STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(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 An unannounced Quality Indicator Survey was conducted at United Medical Nursing Home from November 6, 2017 through November 14, 2017. Survey activities consisted of a review of 30 residents' clinical records during Stage 1; and review of 39 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The census during the survey was 115 residents. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Abenle
TITLE: Administrator
(X6) DATE: 1/17/2018

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 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 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 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	F 156		

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F 156	Continued From page 2 (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective	F 156	1. **Resident # 52** rights were reviewed immediately by social worker/Activities director with resident. 2. No other resident was affected by this deficiency evidenced by review of resident's right with all residents on admission. Employee # 8 was counseled on reviewing of resident's right on admission, quarterly care plan meetings, and family/resident's council meetings. The SW. admissions and Recreation Therapy staff will also review residents' rights 3. To prevent future occurrences, the Admissions Coordinator, Social Workers and Director of Recreation Therapy will be re-educated on residents' rights. The Director of Recreational Services will have Residents Rights on the agenda for discussion at each Resident Council meeting.	11/13/17 11/13/17 12/29/17 and ongoing

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F 156	Continued From page 3 services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans	F 156	4. Residents Rights review audits will be added as a Social Work Department quality indicator to ensure compliance until three months of greater than or equal to 95% compliance is achieved. The results of the monthly audits will be provided to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. **5.** Correction Completion date: 12/29/17	Ongoing

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F 156	Continued From page 4 Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not	F 156		

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F 156	Continued From page 5 limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 156		

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F 156	Continued From page 6 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 156		

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F 156	Continued From page 7 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview for one (1) of 39 Stage 2 sampled residents, the facility staff failed to discuss and review the rights of residents throughout their stay in the facility. Resident #52. Findings included.... During an interview on November 11, 2017, at approximately 11:00 AM, Resident #52 stated "the staff does not talk about or review our rights unless there is a problem, they just don't tell of us our rights as residents." On November 13, 2017, at approximately 1:00 PM, a face-to-face meeting with Employee # 8 stated, "We don't usually discuss resident rights unless there is a concern, then it is addressed, we don't just review their rights." Employee#18 acknowledged the findings at the	F 156		

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F 156	Continued From page 8 time of the interview.	F 156		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 157	1. **Resident # 24** responsible party was notified on November 9th 2017. The Clinical Manager of the unit was counseled for the absence of documentation in the resident's medical record and failure to notify the RP when an allegation of abuse was reported while receiving care from the nursing staff. 2. No other resident was affected by this deficient practice as evidenced by results of the audits of Medical records of all residents with allegations of abuse and grievances. Review of any alleged abuse/grievances will be done by the Director of nursing to ensure compliance with notification of the resident's responsible party. 3. To prevent future occurrences all staff will be re-educated on the facility policy for notification of the RP when there is an allegation of abuse/grievance.	11/9/17 11/9/17 12/29/17

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F 157	Continued From page 9 Resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview for one (1) of 39 sampled residents, the facility failed to notify the resident's Responsible Party (RP) of an allegation of abuse experienced while receiving care from the nursing staff. Resident #24. Findings included ... Resident #24 last admitted to the facility on July 26, 2013, with diagnoses which included Non-Alzheimer's Dementia, Hypertension, Age-related Debility, Cerebrovascular Accident, Seizures and Thyroid Disorder. While conducting a Stage 1 resident interview on November 7, 2017, at approximately 3:00 PM, the surveyor asked; has anyone ever abused you in any way? He responded, "Yes." The resident further stated that "the nurse hit me; it was a long time ago." The roommate interjected and stated, "It was two months ago." The surveyor interviewed Resident #24 roommate about the alleged incident. "I was lying	F 157	Notification of RP will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results will be reported to the Quarterly Quality Assurance Committee meeting by the DON. 5. Correction completion date 12/29/17	Ongoing

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F 157	Continued From page 10 right here in this bed, and I heard him [Resident #24] say, you hit me. Don't hit me" The roommate stated that he reported the incident to the nurse the next day. During a face-to-face interview with Employee #6 at appropriately 3:00 PM on November 7, 2017, Employee #6 initially she acknowledged receiving a report which she interpreted as a complaint and not as an allegation of abuse. According, to Employee #6, the incident occurred sometime during the night shift on September 12, 2017. Resident #24 clinical record lacked documented evidence of the responsible party notification. During the second interview with Employee #6 on November 7, 2017, at approximately 4:00 PM, she acknowledged the failure to notify Resident #24 responsible party of the allegation of abuse.	F 157		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 167		

