff failed to hold doses of vancomycin for one (1) resident after notification that the Vancomycin Trough level was greater than the toxic range of 20 mcg/ml; and failed to administer insulin in accordance with the physician's order for one (1) resident. Residents #4 and 258. The findings include: 1. According to the facilities "Guidelines for Therapeutic Drug Monitoring of Common Agents in Adults" last revised June 2002 stipulated, "Drug Name =Vancomycin IV [intravenous] ...Therapeutic Range =Trough 5-10 mcg/ml; Toxic range > 20 mcg/ml ..." On August 18, 2017, a clinical record review showed a Physician's order dated August 5, 2017, which directed, "Vancomycin IVPB (intravenous piggyback) [1 gm] 12 H (hours) ..." for Resident #4. The Daily Progress note from the Infectious Disease Physician dated August 11, 2017, at 1:59 PM showed "...[Resident] found to have GPC (Gram Positive Cocci in Clusters) bacteremia ...unclear source ... Plan: to continue	F 309	Assurance Committee meeting. 5. Date Corrective Action Completed: The corrective action was completed on October 2, 2017 **The following comments are in response F520 – Failure to conduct a quality assessment assurance committee meeting at least quarterly and failure to ensure the Director of Nursing Services was present at 1 of 3 QAA committee meetings:** 1. Corrective Action for Identified Residents: There are no further corrective actions for the residents found to have been affected by this deficient practice as residents were not impacted by the process. 2. Identification of Other Residents Having the Potential of Being Affected: Other residents having the potential to be affected by the same deficient practice will be identified by the healthcare team based on predetermined quality, safety and service measures that are assessed against industry benchmarks and organization targets on a monthly basis. 3. Systemic Changes to Prevent Recurrence: The following systemic changes were put in place to ensure the deficient practice will not recur: a. The facility will maintain QAA meetings on a quarterly basis assuring attendance at a minimum to include the Administrator, the Director of Nursing (DON) and the Medical Director or his/her designee. b. The above attendees were briefed on the meetings and their attendance requirements. c. If one of the above attendees are unable to attend or if the QAA meeting needs to be canceled for an unforeseen reason, the quarterly	

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F 309	Continued From page 23 Vancomycin 1 gm IV (intravenous) q (every) 12 hours for 4 [four] weeks." The physician ordered a Vancomycin trough level on August 12, 2017, at 3:00 AM and the staff obtained the specimen at 3:08 AM. The results indicated the Vancomycin level high was 30.8 at 4:26 AM. According to the Medication Administration Record, the resident received Vancomycin 1 gram IV on August 12, 2017, at 3:53 AM and 3:02 PM; August 13, 2017, at 3:32 AM and 2:59 PM; and on August 14, 2017, at 4:04 AM. Resident #4 received five (5) doses of Vancomycin before withholding the medication, per the physician's order. Further review of the Attending Progress Notes dated August 12, 2017, at 2:38 PM and August 13, 2017, at 5:28 PM lacked documented evidence the physician reviewed and addressed the Vancomycin trough level result of 30.8, in the plan of care. According to the Nursing Notes written on August 14, 2017, at 9:00 AM, the physician was notified of the elevated Vancomycin trough level with a "face-to-face" acknowledgment. A pharmacy order was written on August 14, 2017, at 2:22 PM directing the nursing staff to "hold Vancomycin for 24 hours."	F 309	meeting will be rescheduled and all members of the QAA committee will be notified through emails. d. The committee will coordinate and evaluate activities such as identifying quality, safety and service issues that require improvement activates. e. The committee will develop and implement plans to improve identified issues. 4. Monitoring and Integration into the Quality Assurance System: Monthly audits of targeted issues will be reported at the quarterly QAA meetings. Improvement activities will be adjusted based on outcomes not meeting identified targets. Attendance of the Administrator, the Director of Nursing (DON) and the Medical Director or his/her designee will be verified prior to the day of the meeting, and rescheduled as needed. 5. Date Corrective Action Completed: The corrective action was completed on August 2, 2017. END OF DOCUMENT	

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F 309	Continued From page 24 At 7:19 PM the nursing notes acknowledged the order to hold the Vancomycin. During a telephone interview with Employee #4 on August 18, 2017, at 9:9 AM, the employee stated, "I spoke with the [Employee #3] the same day. And I told [him/her] to hold the dose [of Vancomycin] and get the [a random Vancomycin level]. I am not sure what happened on the 12th [August 12, 2017]. When I saw the random draw was 24.4 I told them to hold the dose [of Vancomycin]." During a telephone interview with Employee #3 on August 18, 2017, at 1:05 PM, a review of the findings above was communicated, Employee #3 had no comment. The clinical record lacked evidence that facility staff held Vancomycin doses secondary to elevated Vancomycin trough level of 30.8. Consequently, the resident received five doses of Vancomycin before the medication was held. At the time of the review, the resident had no known adverse effects. 2. Facility staff failed to administer insulin per the physician's order for Resident # 258. A clinical record review on August 18, 2017, showed physician's orders dated August 14, 2017, which directed the following:, "Insulin lispro (Humalog) 100 unit/ml pen 2-8	F 309		

