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
	095021	A. BUILDING ______ B. WING ______	08/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey conducted at Health Rehabilitation Center at Thomas Circle August 2, 2017, through August 7, 2017, consisted of a review of 30 resident clinical records during Stage 1; and review of 25 sampled residents during Stage 2. Based on observations, record reviews, and staff interviews, an analysis of the findings determined 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 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube	F 000	The Residences at Thomas Circle files this Plan of Correction for the purpose of regulatory compliance. The facility submits this document to comply with applicable law and not as an admission or statement of agreement of deficient practices herein.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 9/28/17

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 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		
F 241 SS=E	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	F 241	1.Residents #6 and #35 are served their meals consecutively. 2. DON or designee have conducted meal rounds to ensure residents seated at the same table receive meals consecutively.	

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F 241	Continued From page 2 individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations during a dining observation for two (2) of 25 sampled residents, it was determined that facility staff failed to respect one resident's dignity when serving their lunch meal on August 2, 2017 (Resident #6). The findings include: An observation on August 2, 2017, at approximately 12:20 PM revealed Residents #6 and 35 seated at the dining table together. The facility staff served Resident #35 lunch. However, Resident #6 had not received a lunch tray at that time. At approximately 12:30 PM an employee approached Resident #35 and queried why he/she was not eating. Resident #35 responded, "I am waiting until [he/she] (Resident #6) gets his/her] tray." During a face-to-face interview, on August 4, 2017, at approximately 3:00 PM, the incident was discussed and acknowledged by Employee #2.	F 241	3. DON or designee has re-in-serviced dietary and nursing staff. DON or designee will conduct monthly rounds of dining room during meals. 4.DON or designee will document findings and report monthly to the Quality Assurance Committee for review, evaluation and approval.	9/22/17
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	F 246	1.Resident #25 was provided on 8/4/17 with a pendant that he was able to use to call for assistance once he was ready to return to the floor.	

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F 246	Continued From page 3 do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident Interview and staff interview for one (1) of 25 sampled residents, it was determined that facility failed to accommodate the needs of one (1) resident to return to his/her room, promptly, after visiting the patio (Resident #25). The findings include: During a conversation with the resident on August 3, 2017, at approximately 10:30 AM, the resident looked out of his/her window, pointed to the patio and stated, "It is simply beautiful out there. I love going out there, but when I go out there, I have a hard time getting back in. I cannot get back in without assistance, so I usually have to wait for someone to come and get me." When asked if informed the staff of the desire to return to the floor more promptly when he goes out on the patio, the resident responded, "No. I do not because I know they are busy and I do not want to bother them." On August 4, 2017, at approximately 2:00 PM, the staff was observed wheeling the resident, in the wheelchair, outside on the patio. The employee left the resident outside reading a newspaper. At approximately 2:50 PM, Resident #25 folded the newspaper and placed it on his/her lap. During a follow-up observation at approximately 3:00 PM, the surveyor approached the resident	F 246	2.Interdisciplinary team has assessed residents who may need the use of pendants when enjoying public areas in the community for their safety. 1.DON or designee will continue in-servicing nursing staff and activities staff as to the use of pendants. 2.DON or designee will monitor, document findings, and present to the Quality Assurance Committee for review, evaluation, and approval on a monthly basis.	

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F 246	Continued From page 4 and inquired whether he/she was ready to return to his/her room. The resident responded, "Yes, I am." The surveyor went to the receptionist and requested transport for the resident to return to the unit. At approximately 3:20 PM, the resident was observed still awaiting return transport to the unit. The surveyor asked the receptionist if the unit was called to request an escort. The receptionist responded, "I called as soon as you asked me but no one came." During a face-to-face interview, on August 4, 2017, at approximately 3:30 PM, the incident was discussed with and acknowledged by Employees #2 and 3.	F 246		
F 247 SS=D	483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review for one (1) of 25 sampled residents it was determined that facility staff failed to provide adequate notice before performing an inter-facility room change (Resident# 68). The findings include: According to the facility's policy regarding	F 247	1.Resident #68 was discharged from from the facility. 2.Social Worker or designee has conducted an audit to ensure notice has been provided before room/roommate change.	

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F 247	Continued From page 5 'Admissions, Transfers, and Discharges [Room to Room Transfers],' within a Nursing Facility, "unless medically necessary or for the safety of the resident(s) a resident will be provided with an advance notice of the room transfer ....." During a face-to face interview on August 2, 2017, at 11:40 AM with Resident #68, in response to the question "Where you given notice before a room change or change in roommate?" The resident responded, "it was ill-prepared they just walked in and told me they were moving me I thought they were joking, no one prepared me." Consequently, during a face-to-face interview on August 8, 2017, at 1:00 PM with Employee# 12, the employee stated: "I did tell the resident that in two (2) days a room would be available but I did not put it in my note." On August 8, 2017, a review of the clinical record for Resident #68 revealed the resident underwent an inter-facility room change on July 17, 2017. The record lacked documented evidence that the resident was provided adequate notice before the room change. During the face-to-face interview on August 8, 2017, at 1:30 PM, Employee #12 acknowledged the findings.	F 247	3. Social Worker or designee will audit documentation monthly. 4.Social worker will document findings and report to the Quality Assurance committee monthly for review, evaluation, and approval.	9/22/17
F 248 SS=E	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities.	F 248		

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F 248	Continued From page 6 (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 25 sampled residents, it was determined that facility staff failed to ensure that residents received an ongoing program of activities designed to meet the interests, the physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment (Residents #51, and 65). The findings include: 1. During Stage 1 interview, Resident #51 stated "I don't participate in activities because not much is offered that I like ...I did go on a trip recently". "I mostly sit out there and watch television." A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of July 4, 2017, under Section F, Preferences for Customary Routine and Activities, the staff coded the resident daily activities preferences as being very important. On August 7, 2017, medical record review revealed no evidence of documentation for participation in any activities by the resident.	F 248	1. Residents #51 and 65 will be reassessed to assure that leisure activities of their choice and preference are being offered and/or provided and documented. 2. Activities manager or designee has assessed residents to assure that leisure activities of their choice and preference are reflected on the monthly calendar and documented upon admission, quarterly and annually. 3.Activities Manager or designee will continue In-servicing activities staff on assessment, documentation, development of quality activity to match resident preferences.	

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F 248	Continued From page 7 During a face-to-face interview with Employee # 6 on August 7, 2017, at 2:00 PM, the employee stated, "I have not documented any of the resident's activities at this time." There was no evidence that facility staff ensured that an ongoing program of activities designed to meet the interests, the physical, mental, and psychosocial well-being was provided for Resident #51. A face-to-face interview was conducted with Employee #1 on August 7, 2017, at 3:00 PM. After the record review, he/she acknowledged the findings. 2. During stage 1 interview, Resident #65 stated "I don't participate in activities much here. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 21, 2017, under Section F, Preferences for Customary Routine and Activities was coded for having daily activities as very important. On August 7, 2017, a medical record review revealed no evidence of documentation for participation in any activities by the resident. During a face-to-face interview with Employee # 6 on August 7, 2017, at 2:00 PM. He/she stated, "I have not documented any of the residents' activities at this time." There was no evidence that facility staff ensured	F 248	-continued from page 7 Activities Manager or designee will conduct monthly documentation audits and effectiveness of activity programs. 4.Activities Manager or designee will document audit findings and report to the Quality Assurance Committee monthly for review, evaluation and approval.	9/22/17

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F 248	Continued From page 8 that an ongoing program of activities designed to meet the interests, the physical, mental, and psychosocial well-being was provided for Resident #65. A face-to-face interview was conducted with Employee #1 on August 7, 2017, at 3:00 PM. After the record review, he/she acknowledged the findings.	F 248	1.(1)Painting of rooms #202, 203, 206,207,208	
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 Based on observations made on August 2, 2017, at approximately 11:00 AM, it was determined that the facility failed to maintain resident environment in a comfortable, orderly manner as evidenced by The findings include: 1. Walls in 11 of 12 resident's rooms were marred, scarred and dented in several areas to include rooms #202, 203, 206, 207, 208, 212, 214, 215, 216, 217, and 218. 2. Exhaust vents did not function as intended in four (4) of 12 resident's rooms including rooms #214, 215, 217, and 218. 3. Window blinds in three (3) of 12 resident's rooms soiled with dust (Rooms #207, 212, 217) and the overhead light fixture was dusty, in room	F 253	212, 214, and 216, 217, and 218 has been put out for bid. (2)Exhaust fans in rooms #214, 215, 217 and 218 have been fixed. (3)Window blinds in room #207, 212, and 217 have been dusted. (4)Paint for entrance doors has been put out for bid. (5)The call bell housing in room #214 has been Ordered. (6)The ceiling tile in room #218 has been changed.	

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F 253	Continued From page 9 #218. 4. The entrance door to three (3) of 12 resident's rooms marred with several scratches in rooms #207, 217 and 218. 5. The call bell housing was hanging loosely off the wall in resident room #214, one (1) of 12 resident's rooms surveyed. 6. A ceiling tile stained with several dark spots in one (1) of 12 resident's rooms (Room #218). The observations made in the presence of maintenance staff, who confirmed the findings.	F 253	Continues from page 9 3 Director of Plant Operations, Director of Environmental Services or designees will conduct monthly rounds to identify issues. 4.Plant Operations Director and Environmental Services Director will document findings and present monthly to the Quality Assurance Committee for review, evaluation, and approval.	9/22/17
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (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	F 279		

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F 279	Continued From page 10 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. (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:	F 279	1.Resident #51's, #65's, #68's, and #71's care plan have been created with goals and approaches to address the residents' activities preferences. 2.Activities Manager or designee has audited charts to ensure that residents have care plans addressing their activities preferences. 3.Activities Manager or designee will audit charts monthly to ensure care plans are developed to reflect residents' preferences. 4.Activities Manager will document audit findings and present to the Quality Assurance Committee monthly for review, evaluation and approval.	9/22/17

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F 279	Continued From page 11 Based on observations, record review and staff interview for five (5) of 25 sampled residents, it was determined that facility staff failed to develop care plans with goals and approaches to address: Activities needs for ; Residents #51, #65, #68, #69, and #71. The findings include: 1. Facility staff failed to initiate a care plan with goals and approaches to address activities preferences for Resident #51. A review of the medical record revealed the resident was admitted to the facility on June 27, 2017, with diagnoses that include: Acute UTI (urinary tract infection) coronary artery disease, Hypertension ... A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of July 4, 2017, under Section F, Preferences for customary routine and having daily activities was coded as very important. A review of the care plans in the resident's clinical record lacked evidence that a care plan was developed with goals and approaches to address the resident's activities preferences. A face-to-face interview was conducted with Employee #6 on August 7, 2017, at approximately 12:30 PM. After reviewing the record, Employee #6 acknowledged the findings. 2. Facility staff failed to initiate a care plan with goals and approaches to address activities preferences for Resident #65.	F 279		

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F 279	Continued From page 12 A review of the medical record revealed the resident was admitted to the facility on March 14, 2017, with diagnoses that include: Hypertension, Vitamin D deficiency, Fibromyalgia ... A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 21, 2017, under Section F, Preferences for customary routine and having daily activities was coded as very important. A review of the care plans in the resident's clinical record lacked evidence that a care plan was developed with goals and approaches to address the resident ' s activities preferences. 3. Facility staff failed to initiate a care plan with goals and approaches to address activities preferences for Resident# 68. A review of the medical record revealed the resident was admitted to the facility on July 14, 2017, with diagnoses that include: Nausea, Essential (Primary) Hypertension, Asthma ... A face-to-face interview was conducted with Employee #68 on August 7, 2017, at approximately 12:30 PM. After reviewing the record, Employee #68 acknowledged the findings. 4. A review of the medical record revealed the resident was admitted to the facility on July 22, 2017, with diagnoses that include: Vitamin D Deficiency, Essential (Primary) Hypertension, Constipation, ... Facility staff failed to initiate a care plan with goals and approaches to address activities	F 279		

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F 279	Continued From page 13 preferences for Resident #69. A face-to-face interview conducted with Employee #68 on August 7, 2017, at approximately 12:30 PM. After reviewing the record, Employee #68 acknowledged the findings. 5. A review of the medical record revealed the resident was admitted to the facility on July 11, 2017, with diagnoses that include: Urinary tract Infection, Vitamin B12 deficiency Anemia, Hyperlipidemia .... Facility staff failed to initiate a care plan with goals and approaches to address activity preferences for Resident#71. A face -to-face interview was conducted with Employee# 68 on August 7, 2017, at approximately 12:30 PM. After record review, Employee #68 acknowledged the findings.	F 279		
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	F 371	1.Convector Ovens, cooking grill, 8 stove burners, and 10 food trays have been cleaned. 2.F&B Director or designee has conducted Environmental round of the kitchen to Identify areas needing cleaning. 3.F&B Director or designee will continue to re-in-service kitchen staff on cleaning schedule. F&B Director or designee will conduct monthly rounds. 4. F&B Director or designee will document environmental round findings and present to the Quality Assurance Committee monthly for review, evaluation, and approval.	9/22/17

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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:

Based on observations made on August 2, 2017, at approximately 9:00 AM, it was determined that the facility failed to maintain food preparation equipment in sanitary conditions as evidenced by convection ovens soiled throughout with leftover food deposits, cooking grill soiled with burnt food particles, stove soiled, and food trays stored in the food warmer soiled with dry food and liquid spills, in 21 of 21 observations.

The findings include:

1. Two (2) of two (2) convection ovens soiled throughout with leftover food deposits.

2. One (1) of one (1) cooking grill soiled with burnt food particles.

3. Eight (8) of eight (8) burners from one (1) of one (1) stove soiled.

4. Ten (10) of ten (10) food trays stored in the food warmer soiled with dry food and liquid spills and requiring cleaning.

The Executive Chef and Dietary Manager present at the time observation confirmed and

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F 371	Continued From page 15 acknowledged the findings.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1.Resident #47 has been discharged. 2.DON or designee has conducted audit of medication room and carts. 3.DON or designee will continue to re-in-service RNs and LPNs regarding the facility's discontinued medication order policy. DON or designee will conduct monthly audits of medication room and carts. 4.DON or designee will document audit findings and present to the Quality Assurance Committee monthly for review, evaluation, and approval.	9/22/17

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F 431	Continued From page 16 (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview during a review of medication storage it was determined that facility staff failed to discard expired refrigerated medication as per manufacturer label for one (1) of 23 sampled residents (Resident# 47). The findings include: During the medication storage observation and review conducted on August 4, 2017, at approximately 10:30 AM on Unit 2, the following was observed: The unit refrigerator contained a bag of a solution with a manufacturer label: Vancomycin 1.25 GM (gram) IV(intravenous) SOLN (solution) qty (quantity) 250; LOT: 7602947, EXP (expiration 08/3/17). At the time of the observation, a face-to-face interview with Employee# 3, he/she	F 431		

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F 431	Continued From page 17 acknowledged the findings and removed the solution from the refrigerator.	F 431		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a	F 441	1.A-Staff #4 was re-in-serviced on policy for hand washing/hand sanitizing. B- Hand Sanitizer was placed inside the soiled utility room and outside the soiled utility room. C-Resident #32 has been discharged. Infection Control Surveillance form has been revised to include type of organisms and infection resolution. 2.Director of Nursing or designee has Conducted infection control round. 3.Director of Nursing or designee will continue re-in-servicing nursing staff on facility's hand washing/hand sanitizing policy and infection control practices. Director of	

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F 441	Continued From page 18 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on an observation at approximately 10:45AM on August 7, 2017, it was determined that facility staff failed to practice, in a manner, to assist in preventing the spread of infection, as evidenced by (a) failing to consistently sanitize hands when changing gloves during a dressing change and (b) washing soiled hands at a sink that is used for preparing refreshments for the	F 441	-continued from page 18 Nursing has implemented new Infection control Surveillance form to better capture organisms and infection resolution. DON or designee will conduct monthly infection control rounds. New sink will be placed in the Dirty Utility Room as project put out for bid. 4.DON or designee will document round findings and present monthly to the Quality Assurance Committee for review, evaluation, and approval.	9/22/17

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F 441	Continued From page 19 residents' consumption in two (2) of two (2) observations. The findings include: A. Employee #4 failed to wash his/her hands after removing gloves and before donning new gloves during a dressing change. A dressing change observed on August 7, 2017, at approximately 10:45 AM. Employee #4 washed his/her hands before beginning the procedure. The employee used hand sanitizing solution during the dressing change and before putting on gloves. The employee changed his/her gloves five (5) times but failed to sanitize his/her hands two (2) of the five (5) times. During the face-to-face interview with the Employee #4 on August 7, 2017, immediately after the dressing change; the employee responded, "Hands should be cleaned after changing and before putting on new gloves," when queried about the process for changing gloves. Employee #2 acknowledged the finding during a face-to-face interview on August 7, 2017, at approximately 3:00 PM. B. Facility failed to provide a sink for staff to wash their hands after disposing of soiled materials in the Soiled Utility room.	F 441		

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At approximately 11:00 AM on August 7, 2017; Employee #4 deposited soiled materials from a dressing change in the Soiled Utility Room, exited the room and washed his/her hands at the sink in the Resident's Snack Preparation area. When asked why he/she washed his/her hands at that sink the employee responded, "This is the closest one to the soiled utility room." (There was no sink in the soiled utility room.) Employee #4 confirmed that the sink is used by the Activity Department to prepare the residents' snack.

Employee #2 acknowledged the finding during a face-to-face interview on August 7, 2017, at approximately 1:00 PM.

C. Facility staff failed to maintain a safe sanitary and comfortable environment after placing a meal plate on the over-bed-tale next to a urinal.

The findings include:

On August 2, 2017, at approximately 12:30 PM Employee #13 was observed to enter Resident# 32's room with a tray holding a meal plate with a plastic covering. Employee#13 placed the tray on the over-bed-table next to the resident's urinal filled with a yellowish colored fluid.

A face-to-face interview conducted on August 2, 2017, at apporximately 12:30 with Employee#13. The employee states, "I placed the food there because I did not want to walk back out of the room since I had already walked in with the lunch tray, I should have moved the urinal first."

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Employee#13 acknowledged the findings at the time of the observation on August 2, 2017, at approxiamtely 12:30 PM.

Surveyor: Gloria Jones

Based on a review of the facility ' s Infection Control Program and through staff interview, it was determined that facility staff failed to ensure the implementation of infection control program that included a consistent and systematic collection, analysis, interpretation and dissemination of data to identify infections and infection risks in the facility.

The findings include:

A review of the facility ' s infection control surveillance documentation, " Infection Control Log, " lacked evidence of a methodology to consistently collect, analyze, interpret and disseminate data related to infections in the facility. The facility ' s documentation on the "Infection Control Log" was inconsistent for the following items: organism type, significant organism, and resolved date.

A review of the facility ' s monthly " Infection Control Log" for the period of January 2017 and June 2017 revealed the following:
February 2017- one (1) of three (3) residents were identified as having infections did not have the known organism recorded.
" On February 13, 2017 Resident #32 was coded as '1' indicating the type of organism was 'not

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F 441	Continued From page 22 known or not applicable'. A review of the Residents laboratory results sheet dated February 17, 2017 revealed, urine culture was greater than 100,000 CFU/ML (colony-forming units/milliliter) Escherichia Coli (E. Coli) organism. There was no evidence facility staff coded the resident as '2' indicating E. Coli organism. March 2017- three (3) of four (4) residents were identified as having infections did not have the known organism recorded. " On March 8, 2017 Resident #32 was coded as '1' indicating the type of organism was 'not known or not applicable'. A review of the Residents laboratory results sheet dated March 10, 2017 revealed, urine culture was greater than 100,000 CFU/ML Escherichia Coli (E. Coli) organism. There was no evidence facility staff coded the Resident as '2' indicating E. Coli organism that was facility acquired. " Resident # TF1 was listed as having an infection on March 31, 2017. The resident was coded as '1' indicating the type of organism was 'not known or not applicable'. A review of the medication administration note dated March 31, 2017 at 23:26, " ...Clarithromycin [antibiotic] 500mg 1 tablet by mouth two times a day for H. pylori (Helicobacter pylori) for 7 days". There was no evidence facility staff recorded the resident for having H. pylori organism. " On March 24, 2017 Resident #8 was coded as '1' indicating the type of organism was 'not known or not applicable'. A review of the Residents laboratory results sheet dated March 26, 2017 revealed, urine culture was greater than 100,000 CFU/ML Escherichia Coli (E. Coli) organism.	F 441		

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F 441	Continued From page 23 There was no evidence facility staff coded the resident as '2' indicating E. Coli organism that was facility acquired. April 2017 Infection Control Log or infection control surveillance data was provided for review May 2017- two (2) of three (3) residents were identified as having infections did not have the known organism recorded. " On May 3, 2017, Resident # 1 was coded as '1' indicating the type of organism was 'not known or not applicable' and the resident was coded as not having a significant organism. A review of the Residents laboratory results sheet dated May 5, 2017 revealed, urine culture was greater than 100,000 CFU/ML gram negative rods was the organism. A review of the nurse progress notes dated May 6, 2017 at 14:03 [2:03 PM] revealed, "Resident urine culture result received, source organism 1, > 100,000 CFU/ML gram negative rods ..." May 6, 2017 at 14:55 [2:55 PM] revealed, " ...start Macrobid [antibiotic] 100mg by mouth bid x 3 days." May 8, 2017 at 15:41 [3:41 PM] revealed, "today social worker spoke with resident ...and [his/her] power of attorney in regards to a needed room change, for isolation needs for patient at this time. Patient and [his/her] power of attorney are in agreement with the room change ..." May 8, 2017 at 16:46 [4:46 PM] revealed, "Culture result reviewed by MD [medical doctor] with new order for contact isolation due to ESBL (Extended-spectrum beta-lactamases). Resident and RP (responsible party) made aware.	F 441		

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There was no evidence that facility staff recorded ESBL as a facility acquired, significant organism, requiring the resident to be placed on contact isolation on the May 2017 Infection Control Log. In addition, there was a three-day lapse between the time the organism was identified and the resident was placed on contact isolation.

The facility failed to record the known organism for residents; and failed to record the occurrence when Resident # 1 was placed on contact isolation; and no evidence the facility staff recorded the dated identified infections resolved.

" On May 18, 2017 Resident #13 was coded as '1' indicating the type of organism was 'not known or not applicable'. A review of the Residents laboratory results sheet dated May 22, 2017 revealed, urine culture was greater than 100,000 CFU/ML Escherichia Coli (E. Coli) organism.

There was no evidence facility staff coded the Resident as '2' indicating E. Coli organism that was facility acquired.
Through record review, it was determined that in February 2017 one (1) resident was diagnosed with a urinary tract infection and E.Coli was the source organism. In March 2017 two (2) residents were identified with urinary tract infections and E. Coli was the source organism. May 2017 two (2) residents was diagnosed with a urinary tract infection one source organism was ESBL and the other was E. Coli. There was no evidence of staff used the surveillance outcomes to in-service or train staff to help prevent the occurrence urinary tract infections.

A face-to-face interview was conducted with

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(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 441	Continued From page 25 Employee # 2 at approximately 2:30 PM on August 3, 2017. The employee acknowledged that the Line Listing of the facility ' s infections did not accurately depict the known organism(s) for several residents, lacked inclusion of one (1) resident who was on isolation; and no evidence the facility staff recorded the dated identified infections resolved. Surveyor: Tamara Freeman	F 441		
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations made on August 2, 2017, at approximately 9:30 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by a small crawling pest observed on the kitchen hood. The findings include: A small pest was observed crawling around the kitchen hood system at approximately 9:45 AM on August 2, 2017. The Executive Chef and Dietary Manager were present at the time of observation and acknowledged the finding.	F 469	F469 1.Kitchen has been treated by new pest control company on a weekly basis. 2.F&B Director or designee has conducted environmental round to identify any pest control issue. 3.Facility has contracted with new pest control company to improve services. F&B Director or designee will conduct monthly Environmental rounds. 4.F&B Director or designee will document environmental rounds findings and present to the Quality Assurance Committee monthly for review, evaluation, and approval.	9/22/17