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F 167	Continued From page 11 certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to make available for examination the most recent survey results. The census in the facility on the first day of the survey was 115 residents. Findings included... On November 6, 2017, at approximately 1:30 PM, the State Agency, Representative observed binders located on the 6th and 7th floor next to the elevators. The binders on each floor contained "The Statement of Deficiencies" dated November 9, 2015, which did not reflect the most recent annual recertification survey results completed on December 5, 2016. There was no evidence that the facility staff made available for examination, the most recent survey results for residents and visitors review. Employee #2 acknowledged the findings during a face-to-face interview on November 6, 2017, at	F 167	1. The location of the survey report was posted on the 6th and 7th floor by the elevator in front of the nursing station **immediately upon discovery.** 2. Revised and typed survey report were permanently posted on the 6th and 7th floor by the elevator in front of the nursing station. 3. To prevent future occurrences staff and residents were reminded of the location of the survey results during quarterly care plan meetings, and will be included in the agenda for family/resident's council meeting. Resident's families and the Resident will be informed of the location of the postings during residents/Family councils meeting. 4. Verification of location of the required postings will be added as a quality indicator on the environment of care rounds and nursing for review during daily stand-up meetings to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the DON and presented at the quarterly Quality Assurance Committee meeting. The QAC will ensure oversight and correction of any identified deficiency. 5. Correction Completion date: 12/29/17	11/6/17 11/6/17 12/21/17 Ongoing

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F 167	Continued From page 12 approximately 3:30 PM.	F 167	5.	
F 168 SS=C	RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES CFR(s): 483.10(g)(10)(ii)(k) (g)(10) The resident has the right to- (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. (k) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to provide residents and visitors the current contact information for the State Agency to facilitate the opportunity for communication. The census in the facility on the first day of the survey was 115 residents.	F 168	1. This deficiency was corrected immediately. Contact information for the State Agency, to facilitate the opportunity for communication to residents and visitors was updated and placed in hallway showcases on the 6th and 7th floors. 2. No other resident was affected by this deficient practice. Revised and typed postings were permanently posted in the hallways on the 6th and 7th floor. 3. To prevent future occurrences residents and visitors were reminded of the location and update of the State Agency by the Social Work and Recreation Departments during the family/resident's council meeting. 4. Verification of location of the required postings will be added as a quality indicator on	11/6/17 11/6/17 12/21/17 Ongoing

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	095039		11/14/2017

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F 168	Continued From page 13 Findings included... On November 6, 2017, at approximately 1:30 PM, signage related to contact information for agencies acting as client advocates was posted on the wall, in the hallway of the facility. The signage posted did not show the correct name of the Program Manager for the Department of Health, Health Care Facilities Division. There was no evidence that the facility staff provided residents and visitors the current contact information for the State Agency. Employee #2 acknowledged the findings during a face-to-face interview on November 6, 2017, at approximately 3:30 PM.	F 168	(#4 Cont'd) the environment of care rounds and as a nursing quality indicator for review during the daily stand-up meetings to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the Social Work and Recreation Departments and presented at the quarterly Quality Assurance Committee meeting. The QAC will ensure oversight and correction of any identified deficiency. 5. Corrective Action Completion date: 12/29/17	Ongoing
F 170 SS=D	RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL CFR(s): 483.10(g)(8)(i)(9)(i)-(iii)(h)(2) (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.	F 170		

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F 170	Continued From page 14 (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on a resident and staff interviews for one (1) of 39 Stage 2 sampled residents, the facility staff failed to deliver mail to residents when there is regularly scheduled postal delivery to the facility. (Resident #52) Findings included... During an interview on November 11, 2017, at, approximately 11:00 AM, Resident #52 stated, "We don't get mail on Saturdays. I know that I don't get mail and there are a couple of other residents that I know of that don't get mail either." On November 13, 2017, at approximately 1:00 PM, during a face-to-face interview with Employee# 18 stated, "This has been an ongoing problem at the facility. If my assistants are not here, the residents do not get their mail. Yes, my staff work on Saturdays but if they do not come to the floor, no one wants to accept responsibility for the resident's mail, so the residents get their mail delivered on Monday, and currently there is no process in place."	F 170	1. Saturday mail delivery resumed on November 18th The Director of Therapeutic Recreation was reeducated on the regulatory requirement and facility responsibility for delivery of mail to residents. 2. Mail is being delivered to residents in a timely manner by the staff of the recreation department (Monday-Saturday). Recreation aides assigned to weekday and weekend coverage will deliver resident's mail within 24hrs of receipt by the facility. The Director of Recreation will ensure mail delivery. 3. To prevent future occurrences, recreation department staff was re-educated regarding the regulatory requirement for delivery of mail to residents to ensure compliance. The Director of Therapeutic Recreation/designee will monitor mail delivery to ensure compliance. 4. Resident mail delivery will be added as a recreation therapy quality indicator to ensure compliance.	11/18/17 11/9/17 Ongoing Ongoing

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F 170	Continued From page 15 Employee#18 acknowledged the findings at the time of the interview.	F 170	The Director of Therapeutic Recreation will present the results of the monitoring monthly to the Assistant Administrator until three consecutive months of greater than or equal to 95% compliance is achieved and to the quarterly Quality Assurance committee. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	F 225		

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F 225	Continued From page 16 including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 Stage 2 sampled residents, facility staff failed to report an alleged abuse to the State Agency. Resident #24. Findings include ...	F 225	1. **Resident #24** incident of alleged abused was reported to the state agency on November 9th 2017 The clinical manager of the unit was counseled after the surveyor visit regarding the identified absence of staff's failure to report the alleged abuse to the state agency 2. No other resident was affected by this deficient practice as evidenced by audit results of all Medical records of residents with allegations of abuse to ensure that it was reported to the state agency. 3. To prevent future occurrences, all staff, including nursing leadership, licensed nurses, CNAs, Social Work and Recreation Therapy, was re-educated, on the facility policy for notification of the state agency when there is an allegation of abuse to ensure compliance. 4. Abuse allegations/investigation will be added as a nursing quality indicator to ensure compliance. Compliance monitoring will be done by the DON/designee. Results of the audits will be reported to the Assistant Administrator monthly and presented at the quarterly Quality Assurance committee meeting.	11/9/17 11/12/17 12/5/17 and ongoing Ongoing

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F 225	Continued From page 17 22 District of Columbia Municipal Regulations 3232.4 stipulates, "Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence." During a Stage 1 Resident interview at approximately 3:00 PM on November 7, 2017, Resident #24 informed this writer that a CNA hit him on his arm while providing his care. The resident was unable to confirm the date or time of the incident. However, the resident's roommate (Resident #127) stated the alleged incident occurred approximately two (2) months ago. A review of the "Resident Concern/Complaint Form" dated September 12, 2017 revealed "The nurse reported to this worker (social worker, Employee #10) that a certified nurse aide (CNA) had hit his roommate last night." During a face-to-face interview with Employee #6, 7th floor Unit Manager at approximately 5:30 PM on November 7, 2017, Employee #6 stated she was aware that a resident alleged he was hit by a CNA. The employee responded, "A few months ago the Social Worker investigated a concern from the resident." During a face-to-face interview with Employee #11 at approximately 5:40 PM on November 7, 2017, Employee #11 stated she received the	F 225	The QAC will ensure oversight and correction of any identified deficiencies. Corrective action completion date: 12/29/17.	Ongoing

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F 225	Continued From page 18 complaint from the resident's roommate and forwarded it to the Social Worker and her Supervisor. She stated Resident #24 did not identify the location where he was hit. The employee admits that she did not assess the resident's body for injuries and made no documentation in the resident's clinical record. Her responsibility as she understood it was to collect the information about the complaint and pass it on to her supervisor. She did not initiate an incident report or call the Responsible Party to report the allegation. During a subsequent face-to-face interview with Employee #2 at approximately November 7, 2017 at 6:02 PM, the Employee acknowledged reporting the incident as a complaint. The employee stated they interviewed Resident #24 and asked if he remembered somebody hitting him. The resident was unable to tell what day it happened. He said the person tapped him because he was not doing what she asked. Also, Employee #2 stated the facility did not notify the State Agency. Facility staff failed to report an allegation of abuse of a resident by the facility staff to the State Agency. Employee #2 acknowledged the finding.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and	F 226		

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F 226	Continued From page 19 exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 39 Stage 2 sampled residents, facility staff failed to report an alleged abuse to the State Agency in accordance with the facility policy for one (1) Resident #24. Findings include ... Facility Policy: "Resident abuse, neglect,	F 226	1. **Resident # 24**- RP was notified on November 9th 2017. The Clinical Manager of the unit was counseled for the absence of documentation in **Resident# 24's** medical record and failure to notify the RP when an allegation of abuse was reported while receiving care from the nursing staff. 2. No other resident was affected by this deficient practice as evidenced by audits of all Medical records of residents with allegations of abuse to ensure compliance. 3. To prevent future occurrences, In-service training will be provided to all staff regarding the facility policy on notifying the RP when there is an allegation of abuse identified. 4. Notification of RP will be added as a nursing quality indicator for review during the daily stand-up meetings to ensure sustained compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results will be reported to the Quarterly Quality Assurance Committee meeting by the DON. 5. Completion date: 12/29/17	11/9/17 11/9/17 Ongoing Ongoing

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F 226	Continued From page 20 exploitation and misappropriation of property" Policy Number SNS 51, effective updated 11/5/15 stipulates: "All incidents of possible abuse, neglect, or mistreatment, including injuries that suggest abuse, neglect, or mistreatment of a resident, will be reported as soon as reasonably practicable, to the administrator, director of nursing or their designees. An "Occurrence Report" will be completed consistent with the policies and procedures to occurrence reports. The administrator and Director of Nursing will determine whether the information contained in the Occurrence Report warrants suspicion of abuse and if so require notification and investigation of the incident consistent with Corporate Policy and Procedure, regulatory Agencies and with applicable legal obligations. Reporting Suspected Abuse: If the Administrator or Director of Nursing determine that abuse is suspected, they or their designee must: Immediately report the case of suspected abuse to the appropriate jurisdictional authorities; License Regulatory Agency, Ombudsman Office. Treating Suspected Abuse: Residents who are the suspected object of abuse, neglect or mistreatment should: Be physically examined immediately by a Registered Nurse to determine whether the resident has suffered symptoms of physical harm."	F 226		

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F 226	Continued From page 21 During a Stage 1 Resident interview at approximately 3:00 PM on November 7, 2017, Resident #24 informed this writer that a CNA hit him on his arm while providing his care. The resident was unable to confirm the date or time of the incident. However, the resident's roommate (Resident #127) stated the alleged incident occurred approximately two (2) months ago. A review of the "Resident Concern/Complaint Form" dated September 12, 2017 revealed "The nurse reported to this worker (social worker, Employee #10) that a certified nurse aide (CNA) had hit his roommate last night." A face-to-face interview was conducted with Employee #6, 7th floor Unit Manager at approximately 5:30 PM on November 7, 2017. Employee #6 was asked whether she was aware that a resident alleged he was hit by a CNA. The employee responded, "A few months ago the Social Worker investigated a concern from the resident." A face-to-face interview was conducted with Employee #11(the nurse assigned to the resident) at approximately 5:40 PM on November 7, 2017. Employee #11 stated she received the complaint from the resident's roommate (Resident #127) and forwarded it to the Social Worker and her Supervisor. She stated [Resident #24] did not show her where he was hit. The employee admits that she did not assess the resident's body for injuries and made no documentation in the resident's record. Her responsibility as she understood it was to collect the information about the complaint and pass it on to her supervisor.	F 226		

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F 226	Continued From page 22 She did not initiate an incident report or call the RP to report the allegation. A face-to-face interview was conducted with Employee #2 at approximately 6:02 PM on November 7, 2017. The employee acknowledged that the report was initiated as a complaint. The employee stated they interviewed [Resident #24] and asked if he remembered somebody hitting him. The resident was unable to tell what day it happened. He (Resident #24) said the person tapped him because he was not doing what she (Employee #12) asked. Employee #2 was asked whether the allegation that a CNA hit Resident #24 was ever sent to the State. Employee #2 stated, "No." Facility staff failed to report an allegation of possible abuse of a resident by a CNA to the State Agency in accordance with the facility policy. Employee #2 acknowledged the finding.	F 226		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews for six (6) of 39 Stage 2 sampled residents, the facility staff failed to respect residents' dignity while dining as evidenced by:	F 241		

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F 241	Continued From page 23 three (3) residents' sat idle while others at the same table ate their meal, failed to provide one (1) resident dignity by standing and feeding him, and failed to provide one (1) resident dignity by placing a dirty tray on the table while he dined. Also, one (1) resident was observed sitting in the rehabilitation area wearing glasses with a missing lens. Residents' #43, #46, #58, #89, #100, and #132. Findings included... 1. Facility staff failed to provide dignity by allowing Resident #43 to sit idle while others dined at the same table. During a dining observation on the sixth floor on November 6, 2017, at approximately 1:00 PM. Resident #43 sat at a table eating her lunch with her family present. At the same table, Resident # 89 sat idly without any lunch tray. At approximately 1:10 PM, Employee #13 asked why Resident #89 did not have a lunch tray. Employee #13 replied, "He usually eats on the 7th floor." Resident #89 was then removed from the sixth-floor dining room and taken to the seventh-floor dining room for lunch. 2. Facility staff failed to provide Resident #100 dignity by standing and feeding him. During a dining room observation on the sixth floor on November 8, 2017, at approximately 11:45 AM showed Resident #100 seated while Employee #14, CNA stood over Resident #100 while assisting him to eat.	F 241	**Residents #43, #46, #58, #89** **1. Resident #43-** was served her lunch immediately. **Resident #46-** meal tray was immediately served. **Resident #58-** meal tray was served immediately, **Resident # 89** was immediately removed to the 7th floor, and was served lunch. The involved employees were counseled for failure to respect residents 'dignity by allowing them to sit idle while others were dining and for not redirecting resident to dining area on another floor. **Resident #100** – the dirty tray was removed immediately. The involved employee was counseled for failure to respect residents' dignity by standing while feeding and placing a dirty tray on table while the resident dined. **Resident #132-** the glasses were removed and resident has been scheduled for eye appointment with the ophthalmologist. 2. No other residents were affected by these deficient practices as evidenced by rounds being made by clinical managers/designee to ensure that all staff assigned to the dining room,	11/6/17 11/6/17 11/6/17 12/19/17 Ongoing

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F 241	Continued From page 24	F 241	during meal times are treating residents with dignity and respect, serving residents at the same time, and assisting them with meal consumption.	Ongoing
	3. Facility staff failed to provide dignity by allowing Resident #46 to sit idle while others dined at the same table. On November 8, 2017, at approximately 12:00 PM, a dining observation on the 6th floor occurred. During this time, Resident #102 was eating her lunch tray while Resident #46 sat idly at the same table without a lunch tray. Resident #46's lunch tray arrived at 12:07 PM.		Additionally, all residents wearing eyeglasses were identified to ensure proper fit and no missing pieces.	11/9/17
	4. Facility staff failed to provide Resident #100 dignity by placing a dirty tray on the table while he dined. On November 8, 2017, at approximately 12:40 PM, a dining observation on the 6th floor occurred. During this time, Employee #15, CNA picked up a dirty tray from another resident's table and placed the dirty tray across from Resident # 100 who was still eating his lunch. These observations were shared with Employee #7 on November 8, 2017, at 1:00 PM and she acknowledged the findings.		3. To prevent future occurrences, all nursing staff were in serviced on the provision of care that enhances dignity and respect while assisting residents during meal consumption to ensure compliance. Clinical managers/designee will monitor/observe the dining room daily during meal times to ensure that staff are assisting residents consume their meals and that they are served at the same time to promote enhanced dignity and respect.	12/10/17 and ongoing
	5. During a dining observation, facility staff failed to respect one (1) resident's dignity when serving his lunch meal on November 6, 2017. Resident #58 An observation on November 6, 2017, at approximately 11:55 AM revealed Residents #58, and #63 seated at a dining table together. The		Nursing management and social workers will monitor the ophthalmology appointment logs on each unit daily	Ongoing

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F 241	Continued From page 25 facility staff served Resident #63 lunch. However, Resident #58 did not receive a lunch tray at that time. At approximately 12:03 PM, eight minutes later, an employee approached Resident #58 ' s table with a tray and stated, "Here is your lunch." Resident #58 ' s lunch tray was given to him when Resident #63 sat at the table with him was finished eating his lunch. During a face-to-face interview on November 6, 2017, at approximately 12:55 PM with Employee #6. She acknowledged the finding and stated, "Staff knows better. We will in-service them." 6. Facility staff failed to promote care for a resident in a manner that maintains or enhances the resident's dignity. Resident #132. On November 13, 2017, at approximately 10:05 AM, there was an observation of Resident #132 sitting in the physical rehabilitation area of the facility wearing glasses with a missing left lens. A resident interview on November 13, 2017, at approximately 10:10 AM revealed, "I told them that I had the hundred dollars for the glasses but they never told me when I was supposed to go to the eye doctor and I spent the money, see the lens is missing, I need my glasses because I can't see close up it looks blurry." A face-to-face interview with Employee #7 [Nursing Supervisor] on November 13, 2017, at approximately 11:30 AM, "I know he had an eye doctor appointment, but I think it was missed, and	F 241	In service was provided to all staff to ensure identification of any resident with missing lens/parts, reporting and scheduling ophthalmology appointments for replacement of glasses. 4. Meal time observation and coordination of resident treatment, devices and/or services will be added as nursing quality indicators to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. The DON will report the results of these monitoring/audit reviews to the Assistant Administrator monthly and present with any action plan for improvement to the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Completion date: 12/29/17	12/5/17 Ongoing

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F 241	Continued From page 26 the social worker would know more about it." On November 13, 2017, at approximately 12:15 PM, during a face-to-face interview with Employee #10 [Social Worker], she states, "Yes, he was scheduled for an eye appointment, but his insurance would not cover the full amount, the resident would be responsible for 20 %, so the appointment was canceled, we need to reschedule the appointment." Employees # 7 and #10 acknowledged the findings.	F 241		
F 244 SS=E	LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION CFR(s): 483.10(f)(5)(iv)(A)(B) (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on a resident interview and record review of (one) 1 of 39 sampled residents, the facility staff failed to act upon resident grievances and concerns regarding care and life at the facility.	F 244	1. Resident Council meeting minutes for August, September and October were provided to the Administrator for review and response/ follow-up on any grievances/complaints that needed to be addressed with residents. Policy for Cell phone use and providing assistance to residents in a timely manner as well as not using resident sitting area as a breakroom were addressed in a staff meeting. 2. No other resident was affected by this deficient practice. All Resident/family satisfaction surveys will be conducted to identify concerns and grievances. Management will provide a response and rationale for such response within seven (7) days of receipt.	11/9/17 11/30/17 Ongoing

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F 244	Continued From page 27 Resident # 52. Findings included..... On November 11, 2017, at approximately 10:00 AM a review of the resident council meeting minutes (permission obtained to review) and Resident interview #52, reveal ongoing resident concerns of, staff talking on their cell phones while providing care, waiting for long periods of time for staff assistance and staff using the resident day sitting area as a breakroom. On November 11, 2017, at approximately 11:00 AM an interview with Resident #52 stated "there are ongoing issues in the facility. We talk about it month after month. The issues are all written in the minutes. Only if a problem is observed the staff is counseled on the spot, but for the widespread issues we have to really push staff to get an answer." On November 13, 2017, at approximately 1:00 PM a face-to-face interview with Employee #18 who stated "yes there are ongoing issues and I discuss the issues and concerns at in-services and stand-up meetings with department heads. I will check to see if there is a record of the meetings." Upon further review, there was no documented evidence of the said meetings and or evidence of the facilities actions in response to the resident's grievances regarding the care and life at the facility. Employee#18 acknowledged the findings at the time of the interview.	F 244	3. To prevent future occurrences, the Resident Council president will send an invite when Administrator or another Department is requested to attend. Administrator/Department will also request a meeting with residents to provide updates as needed. Issues related to specific departments will be forwarded for timely resolution. The Therapeutic Recreation and Social Work departments will be re-educated on addressing resident/family grievances and concerns and providing timely feedback/resolution. 4. Audits of resident/family grievances, concerns and resident satisfaction surveys will be added as Social Work and Therapeutic Recreation quality indicators to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17.	Ongoing 11/13/17 Ongoing

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F 246 F 246 SS=D	Continued From page 28 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, for one (1) of 39 Stage 2 sampled residents, it was determined that facility staff failed to ensure that Resident #24 received regular showers. Findings include... During a Stage 1 interview on November 7, 2017 at approximately 3:00 PM, Resident #24 was asked whether he chose how many times a week he gets a bath or shower. The Resident responded, "They wash me up in the bed. I would like to get some showers. I don't get any." During a face-to-face interview with Employee #6 at approximately 10:00 AM on November 8, 2017, the employee stated that each resident receives at least two showers each week and that all of the showers were documented in a binder.	F 246 F 246	1. **Resident #24** received a shower on 11/6/17 and is scheduled to receive two showers weekly. 2. Shower and personal care schedules were revised with resident input to ensure their preferences are honored. Any identified issues/concerns were addressed. ADL's/personal care will be included in care plan discussions with residents and families. 3. To prevent future occurrences, staff will be re-educated on treatment of residents with dignity and respect and accommodation of their needs and preferences. The clinical manager/designee is monitoring shower/bath documents and randomly observing showers to ensure that schedules are followed.	11/6/17 11/7/17 12/10/17 Ongoing

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F 246	Continued From page 29 The resident's shower sheets were requested on November 13, 2017. The facility provided two (2) sheets for November 10, 2017 and November 11, 2017. According to the documentation the Resident did not receive a shower on either day. Bed baths were documented as given. This writer also reviewed the binder in which the shower sheets are kept, no additional shower sheets were found for the resident. Facility staff failed to ensure that Resident #24 received regular showers. Employee #2 was informed of the finding. Based on resident interview and isolated observation for 1 of 39 sampled residents facility staff failed to provide services with reasonable accommodation of individual needs by not responding with timeliness to a call bell for assistance. Findings included... On November 7, 2017, at approximately 9:30 AM a Resident interview reveal the following response" I have to wait a long time for assistance especially on weekends, they don't have enough help. " On November 7, 2017, at approximately 9:40 AM, Resident #141 pressed the bedside call button for assistance, and an audible alarm could be heard coming from the nursing station, a red light illuminated from the wall unit. The Resident interview continued, and after ten minutes the	F 246	4. Monitoring of showers will be added as a quality indicator to the daily stand-up meeting to ensure compliance until 3 consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator monthly by the DON who will also present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing

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F 246	Continued From page 30 resident states "look someone turned off the call bell, the call box is not lit anymore." Upon observation, the call bell wall unit was no longer illuminating, and the Resident was observed to press the call light again. An audible alarm sounded at the nursing station, after five minutes Resident #41, is in a wheelchair and states "the unit clerk told me to tell you to turn off the call light.I am his roommate, and the clerk at the front desk told me to tell you to turn off the light." At no time during the Resident interview (15 minutes) did staff respond to the call light or enter into the Resident's room to provide assistance. On November 7, 2017, at approximately 10:00 AM a face-to-face interview with Employee# 19, Unit Clerk, stated "yes, I told his roommate to tell the person in the room to turn off the light, he told me someone was in the room I did not know it was you the surveyor. I thought it was the CNA because a lot of the time it is them in the room and they don't turn off the call light." Employee # 7, Nursing Supervisor, stated " you should have said something all of the staff around here someone would have gone into the room, we answer call lights around here this is nothing new." The nursing supervisor directed staff to the resident's room. Employee # 7 stated "when the call bell alarms at the nursing station the staff usually answer, but that did not happen this time." Employees # 7 and #19 acknowledged the findings.	F 246	**Resident #141**- call light was answered. Employee #7 was immediately counseled regarding the requirement for prompt response to the call-bell. 2. No other resident was affected by this deficient practice 3. To prevent future occurrences, all staff was inserviced on timely response to call lights. The DON and Unit Managers will be monitoring and follow-up as needed to ensure timeliness of response and compliance. 4. Monitoring of call light response time will be added as a nursing quality indicator to ensure compliance. Results of the audits will be reported monthly to the Assistant Administrator by the DON and presented quarterly at the Quality Assurance committee meeting. The QAC will ensure oversight and correction of identified deficiencies 5. Corrective Action completion date: 12/29/17	11/7/17 11/7/2017 11/9/17 Ongoing

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F 253 F 253 SS=D	Continued From page 31 HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on an observation on November 8, 2017, at approximately 10:00 AM, the facility staff failed to provide housekeeping and maintenance services necessary to maintain the Resident's room in a sanitary, orderly, and comfortable manner, in four (4) of four (4) observations, as evidenced by: a stained curtain that served as a room divider, wrinkled sheets and no spread on Resident #24's bed, dusty bed rails and frame and dust and tiny deceased insects in the over bed light . Findings include... During a tour of Resident # 24's room on November 8, 2017, at approximately 10:00 AM, the follwing were observed; one (1) of one (1) stained privacy curtain that served as a room divider one (1) of one (1) set of wrinkled sheets and no spread on the Resident 's bed one (1) of one (1) bed with dusty bed rails and frame one (1) of one (1) over-the-bed light contained tiny deceased insects The observations made in the presence of	F 253 F 253	1. **Resident #24** was not harmed by the deficient practice. The stained privacy curtain was replaced. A spread has been placed on the residents' bed and the wrinkled sheets were replaced. The bed with dusty bed rails and frame was cleaned. The over the bed light that contained tiny deceased insects has been removed and cleaned. 2. The Director of Environmental Services will make rounds on all resident rooms to ensure that a sanitary, orderly and comfortable interior is maintained. 3. To prevent future occurrences, all environmental services staff has been re-educated on the 10-step cleaning process, to ensure compliance. 4. Resident Room observation is an Environmental Services quality indicator that will be used to ensure compliance.	11/8/17 Ongoing 11/8/17

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F 253 F 280 SS=D	Continued From page 32 Employee #6 at approximately 11:00 AM on November 9, 2017, were acknowledged. RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 253 F 280	4. (cont'd) Results of the audits will be reported to the Assistant Administrator and presented by the Director of Environmental Services at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing

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F 280	Continued From page 33 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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.	F 280	1. The care plan for **Resident #122** was revised to include goals and approaches for the resident non-compliance with medication treatment plan. 2. No other residents was affected by this deficient practice. Medical records of all residents refusing or non-compliant with medication treatment plan were audited to ensure a corresponding care plan is included for resident non-compliance with his/her medication treatment plan 3. To prevent future occurrence, the IDT team were re-educated on care plan updates as they relate to resident non-compliance with plan of care.	11/7/17 11/7/17 11/9/17

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F 280	Continued From page 34 (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 record review and staff interview for one (1) of 39 sampled stage 2 residents, the facility staff failed to review/revise the care plan to include goals and approaches for the management of Resident # 122, noncompliant with medication treatment plan. Finding include... A review of the resident's nursing progress notes revealed Resident #122 refused Sertraline 150 mg one (1) daily for depression on July 13, 2017 and refused Depakote 500 mg two (2) times daily on July 24, 2017. The clinical record lacked evidence that staff updated the care plan to incorporate measures to manage episodes of medication treatment plan noncompliance. Employee #1 acknowledged the findings during a face-to-face interview conducted on November 14, 2017, at approximately 11:00 AM.	F 280	4. Audits of care plan updates for resident noncompliance will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans	F 281		

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F 281	Continued From page 35 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview of one (1) of 39 Stage 2 sampled residents, the facility staff failed to check gastrostomy (G-tube) placement prior to administration of medication; and administer eye drops in accordance with accepted professional standards of quality during Medication Administration for Resident #54. The findings include: 1. Facility staff failed to check G-tube placement prior to administration of medication in accordance with accepted professional standards of quality during Medication Administration Observation for Resident #54. According to The Lippincott Manual of Nursing Practice, Seventh Edition, "To check for tube patency and position remove the cap or plug from the feeding tube and use the syringe to inject 5 to 10 cc of air through the tube. At the same time, auscultate the patient ' s stomach with the stethoscope. Listen for a whooshing sound to confirm tube positioning in the stomach. Also, aspirate stomach contents to confirm tube patency and placement," (p. 1463). During medication administration observation on	F 281	1. **Resident #54** was observed and not harmed by this deficient practice. A medication error incident report was completed. The involved nursing employee was re-educated regarding failure to check gastrostomy G-tube placement prior to administration of medication and administering eye drops in accordance with accepted professional standards. 2. Med pass observations of staff were conducted during administration of eye drops and medication via gastrostomy G-tube to ensure administration in accordance with accepted professional standards. 3. To prevent future occurrence, all medication nurses were re-educated to ensure administration of eye drops and medication via G-tubes in accordance with accepted professional standards and to ensure compliance.	11/7/17 11/7/17 11/9/17

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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 281	Continued From page 36 November 6, 2017, at 9:40 AM, Employee #26 checked for residual by placing 10 cc syringe into the G-tube, pulling back on the plunger with no residual noted. Employee #26 administered these medications to Resident # 54 via the G-tube: Thorazine 50mg [anti-psychotic -mental mood disorder], Loratadine 10mg [Antihistamine - allergy symptom], Magnesium Oxide 400mg, Folcaps [folic acid/vitamin B6/B12] one (1) capsule, Potassium Chloride 20mcq/15ml (30ml) [mineral supplements], and Lactulose 30ml [constipation] via G- tube. