DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(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 000	INITIAL COMMENTS	F 000		

F 000 INITIAL COMMENTS

An unannounced Long Term Care Survey was conducted at Stoddard Baptist from January 22, 2019 through January 29, 2019. Survey activities consisted of a review of 37 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 146.

Please begin typing your responses here:

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Makeba Johnson RN, LNHA
TITLE: ADMINISTRATOR
(X6) DATE: 2/20/19

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

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Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet
Prn - As needed
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian

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F 000	Continued From page 2 RN- Registered Nurse ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 sampled residents, the dietitian signed Section K of the Minimum Data Set (MDS) on October 10, 2018, after the MDS coordinator had signed the document on October 01, 2018, thereby attesting that the document was complete. Resident #3. Findings included... A review of Resident #3's admission Minimum Data Set (MDS) dated October 01, 2018 showed that the dietician signed Section K of the MDS on October 10, 2018, nine days after Employee #7 (The MDS Coordinator) signed that the assessment was complete. Section Z of the MDS is titled Assessment Administration. In Section Z0400 (Signature 0f Persons Completing the Assessment or entry/Death Reporting) Every discipline (Dietary, Nursing, Social Work, Activities etc.) completes a	F 641	F641 – Resident #3 1. A review of the MDS and Reassessment of Resident #3 was done. The assessment is accurate; however, the MDS RN assessment dates cannot be corrected retrospectively. 2. All other MDS for the prior 6 months were reviewed for RN./MDS completion dates, particularly as it pertains to signature dates by other disciplines. There were no other MDS found impacted by this practice. 3. The interdisciplinary team was reeducated regarding MDS and date assessments are signed off 4. Assessment dates on MDS will be monitored by Medical Records for accuracy monthly and reported to QAPI quarterly. 5. Completion date 2/14/19	

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F 641	Continued From page 3 section of the MDS and each individual signs and dates the section they complete. Each individual acknowledges the following: "I certify that the accompanying information accurately reflects resident assessment information on the dates specified. To the best of my knowledge, this information was collected with applicable Medicare and Medicaid requirements. . . ." Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion is at the end of the MDS. This section is divided into two parts, A and B. A is for the signature of the RN Assessment Coordinator Verifying Assessment Completion. B is for the date that the RN Assessment Coordinator signed assessment as complete. During a face-to-face interview with Employee #7 at 10:00 AM on January 28, 2019 she stated that the MDS was a correction and the original date had to be maintained. The employee added that she would bring a copy of the original MDS. The employee brought a copy of an admission MDS assessment with a completion of October 01, 2018 where Section K was dated as complete on October 01, 2018, and Section F was dated as completed on October 02, 2018. The employee was queried regarding Section F being completed on October 02, 2018, which was also after the attestation date of October 01, 2018. The employee said "I do not understand what happened. It must have been a problem with the computer. At the time of the interview, Employee #7 acknowledged that sections on the MDS were completed after she signed and attested that the	F 641		

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F 641	Continued From page 4 assessment was completed.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 37 sampled residents, the facility staff failed to update/revise care plan to include specific interventions for a resident at high risk for aspiration. Resident #110.	F 657	F657 – Resident #110 1. Resident #110 was assessed and care plan updated and completed by RN to include swallowing and risk for aspiration. 2. All other residents with swallowing problems and risk for aspiration were reviewed. There were no other residents impacted by this practice 3. All interdisciplinary team members were reeducated regarding care plans ensuring they are person centered and meet all the needs of the residents. 4. Care plans will be audited by nursing leadership monthly and reported to QAPI quarterly. 5. Completion date 2/14/19.	1/28/19

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F 657	Continued From page 5 Findings included... Resident #110 was admitted to the facility on 10/1/14 with diagnoses to include Dysphagia, Oropharyngeal Phase, Pneumonia, Pressure ulcer, Weight loss, Gastritis and Cardiac Arrhythmia. Review of Resident #110 Quarterly Minimum Data Set [MDS] dated 12/26/18 showed Section C [Cognitive Patterns] the resident had a Brief Interview for Mental Status [BIMS] with a score of "15" which indicate she was cognitively intact. Under Section K [Swallowing/Nutritional Status] resident is coded as not having signs and symptoms of possible swallowing disorder. Review of Speech Therapy Discharge Summary [dates of service 9/25/18-10/8/18] on 1/28/19 at 2:30 PM showed "swallow strategies/positions, it is recommended the patient use the following strategies and/or maneuvers during oral intake: alternation of liquids/solids, alternation of temperatures, rate modification, bolus size modifications, hard throat clear/swallow, no straws and general swallow techniques/ precautions upright posture during meals and upright posture for >30 minutes after meals. Patient and Caregiver Training: Instructed patient and primary caregivers in safe swallow techniques, staff have been in serviced and trained on aspiration precautions."	F 657		

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F 657	Continued From page 6 Further review of the medical record showed a Mann Assessment Swallowing Ability (MASA) Scoring Sheet dated 1/18/19 with a score of "132" which indicate moderate aspiration, additional problems: at risk for silent aspiration; summary: severe oropharyngeal dysphagia high risk for aspiration. A further review of the medical record showed a physician's order dated 1/24/19 "may continue present diet with honey thick liquid, aspiration precautions." Review of Resident #110's Nutrition care plan failed to show updates or revisions to include swallowing strategies/maneuvers, caregiver training provided by the speech therapist on safe swallowing strategies for resident at high risk for aspiration. During an interview on 1/28/19, at 3:00 PM, Employee #4 acknowledged the finding and stated "yes, I can update the care plan."	F 657	F660 – Resident #68 1. The Interdisciplinary Team met with Resident #68. Resident stated a desire to go home; however, also stated being happy in facility until discharge happens. Resident #68's care plan was updated to address discharge plans. 2. All other resident care plans were audited for discharge plans and updated as appropriate. 3. Interdisciplinary Team was provided in-service reeducation on the need to address discharge planning on all residents. 4. Social worker will audit care plans for availability and documentation of discharge plans monthly and report to QAPI quarterly. 5. Completion date: 2/14/19	1/31/19
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660		

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F 660	Continued From page 7 rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F 660	F 660 Resident #118 1. The Interdisciplinary Team met with Resident #118. Resident indicated a desire to go home; however, is content being at facility. Care plan was updated to address discharge plans. 2. All other resident care plans were audited for availability of discharge plans and updated as appropriate. 3. The Interdisciplinary Team was reeducated on the need to address discharge plans for all residents by the Director of Nursing and Social Services Director. 4. Social Worker Director/ designee will audit care plans for availability and documentation of discharge plans monthly and report to QAPI quarterly 5. Completion date: 2/14/19	1/31/19

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F 660	Continued From page 8 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of 37 sampled residents, the facility staff failed to develop and implement a discharge plan for Resident's # 68 and 118. Findings included ... 1.Resident #68 was admitted, with diagnoses to include; Coronary Artery Disease, Cerebrovascular Accident, Hemiparesis, and Hypertension.	F 660		

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F 660	Continued From page 9 During a face-to-face interview on January 23, 2019, at 10:30 AM, Resident #68 stated he would like to go home but no one ever discussed this with him, and he did not realize it was an option. A review of the Quarterly Minimum Data Set (MDS) dated December 03, 2018, showed that in Section G (Functional Status) the resident required extensive assistance with one person assistance and under Section Q (Assessment and Goal Setting) active discharge planning already occurring for the resident to return to community was coded as, "no". A review of Resident #68's care plan on January 28, 2019, at 9:00 AM revealed no documentation regarding the resident's discharge wishes or discharge plans. There was no evidence of discharge planning or that the facility staff discussed discharge planning with the resident during his initial comprehensive assessment or subsequent Interdisciplinary Team meetings. Employee #6 acknowledged the findings during a face-to-face interview on January 28, 2019, at 10:00 AM. 2. Resident# 118 was admitted to the facility on 2/13/16 with diagnoses which include Chronic Obstructive Pulmonary Disease, Anemia, Coronary Artery Disease, Hypertension, Alzheimer's disease and Hip Fracture. During a face-to-face interview on 1/23/19 at 11:00 AM, Resident# 118 stated I have been here	F 660		

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F 660	Continued From page 10 for a while now and it would be nice to go home, but no one talked to me about it yet. Review of Resident# 118 Comprehensive Minimum Data Set [MDS] dated 12/20/18 showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "4" which indicate severe cognitive impairment. Section G [Functional Status] resident required limited assistance with activities of daily living (dressing, eating, personal hygiene and toileting) and under Section Q [Participation in Assessment and Goal Setting] Q0300. Resident's Overall Expectation for discharge was left blank (not coded). A review of Resident# 118 Socail Service care plan showed "to evaluate for discharge from the facility every three months, explore alternative care options with resident and family, discuss benefits and options to placement settings." A further review of the medical record showed care plan and interdisciplinary meetings, but no evidence facility staff discussed discharge planning with the resident and/or resident family. During a face-to-face interview on 1/23/19 at 3:00 PM Employee# 6 stated: "I should have discussed discharge, I will get on it right away." Facility staff failed to show evidence discharge planning was discussed during the initial comprehensive assessment or at subsequent Interdisciplinary Team Meetings. During a face-to-face interview on 1/28/19 at 3:00 PM Employee# 6 acknowledged the finding.	F 660		
F 684	Quality of Care	F 684		

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F 684 SS=D	Continued From page 11 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 37 sampled Resident, facility staff failed to follow Physician's Order to monitor hourly one resident who sustained an unwitnessed fall with injuries. Resident # 345. Findings included . . . Resident #345 was admitted to the facility January 18, 2019 from an area hospital with multiple diagnoses, which include Acute Pain, Altered Mental Status, Delirium, Cognitive impairment, Cognitive Safety Issues, Protein Malnutrition, Abdominal Aortic Aneurysm without rupture and Failure to Thrive. The resident Sustained a Closed Odontoid Fracture and Ear lobe laceration post fall on January 04, 2019. A review of the Quarterly MDS (Minimum Data Set) dated 11/28/2018 showed, Section C Cognitive Patterns C0500 BIMS score "5" for severe cognitive impairment. Section G Functional status G0110 coded "3" extensive	F 684	F684 – Resident #345 1. Resident #345 was reassessed; documentation of hourly monitoring could not be corrected retrospectively. 2. A review of residents at risk for falls was conducted as it pertains to physician orders of hourly monitoring. There were no other residents impacted by this practice. 3. Nursing staff were reeducated on accurately implementing doctor's orders on monitoring for comfort, fall and behavior. 4. The nursing leadership will audit residents with orders for hourly monitoring for accuracy and documentation monthly and report to QAPI quarterly. 5. Completion date: 2/14/19	

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F 684	Continued From page 12	F 684		

assistance, (resident involved in activity, staff provide weight bearing support) for bed mobility, transfer, walk-in the room, walk in the corridor, locomotion on the unit and toilet use, G0300 Balance during the transition and walking coded "1"(not steady, but able to stabilize without staff assistance), G0400 coded "0" for Functional limitation in Range of Motion, no impairment, G0600 Mobility Devices (Cane/Walker). Section I Active Diagnoses included Hypertension, Hyperlipidemia, non-Alzheimer's Dementia, Anxiety Disorder, Depression, Hypothyroidism, Polyneuropathy and Hyperkeratosis of yaws.

A review of the Care Plan initiated March 12, 2018 and revised on January 18, 2019 indicated, Resident is at risk for falling R/T [related to] Hx [history] of falls, Arthritis, Osteoporosis, Dementia, Visual Deficit, Anxiety Disorder, and Hearing Deficit.

A review of the Physician's Order Sheet [POS] for January 2019, (signed and dated by the physician on January 23, 2019) directed, "Monitor Resident hourly for comfort, fall and behavior daily."

A review of Resident #345's Treatment Administration Record [TAR] showed that the Physician's order to "Monitor resident hourly for comfort, fall, and behavior daily" was not followed as directed by the physician.

A review of the Monitoring Record on the TAR showed three spaces allotted for staff signatures to document when staff monitored the resident.

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	095020	A. BUILDING _____ B. WING _____	01/29/2019

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STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

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F 684	Continued From page 13 The spaces were noted as AM [morning], PM [evening], NOC [night] indicating monitoring completed once on each shift. Showed the facility staff were monitoring the resident three times a day instead of hourly as ordered by the physician. A review of the Nursing Progress Note dated December 1, 2018 to January 23, 2019, showed the dates the nurses documented on resident #345 as follows: December 9, 2018 4:19PM December 17, 2018 11:43AM January 4, 2019 6:24PM, 7:21PM, 10:29PM, 11:19PM Hospital ER January 18, 2019 9:51PM admit to facility January 19, 2019 5:52AM, 3:17PM, 11:07PM January 20, 2019 5:30AM, 3:37PM, 8:17PM January 21, 2019 7:03AM, 2:02PM, 10:03PM, January 22, 2019 4:48AM, 10:06AM, 2:47PM, 3:25PM, 9:17PM The evidence showed that facility staff failed to follow the Physician's Order to monitor Resident #345 (who had a history of falls) hourly for comfort, fall and behavior. Employee #5 acknowledged the findings during a face-to-face interview at 11:00 AM on January 25, 2019.	F 684		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits	F 711		

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F 711	Continued From page 14 The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(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 medical record review and staff interview for two (2) of 37 sampled residents the physician failed to review the resident's total program of care to include a co-signature for a telephone order for one (1) resident who receives enteral feeding and to consider tapering the dose of prednisone for one (1) resident. Residents # 62 and #118. Findings included ... Record review of facility's policy titled "Physician Order Admission/Re-admissions revision date of 10/11/18 showed "all resident orders should be reviewed by the physician at least every 60 days for intermediate residents and 30 days for skilled residents, the physician countersigns telephone orders within 10 days."	F 711		

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F 711	Continued From page 15 1.Resident #62 was admitted to the facility on 8/27/18 with diagnoses to include Heart Failure, Pneumonia, Hypertension, Hyperlipidemia and Parkinson's disease. On 1/23/19 at 10:00 AM, Resident #62 was observed lying in bed on his left side with Jevity 1.5 infusing at 90ml/hr via gastrostomy-tube. On 1/25/19 at 11:00 AM the resident was observed receiving Jevity 1.5 infusing at 90 ml/hr via gastrostomy-tube. Review of the Quarterly Minimum Data Set [MDS] dated 11/28/18 showed that under Section C [Cognitive Patterns] Resident #62 had a Brief Interview for Mental Status [BIMS] score of "11" which indicates the resident's cognition is moderately impaired. Under Section K [Swallowing/Nutritional Status] K0510- indicates the resident has a feeding tube (nasogastric or abdominal). Review of the care plan showed "feeding tube; resident requires feeding tube related to Dysphagia post Stroke." A further review of the medical record showed a Pharmaceutical Service Enteral Protocol dated 11/5/18 Enteral Protocol with a telephone order "tube feeding nutrient Jevity 1.5 at 90ml/hour X 18 hours up at 6:00 PM down at 12 noon." A review of the form showed the section for the physician's signature is left blank, indicating that she did not cosign the order and review this order as a part of the total plan of care. During a face-to-face interview on 1/25/19 at	F 711	F711 - Resident #62 1. Resident #62 was immediately reassessed and physician notified of the need to review the plan of care and sign the order. 2. All other resident orders for the prior 6 months were reviewed and addressed with physician as applicable. 3. The Medical Director addressed the concerns and reeducated all other physicians on the need to review care plans and timely sign off on orders. 4. Physician compliance with review of physician's orders and physician's review of plan of care will be audited monthly by Director of Nursing/designee and medical records. The finding will be reported to QAPI quarterly. 5. Completion date: 2/19/19	1/30/19

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F 711	Continued From page 16 11:00 AM, Employee# 4 acknowledged the finding at the time of the medical record review. 2. Resident # 118 was admitted to the facility on 2/13/16 with diagnoses which include Chronic Obstructive Pulmonary Disease, Anemia, Coronary Artery Disease, Hypertension, Alzheimer's disease and Hip Fracture. Review of Resident #118 Quarterly Minimum Data Set [MDS] dated 12/26/18 showed Section C [Cognitive Patterns] a Brief Interview for Mental Status [BIMS] with a score of "15" which indicate cognitively intact. Section O [Special Treatments, Procedures and Programs] respiratory treatments while a resident, Oxygen therapy is selected. Review of Pulmonary Consultation dated 9/4/18 showed continue current therapy except consider tapering Prednisone (Patient is on appropriate therapy but would consider slowly tapering Prednisone 5mg every 2 to 4 weeks). Review of the Medication Administration Record (MAR) for September 2018-January 2019, "Prednisone 20 mg tablet by mouth (1 tablet/20 mg) daily 9:00 AM for: Chronic Pulmonary Disease (COPD). Medical record review failed to show a tapering of Prednisone dose and no documented rational to continue or discontinue the Prednisone dosage (therapy). During a telephone interview on 1/28/19, at 2:00 PM with Employee #8 [Physician] stated I did see the recommendation but I elected not to taper the dose at this time, I should have addressed it in my notes. Employee #8 acknowledged the finding during the interview.	F 711	F711-Resident #118 1. Resident #118 was reassessed and physician notified. Physician reviewed the recommendation from consult and documented response to pulmonary consult recommendation. 2. A review of consults recommendations for the prior 6 months was done and any identified consults needing response were referred to physician as appropriate. 3. The Medical Director addressed the concern and reeducate physicians on the need to reply to consults and document their response. 4. Physician compliance with review of physician's orders and physician's review of plan of care will be audited monthly by Director of Nursing/designee and medical records. The finding will be reported to QAPI quarterly. 5. Completion date: 2/14/19	1/30/19

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain food service equipment in good condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a final rinse temperature of 180 degrees Fahrenheit (F). Findings included ... During a tour of the Dietary Services on January 22, 2019, at approximately 9:25 AM: One (1) of one (1) dishwashing machine failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit (F) during observations between 10:05 AM and 10:50 AM. Final rinse	F 812	F812 1. Outside vendor was immediately called to repair the final rinse cycle and repair was completed the same day. Paper plates were used for lunch. A review of the facility temperature log maintained on the dish machine revealed all temperatures were appropriate prior to date checked. 2. There were no other dish machines in the same condition. 3. The preventive maintenance program has been revised to include monitoring and inspection of the dishwashing machine final rise temperature. Maintenance staff has been provided an in-service on the preventive maintenance of the dish machine and temperature requirements. Dietary staff was also provided reeducation on out of range temperature and to alert maintenance department for repair. 4. The Maintenance Director will review adherence to preventive maintenance program monthly and report to QAPI quarterly. 5. Completion date: 2/15/19.	1/22/19

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F 812	Continued From page 18 temperatures fluctuated between 168 degrees F and 181 degrees F during that time and dietary staff was unable to clean dishes effectively. As a result, paper plates were used for lunch. At approximately 12:16 PM, the dishwashing machine was repaired and final rinse temperatures were between 182 degrees F and 192 degrees F on five (5) of five (5) consecutive dishwashing cycles. On January 24, 2019, at approximately 10:10 AM, the final rinse temperature was observed to be 188 degrees F. These observations were acknowledged by Employee #3 during a face-to-face interview on January 22, 2019, at approximately 10:50 AM.	F 812	F908 2. Outside vendor was immediately called to repair the final rinse cycle and repair was completed the same day. Paper plates were used for lunch. A review of the facility temperature log maintained on the dish machine revealed all temperatures were appropriate prior to date checked. 2. There were no other dish machines in the same condition. 3. The preventive maintenance program has been revised to include monitoring and inspection of the dishwashing machine final rise temperature. Maintenance staff has been provided an in-service on the preventive maintenance of the dish machine and temperature requirements. Dietary staff was also provided reeducation on out of range temperature and to alert maintenance department for repair. 4. The Maintenance Director will review adherence to preventive maintenance program monthly and report to QAPI quarterly. 5. Completion date: 2/15/19.	1/22/19
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain food service equipment in good condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a final rinse temperature of 180 degrees Fahrenheit and by failing to maintain a wheelchair in safe working condition. Findings included ...	F 908		

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F 908	Continued From page 19 1.Facility failed to maintain food service equipment in good condition as evidenced by one (1) of one (1) dishwashing machine that failed to reach a final rinse temperature of 180 degrees Fahrenheit During a tour of the Dietary Services on January 22, 2019, at approximately 9:25 AM: One (1) of one (1) dishwashing machine failed to reach a minimum final rinse temperature of 180 degrees Fahrenheit (F) during observations between 10:05 AM and 10:50 AM. Final rinse temperatures fluctuated between 168 degrees F and 181 degrees F during that time and dietary staff was unable to clean dishes effectively. As a result, paper plates were used for lunch. At approximately 12:16 PM, the dishwashing machine was repaired and final rinse temperatures were between 182 degrees F and 192 degrees F on five (5) of five (5) consecutive dishwashing cycles. On January 24, 2019, at approximately 10:10 AM, the final rinse temperature was observed to be 188 degrees F. These observations were acknowledged by Employee #3 during a face-to-face interview on January 22, 2019, at approximately 10:50 AM. 2. Facility staff failed to maintain a wheelchair used by Resident # 45 in safe operating condition.	F 908	F 908 - Resident #45 Wheelchair 1. Resident #45's wheelchair was immediately repaired. 2 All other manual wheelchairs were checked for any needed repairs. There were no other manual wheelchairs found requiring repair. 3. Maintenance staff was provided an in-service education on preventive maintenance of wheelchairs. Staff were reeducated on wheelchair inspection before use with residents. 4. Engineering and maintenance director will monitor wheelchair preventive maintenance monthly and report to QAPI quarterly. 5. Completion date: 2/14/19	1/28/19

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F 908	Continued From page 20 Record review of facility's policy titled "Wheelchair Preventive Maintenance review date 3/14/18 showed purpose is to ensure all wheelchairs are in proper working order, wheelchairs will be checked and maintained on a regular basis." Observation on 1/28/19 at 10:00 AM showed Resident #45 sitting in a black wheelchair at the nurses' station. During an interview with Employee #4 on 1/28/19 at 10:30 AM while at the nurses station, surveyor heard a thump and saw Resident #45 on the floor (at the nurses station), staff responded immediately and assisted the resident to a seated position in the wheelchair. Resident #45 remained alert and responded appropriately to staff. As staff were placing resident in the wheelchair observed the left arm rest of the wheelchair was loose, and unable to attach and lock onto the frame of the wheelchair. Resident #45 remained alert and responded appropriately to staff. Resident #45 was admitted to the facility on 6/28/18, with diagnoses which include Essential hypertension, Cough variant Asthma, Insomnia, Iron deficiency and Altered Mental Status. During an interview on 1/28/19 at 11:00 AM, Employee #4 stated I will put in a work order to get it fixed, the left arm rest is not locking, I see it. Facility staff failed to maintain a wheelchair used	F 908		

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F 908	Continued From page 21 by Resident #45 in safe operating condition. During a face-to-face interview on 1/28/19 at 11:00 AM the charge nurse, Employee #4 acknowledged the finding.	F 908		