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F 309	Continued From page 25 units, subcutaneous, four times daily before meals and nightly. If fingerstick blood glucose 121-150 mg/dl then hold insulin If fingerstick blood glucose 151-200 mg/dl then give two units If fingerstick blood glucose 201-250 mg/dl then give three units If fingerstick blood glucose 251-300 mg/dl then give four units If fingerstick blood glucose 301-350 mg/dl then give six units If fingerstick blood glucose 351-400 mg/dl then give eight units If fingerstick blood glucose less than 70 mg/dl then follow nursing hypoglycemia protocol ..." On August 14, 2017, at 5:31 PM, the resident's blood glucose level was 199 mg/dl. The clinical record lacked documented evidence the nursing staff administered Lispro insulin in accordance with the Physician's order for two units of Lispro. The clinical record lacked documented evidence that facility staff administered insulin to Resident #258 in accordance with the physician's order. During a face-to-face interview with Employee #15 on August 18, 2017, at approximately 12:45 PM, the employee acknowledged the findings.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents.	F 323		

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F 323	Continued From page 26 The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations made on August 14, 2017, at approximately 12:05 PM, it was determined that the facility staff failed to ensure the resident's environment remains free of accident hazards. The failure was evidenced by two (2) of two (2) packaged needless saline syringes, one (1) of one (1) staple removal kit, and one (1) of one (1) package of intravenous tubing observed stored on the over-the-bed table in one (1) resident's room (Resident # 4). The findings include:	F 323		

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F 323	Continued From page 27 During a tour of Resident #4's room on August 14, 2017, at approximately 12:05 PM, the following was observed on the third shelf over-the-bed-table: A. Two (2) of two (2) packaged prefilled needless saline syringes (used to flush an intravenous line), B. One (1) of one (1) staple removal kit (used to remove surgical skin staples), C. One (1) of one (1) package of intravenous tubing (tubing is used to infuse fluids) At the time of the observation Employee #17 was present and acknowledged the findings. Also, the employee stated, "These items should not be stored at the bedside. We keep this at the nurse's station." There was no evidence that facility staff ensured the resident's environment remained free of accident hazards.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		

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F 329	Continued From page 28 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 sampled Stage 2 records, the facility staff failed to ensure that all medication orders contained an indication for the use of the medications. Resident # 247. The findings include: On August 15, 2017, at 11:15 AM a review of the	F 329		

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F 329	Continued From page 29 physician's medication orders for Resident #247 showed that the physician ordered HCTZ (Hydrochlorothiazide) 12.5 milligrams (mg) daily. However, the order lacked documentation of the indication for the medication use. Employee #14, present at the time of record review, acknowledged the findings.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	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 30 Based on observations, the facility failed to prepare and distribute foods under sanitary conditions as evidenced by one (1) of one (1) refrigerator/freezer unit that soiled on the inside and seven (7) of seven (7) muffin pans that were stained. The observations made on August 14, 2017, at approximately 9:15 AM and on August 17, 2017, at approximately 9:30 AM were in the presence of Employee #5. The findings include: 1. One (1) of one (1) refrigerator/freezer cart shelf soiled. 2. Five (5) of five (5) small muffin pans and two (2) of two (2) large muffin pans soiled. Employee #5 acknowledged the findings at the time of the observations.	F 371		
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly dispose of refuse as evidenced by a spill of used grease that was observed on the floor around the grease trap on the loading dock in one (1) of one (1) observation. The observation made on August 14, 2017, at approximately 9:15 AM and on August 17, 2017, at approximately 9:30 AM in the presence of Employee #5. The findings include: A. Used grease on the floor, around the grease	F 372		

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F 372	Continued From page 31 trap on the loading dock. Employee #5 who acknowledged the findings at the time of the observation.	F 372		
F 386 SS=D	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 26 Stage two sampled residents, it was determined that the physician failed to include a review of the resident's laboratory values for vancomycin in his/her total program of care. Resident #249. The findings include: According to the facilities "Guidelines for Therapeutic Drug Monitoring of Common Agents in Adults" last revised June 2002 stipulated, "Drug Name =Vancomycin IV [intravenous]	F 386		

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F 386	Continued From page 32 ...Therapeutic Range =Trough 5-10 mcg/ml; Toxic range > 20 mcg/ml ..." On August 18, 2017, a clinical record review showed a Physician's order dated August 5, 2017, which directed, "Vancomycin IVPB (intravenous piggyback) [1 gm] 12 H (hours) ..." for Resident #4. The Daily Progress note from the Infectious Disease Physician dated August 11, 2017, at 1:59 PM showed "...[Resident] found to have GPC (Gram Positive Cocci in Clusters) bacteremia ...unclear source ... Plan: to continue Vancomycin 1 gm IV (intravenous) q (every) 12 hours for 4 [four] weeks." The physician ordered a Vancomycin trough level on August 12, 2017, at 3:00 AM and the staff obtained the specimen at 3:08 AM. The results indicated the Vancomycin level high was 30.8 at 4:26 AM. According to the Medication Administration Record, the resident received Vancomycin 1 gram IV on August 12, 2017, at 3:53 AM and 3:02 PM; August 13, 2017, at 3:32 AM and 2:59 PM; and on August 14, 2017, at 4:04 AM. Resident #4 received five (5) doses of Vancomycin before withholding the medication, per the physician's order. Further review of the Attending Progress Notes dated August 12, 2017, at 2:38 PM and August 13, 2017, at 5:28 PM lacked documented evidence the physician reviewed and addressed the Vancomycin trough level result of 30.8, in the	F 386		

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F 386	Continued From page 33 plan of care. According to the Nursing Notes written on August 14, 2017, at 9:00 AM, the physician was notified of the elevated Vancomycin trough level with a "face-to-face" acknowledgment. A pharmacy order was written on August 14, 2017, at 2:22 PM directing the nursing staff to "hold Vancomycin for 24 hours." At 7:19 PM the nursing notes acknowledged the order to hold the Vancomycin. During a telephone interview with Employee #4 on August 18, 2017, at 9:9 AM, the employee stated, "I spoke with the [Employee #3] the same day. And I told [him/her] to hold the dose [of Vancomycin] and get the [a random Vancomycin level]. I am not sure what happened on the 12th [August 12, 2017]. When I saw the random draw was 24.4 I told them to hold the dose [of Vancomycin]." During a telephone interview with Employee #3 on August 18, 2017, at 1:05 PM, a review of the findings above was communicated, Employee #3 had no comment. The clinical record lacked evidence that facility staff held Vancomycin doses secondary to elevated Vancomycin trough level of 30.8. Consequently, the resident received five doses of Vancomycin before the medication was held.	F 386		

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F 386	Continued From page 34 At the time of the review, the resident had no known adverse effects.	F 386		
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain essential equipment in good working condition as evidenced by a pool of water observed on the floor, next to the dishwashing machine, and a fire extinguisher inappropriately stored. On August 14, 2017, at approximately 9:15 AM and on August 17, 2017, at approximately 9:30 AM, Employee #5 was present at the time of the observations. The findings include: A. Approximately half an inch of water observed on the floor next to the dishwashing machine, the facility staff stated that the dishwasher was leaking. B. A fire extinguisher stored on top of an electrical box unsecured	F 456		

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F 456	Continued From page 35 Employee #5 acknowledged the findings at the time of the observations.	F 456		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514		

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F 514	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on record review of two (2) of 26 sampled resident, the facility staff failed to accurately record clinical information for one (1) residents wound and to accurately record one (1) resident 's gender in a clinical note. Residents' # 252 and 245. The findings include: 1. Facility staff failed to accurately document the resident's left shoulder wound for Resident# 252. A further review of the clinical notes revealed the shoulder wound was documented as "right shoulder." A review of the medical record for Resident # 252 reveal Resident as admitted to the facility on August 8, 2017, with a complaint of Generalized Weakness. A face-to-face interview was conducted with Employee # 9 in the presence of Employee #8 on August 17, 2017, at approximately 12:15 PM. Employee #9 stated, "Yes, the wound was on the left shoulder I should have paid more attention to my charting." Employee# 9 acknowledged the findings. 2. Facility staff failed to document the gender of one (1) resident as female. A further review of the clinical note dated August 11, 2017, reveal the resident's gender was documented as "male." Resident# 245.	F 514		

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F 514	Continued From page 37 A telephone interview conducted with Employee# 10 on August 18, 2017, at approximately 3:00 PM. Employee # 10 acknowledged the findings.	F 514		
F 520 SS=C	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the	F 520		

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F 520	Continued From page 38 records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the quality assessment and assurance committee meeting sign-in sheets and staff interview, the facility failed to conduct a quality assessment assurance (QAA) committee meeting at least quarterly for one (1) of four (4) quarters reviewed. In addition, the facility staff failed to ensure the Director of Nursing Services was present at one (1) of three (3) QAA committee meetings. The findings include: 1. Facility failed to conduct a quality assessment assurance (QAA) committee meeting at least quarterly for one (1) of four (4) quarters reviewed. A review of the quality assessment and assurance committee meeting sign-in sheets revealed that the committee met on January 24, 2017, April 25, 2017, and July 25, 2017. After a review of the committee sign-in sheets it was noted the facility did not conduct a quality assessment and assurance meeting in October 2016. There was no evidence that facility staff met at least quarterly to evaluate activities such as	F 520		

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F 520	Continued From page 39 identifying issues with respect to which quality assessment and assurance activities. A face-to-face meeting was conducted with Employee # 15 on August 18, 2017 at 11:00 AM. He/she acknowledged the findings. 2. The facility staff failed to ensure the Director of Nursing Services was present at one (1) of three (3) QAA committee meetings. A review of the quality assessment and assurance committee meeting sign-in sheets revealed that on July 25, 2017 the Director of Nursing Services did not sign the sheet indicating that he/she was in attendance. A face-to-face meeting was conducted with Employee #15 on August 18, 2017 at 11:00 AM. He/she acknowledged the findings.	F 520		