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	HFD02-0026	A. BUILDING: _____ B. WING _____	09/17/2018

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

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L 000	Initial Comments An unannounced Licensure Survey was conducted at Sibley Memorial Hospital Renaissance Skilled Nursing Facility from September 13, 2018, through September 17, 2018. Survey activities consisted of a review of 20 sampled residents. The following deficiencies are based on observation, record review and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS Altered Mental Status ARD assessment reference date BID Twice a day B/P Blood Pressure cm Centimeters CMS Centers for Medicare and Medicaid Services CNA Certified Nurse Aide CFU Colony Forming Unit 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 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	L 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 13, 2018 through September 17, 2018. 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.**	

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L 000	Continued From page 1 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 PU Partial Upper PL Partial Lower Q Every QIS Quality Indicator Survey R/P Responsible party SCSA - Significant change status assessment Sol Solution TAR Treatment Administration Record Trach Tracheostomy TX Treatment	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 2 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on clinical record review, review of the validation report and the Resident Assessments for two (2) of three (3) sampled residents, the charge nurse failed to complete a discharge tracking Minimum Data Set (MDS) and transmit the information to Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within 14 days of the resident being discharged from the facility. Findings included ... 1. Resident #3 was admitted to the facility on April 11, 2018. A review of the Centers for Medicare	L 051	**The following comments are in response L051 (A) – Failure to complete a discharge tracking Minimum Data Set (MDS) and transmit the information to Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within 14 days of the resident being discharged from the facility:** 1. **Corrective Action for Identified residents:** No direct impact identified to the residents from the deficient practice. Tracking was completed while the surveyors were onsite. 2. **Identification of Other residents having the Potential of be Affected:** All residents have the potential of being affected by the deficient practice. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put in place to ensure the deficient practice will not recur: The Minimum Data Set (MDS) staff initiated utilization of the Netsolutions software features for tracking completed and submitted records to Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASA) system within 14 days of the resident being discharged. The MDS staff were educated and initiated on the Netsolutions software on October 1, 2018. The MDS staff are receiving ongoing education and training. 4. **Monitoring: must be integrated into the Quality Assurance System:** Weekly audit of all admission and discharged will be conducted by Nursing leadership or designee for a minimum of three months to ensure compliance. The audit results will be reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee meeting. 5. **Dates when corrective action will be completed:** Tracking was completed on September 17, 2018 and implementation of the Netsolutions was initiated on October 29, 2018.	

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L 051	Continued From page 3 and Medicaid Services (CMS) submission report MDS 3.0 NH (Nursing Home) Final Validation dated September 17, 2018, showed that a 5-day assessment was completed on May 2, 2018, and the resident was discharged from the facility on May 6, 2018. The resident's clinical record and the submission report lacked evidence that a discharge tracking record was completed and transmitted to CMS. 2. Resident #2 was admitted to the facility on April 25, 2018. A review of the CMS submission report MDS 3.0 NH Final Validation dated September 17, 2018, showed that an admission assessment was completed on April 18, 2018, and the resident was discharged from the facility on May 3, 2018. The resident's clinical record and the submission report lacked evidence that a discharge tracking record was completed and transmitted to CMS. During a face-to-face interview on September 17, 2018, at 1:25 PM with Employee #6, he reviewed the submission report and acknowledged that the discharge tracking record was not completed. B. Based on medical record review and staff interview for two (2) of 20 sampled residents, the charge nurse failed to accurately code the Admission Minimum Data Set (MDS) to reflect that two (2) residents' received antibiotics and one (1) resident received opioid medications. Residents' #25 and #36.	L 051	**The following comments are in response L051 (B) – Failure to accurately code the Admission Minimum Data Set (MDS) to reflect that two residents' received antibiotics and one resident received opioid medications:** 1. **Corrective Action for Identified residents:** No direct impact identified to the residents from the deficient practice. Modification were done on the Admission Minimum Data Set for the residents identified and corrected forms were presented to the surveyors. 2. **Identification of Other residents having the Potential of be Affected:** All residents have the potential of being affected by the deficient practice. 3. **Systemic Changes to Prevent Recurrence:** The following systemic changes will be put in place to ensure the deficient practice will not recur: The MDS staff was re-educated on correct MDS coding on September 18, 2018. The MDS staff was retrained to utilize the EPIC feature in the Medication list to sort medication category by therapeutic class for easy identification of medication and correct coding. 4. **Monitoring: must be integrated into the Quality Assurance System:** Weekly audits of the admission MDS will be conducted for accurate coding by the MDS Coordinator prior to submission to CMS. 100% of all MDS will be audited for 100% accurate coding. The audit results will be presented quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee meeting. 5. **Dates when corrective action will be completed:** Correction to the identified admission MDS was completed on September 17, 2018 and re-education was completed on October 29, 2018.	

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L 051	Continued From page 4 Findings included ... 1. Resident #25 was admitted to the facility on August 23, 2018, for skilled Occupational Therapy/Physical Therapy after being hospitalized in an acute care facility with generalized weakness and severe deconditioning. According to the Progress note from the hospital, the resident was treated with Intravenous Cipro, Cefepime and Vancomycin (antibiotics) for Bilateral Lower Lobe Pneumonia and exacerbation of Chronic Obstructive Pulmonary Disease. Review of the resident's medication orders for the facility showed an order for "Azithromycin (antibiotic) tablet 500 mg once per day on Monday, Wednesday, Friday: Route oral. Start 08/24/18 [at] 0900." Review of the Medication Administration Record showed that the medication was documented as administered to the resident on August 24, 27 and 29, 2018. Review of the Admission Minimum Data Set with a completion date of August 30, 2018, under the area of N0410, under Section N (Medications) was coded as "0" indicating the resident did not receive antibiotic during the last seven days. During a face-to-face interview with Employee #6 at approximately 2:00 PM on September 17, 2018, the employee reviewed the MDS and acknowledged that the MDS failed to reflect that the resident received an antibiotic during the assessment period.	L 051	**The following comments are in response L051 (C) – Failure to develop a person-centered care plan with goals and approaches to address the health care needs for resident with Parkinson's disease:** 1. **Corrective Action for identified resident:** There are no further corrective actions for the resident found to have been affected by this deficient practice as the resident has been discharged. The deficiency was noted and addressed in Daily Safety huddles by the Nurse Manager, Quality Compliance Coordinator Nurse and the Charge Nurse after the survey was completed and also addressed during staff meeting by the Director of Nursing. 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 on admission. 3. **Systemic Changes to Prevent Recurrence: The following systemic changes will be put in place to ensure the deficient practice will not occur:** Nursing staff was re-educated on the importance of providing resident-centered care with goals and approaches to address the residents' need by providing each resident with the time needed to communicate with the team. The Quality Compliance Coordinator Nurse developed a compilation of care plans based on the disease process of residents' diagnosed with Parkinson Disease to ensure that goals and approaches are specific to resident's needs . The Nursing Leadership Team provided re-education on resident-centered care focusing on residents' care needs and goals to nursing staff at Daily Safety huddles and at staff meetings during September. 4. **Monitoring: must be integrated into the Quality Assurance System:**	

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L 051	Continued From page 5 2. Resident #36 was admitted on 8/28/18, with diagnoses to include Atrial Fibrillation, Hypertension, Acute Cholecystitis, Chest Pain (on exertion) and Aortic Stenosis. Review of the Admission Minimum Data Set completed on 9/4/18 showed that Section N0410 (Medications Received) was coded as "0" indicating the resident did not receive antibiotic and opioids during the last seven days. Review the physician's order form dated 8/28/18 showed Vancomycin 125 mg, four times a day, oral (by mouth) start date 9/1/18 and a stop date of 9/15/18 and Oxycodone immediate release tablet 5 mg every three hours PRN (as needed) moderate pain (4-6). A review of the Medication Administration Record showed Vancomycin (antibiotic) 125 mg was administered on the following dates: 9/1/18, 9/2/18, 9/3/18, and 9/4/18. A further review of the Medication Administration Record showed Oxycodone immediate release (opioid) tablet 5 mg was administered on the following dates: 8/28/18, 8/29/18, 8/30/18, 8/31/18, 9/1/18, 9/2/18 and 9/3/18. There was no evidence that facility staff accurately coded the MDS to indicate resident received antibiotic and opioid medications as per the physician's order. During a face-to-face interview on 9/17/18, at 2:00 PM Employee #6 acknowledged the findings and stated I made the change on the MDS here is the updated copy.	L 051	The Quality Compliance Coordinator Nurse will round on residents diagnosed with Parkinson Disease to ensure that the nursing staff is spending the time needed with each resident to communicate and care for the resident. The Quality Compliance Coordinator Nurse will also perform monthly chart audits on all resident diagnosed with Parkinson Disease for completeness of care plans for three months for a compliance rate of 100%. The results of the rounding and chart audits will be reported monthly to the Director of Nursing and quarterly at the Quality Assurance Performance Improvement Committee meeting. 5. **Dates when corrective action will be completed:** October 29, 2018.	

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L 051	Continued From page 6 C. Based on medical record review, resident and staff interview for one (1) of 20 sampled residents, the charge nurse staff failed to develop a person-centered care plan with goals and approaches to address the health care needs for Resident #26 with Parkinson's disease. Findings included ... Review of the History and Physical Admission dated 8/24/18, showed the resident was admitted with diagnoses which include Glaucoma, Hypertension, Osteoporosis and Parkinson Disease. During an interview on 9/13/18, at 11:05 AM the resident stated the nurses here don't show patience when they communicate with me, all people with Parkinson's are not the same. While in the residents room, signage was observed posted on the wall that read, "Allow patient extra time to speak and reduce background noise to facilitate communication." Review of the Comprehensive Minimum Data Set [MDS] dated 8/30/18, showed Section C [Cognitive Patterns] Brief Interview for Mental Status [BIMS] score of 15 which indicates "cognitively intact." In Section O Speech-Language Pathology and Audiology Services (Special Treatments, Procedures and Programs), the resident was coded as receiving speech and or audiology services. During an interview on 9/14/18 at 1:00 with Employee #9, she stated, I just asked that the nursing staff be patient with her because of her dysarthria (difficult or unclear articulation of	L 051		

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L 051	Continued From page 7 speech). On 9/14/18, at 10:30 AM a review of the medical record showed a Speech-Language Pathology (SLP) note dated 9/1/18, "Patient observed communicating needs to staff during transfer, environment was complicated by external background noises. SLP discussed solutions to improve communicating during future transfers and interactions with staff. Patient identified one solution "to be polite and given extra time". SLP asked staff to eliminate noises to improve communication situations." A review of the Active Multi-Disciplinary Problems list lacked evidence of Parkinson's disease as an active problem and there was no care plan developed with resident-centered goals/interventions to address communication situations with Resident #26. During a face-to-face meeting on 9/17/18, at 1:00 PM, Employee #3 acknowledged the findings.	L 051	**The following comments are in response L052 – Failure to respond in a timely manner to Resident's request for assistance:** 1. **Corrective Action for Identified residents:** There are no further corrective actions for the resident found to have affected by this deficient practice as the resident has been discharged. The deficiency was noted and addressed in Daily Safety huddles after the survey was done and also addressed during staff meeting by the Director of Nursing on September 24, October 3, and October 5, 2018. 2. **Identification of Other residents having the Potential of be Affected:** In order to prevent other residents from being affected by the same deficient practice, residents needing assistance at meal time will be identified at admission and during daily rounding. 3. **Systemic Changes to Prevent Recurrence: The following systemic changes will be put in place to ensure the deficient practice will not occur:** A new Nurse Call System was implemented in the Nursing Facility on October 25, 2018. The new Nurse Call System enhances the communication between the nursing staff and the residents. It is designed to reduce the response time by the nursing staff. The new VOALTE Smartphone System allows a resident to call directly to the nursing staff and if the call is not responded to within 30 seconds the call is routed to the Buddy Nursing staff, then to the Charge Nurse, and the Nurse Manager. The new Nurse Call System also enhances the communication process between the nursing staff and the resident by using a Buddy Nurse process. If the assigned nursing staff is not available then the call is routed to the Buddy Nursing staff. If the Buddy Nurse does not respond to the call within 30 seconds, the call is then escalated up to the charge nurse and Nurse Manager. An Orchid Rounding Tool on Tablets was implemented to assist with rounding on each resident	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers; (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as	L 052		

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L 052	Continued From page 8 evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, resident and staff interview for one (1) of 20 sampled residents, facility staff failed provide sufficient nursing time to respond in a timely manner to Resident # 189's request for assistance.	L 052	and to immediately resolve or escalate any resident concerns to the Leadership team. The Nurse Manager or designee will conduct daily rounding using the Orchid tool. The Nursing Leadership Team provided re-education on resident-centered care focusing on responding in a timely manner to the resident's needs. All nursing staff were educated and trained on the new VOALTE Nursing Call System. Nursing leadership were educated and trained on utilizing the Orchid tool during rounds. 4. **Monitoring: must be integrated into the Quality Assurance System:** The VOALTE Nursing Call System will be monitored to ensure that there are improvements in nursing staff response time. The data will be collected, analyzed, and reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee meeting. The data from the Orchid rounding tool will also be reported quarterly to the QAPI committee meeting. 5. **Dates when corrective action will be completed :** October 25, 2018.	

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L 052	Continued From page 9 Findings included ... A review of the Resident's History and Physical dated September 10, 2018, showed, she was admitted to the facility on September 13, 2018, with "Left-hand contracture." On September 14, 2018, at 9:29 AM during an interview with Resident #189, a food service staff brought the resident breakfast and stated, "I am just helping to bring a meal to the resident but I will let the front desk know your meal is at the bedside." The food service staff left the resident's room and returned shortly and stated, "There is no one out here they maybe in meetings." The resident immediately put the call light on [9:30 AM], someone responded and stated, "I will send someone in to set you up. By 9:42 AM, no one had come to assist the Resident and she put the call light on for the second time no one answered. The Resident verbalized, "The food will get cold, physical therapy may come and I did not eat." The Resident put the call light on for a third time at 9:45 AM, someone responded to the call and stated, "I will find out when someone will come to the room." At 9:54 AM Employee #8 arrived in the room to assist the resident. Employee #8 was apologetic and stated, "I was attending to another resident." The facility staff failed to provided sufficient nursing time to respond in a timely manner to Resident #189's request for assistance. During a face-to-face interview with Employee #3 on September 14, 2018, at 11:50 AM, she was made aware of the concern and acknowledged the findings.	L 052		

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L 099	Continued From page 10	L 099	**The following comments are in response L099 (A) – Failure to prepare and distribute foods under sanitary conditions:** 1. **Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practices. 2. **Identification of Other residents having the Potential of be Affected:** No additional residents were identified as being affected by the deficient practices. 3. **Systemic Changes to Prevent Recurrence:** • Shelving racks were cleaned while the surveyors were onsite. Cleaning of shelving racks was added to the weekly cleaning list. • Sheet pans that were identified with excess buildup were removed from service and 30 new sheet pans were ordered to replace those in poor condition; Order # 174942 from US Foods. • The interior surface cooking hoods were cleaned by Delta Industrial Vendor on 10/10/2018. • Supply line to the deep fryer was cleaned on 10/15/2018 and is added to cleaning list. • Identified cutting boards with deep grooves were taken out of service. 24 new cutting boards were ordered from US Foods. Order # 174943 The Food and Nutrition Services Management Team have met with and re-educated staff about the importance of cleaning and cleaning assignments.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: A.Based on observations, the facility failed to prepare and distribute foods under sanitary conditions as evidenced by: Shelving racks for pan storage outside of pot and pan area were soiled two (2) of four (4) shelves observed, nine (9) of 11 sheet pans was soiled with food particles, the interior surface of cooking hood adjacent to tray line was soiled, the supply line to the deep fryer was soiled with grease, and cutting boards were found with grooves in two (2) of two (2) red, two (2) of seven (7) white, and two (2) of eight (8) green. Findings included ... 1.Shelving racks for pan storage outside of the pot and pan area were soiled two (2) of four (4) shelves observed 2. Nine (9) of 11 sheet pans was soiled with food particles 3. The interior surface of cooking hood adjacent to tray line was soiled 4. The supply line to the deep fryer was soiled with grease 5. Cutting boards were found with grooves in two (2) of two (2) red, two (2) of seven (7) white, and two (2) of eight (8) green The observations made on 09/13/18, at 12:56 PM	L 099		

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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) COMPLETE DATE
L 099	Continued From page 11 was in the presence of Employee # 4 who acknowledged the findings. On 9/17/18, at approximately 4:08 PM observations were made in the presence of Employees #4 and #5 who acknowledged the findings. B.Based on observations, the facility failed to ensure food were disposed of properly as evidenced by: cardboard and paper products were observed on the ground around the outside of the dumpster and a vertical slat (air curtain) was missing from loading dock area. Findings included ... 1. Around the outside dumpster, cardboard and paper products were observed on the ground 2. A vertical slat (air curtain) was missing from loading dock area The observations made on 9/17/18, at approximately 4:08 PM was in the presence of Employees #4 and #5.	L 099	**4. Monitoring: must be integrated into the Quality Assurance System:** The Food and Nutrition Services Management Team will review compliance with cleaning assignments on a monthly basis. The Patient Services Manager is the lead on this project. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. **5. Dates when corrective action will be completed:** October 29, 2018. **The following comments are in response L099 (B) – Failure to ensure food were disposed of properly:** **1. Corrective Action for identified residents:** No direct impact identified to residents from the deficient practices **2. Identification of Other residents having the Potential of be Affected:** No additional residents were identified as being affected by the deficient practices. 3. **Systemic Changes to Prevent Recurrence:** The Director of Food and Nutrition Services and the Director of Environment of Care met to discuss work processes to ensure that there are no boxes left on the ground near compactor. Re-education of both Food and Nutrition Services and Environment of Care staff were conducted to ensure cardboard and paper products are not on the ground by the dumpster. The vertical Slat (air curtain) was entered for a replacement. Work order number # 109853. The vertical slat (air curtain) will be installed as soon as it arrives. 4. **Monitoring: must be integrated into the Quality Assurance System:** The Food and Nutrition Services leadership team or designee will conduct visual observation of the dumpster area twice a week. The findings will be shared with other support services leaders in the organization.	
L 106	3219.8 Nursing Facilities Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced. This Statute is not met as evidenced by: Based on observations, the facility failed to	L 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 106	Continued From page 12 ensure food were disposed of properly as evidenced by: food and trash observed in one (1) of one (1) trash receptacle. Findings included ... Food and trash observed in one (1) of one (1) trash receptacle located in the cold prep area of the main kitchen . The observations made on 09/13/18, at 12:56 PM was in the presence of Employee #4 who acknowledged the findings.	L 106	Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. **Dates when corrective action will be completed:** October 29, 2018. **The following comments are in response L106 – Failure to ensure food waste were disposed of properly:** 1. **Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practices. 2. **Identification of Other residents having the Potential of be Affected:** No additional residents were identified as being affected by the deficient practices. 3. **Systemic Changes to Prevent Recurrence:** Food and trash was separated while the surveyors were onsite. Just-In-Time education was provided to the staff working at the cold prep area in the main kitchen. The staff working in the cold prep area in the main kitchen was a new employee. Re-education was provided to staff at huddles and department meetings with emphasis on separating food and trash. Proper food disposal was added to the new employee orientation to the Food and Nutrition Services department. 4. **Monitoring: must be integrated into the Quality Assurance System:** The Food and Nutrition Services leadership team or designee will conduct daily visual observation in the kitchen to ensure food and trash are separated. Observation will be conducted for three months to ensure 100% compliance. Any staff found not separating food and trash will be educated on the spot. Ongoing monitoring will be included in the annual report to the Environment of Care Committee.	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations, the facility failed to maintain all mechanical, electrical, patient care equipment in safe operating condition as evidenced by: one (1) of seven (7) knobs was missing from the stove, one (1) of three (3) knobs were missing from the grill; and the exterior surface of the ice machine damaged in main kitchen in one (1) of one (1) observed. Findings included ... 1. One (1) of seven (7) knobs was missing from the stove in the main kitchen 2. One (1) of three (3) knobs was missing from	L 442		

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L 442	Continued From page 13 the grill in the main kitchen 3. The exterior surface of the ice machine was damaged in main kitchen in one (1) of one (1) ice machine observed The observations made on 09/13/18, at 12:56 PM was in the presence of Employee # 4 who acknowledged the findings. On 9/17/18, at approximately 4:08 PM observations were made in the presence of Employees #4 and #5 who acknowledged the findings.	L 442	**5. Dates when corrective action will be completed:** October 15, 2018. **The following comments are in response L442 – Failure to maintain all mechanical, electrical, patient care equipment in safe operating condition (missing stove/grill knobs; damaged exterior surface of ice machine):** **1. Corrective Action for Identified residents:** No direct impact identified to residents from the deficient practices 2. **Identification of Other residents having the Potential of be Affected:** No additional residents were identified as being affected by the deficient practices. 3. **Systemic Changes to Prevent Recurrence:** On October 10, 2018, Work Order was placed with EMR Vendor to replace missing knobs. The Work Order number is 216557. The tech came out and replaced all missing knobs on October 18, 2018. Ice machine damage is cosmetic in nature only and does not affect the safety or functionality of machine. On October 20, 2018, we had a representative onsite and contacted the manufacturer. The damaged part will be replaced as soon as the part arrives. Staff was re-educated to notify the Food and Nutrition Services leadership team when there is damaged or broken equipment. 4. **Monitoring: must be integrated into the Quality Assurance System:** We have added all equipment to the Nutrition Services weekly walk thru to ensure that there are no pieces of equipment in need of repair. Ongoing monitoring will be included in the annual report to the Environment of Care Committee. 5. **Dates when corrective action will be completed:** October 20, 2018.	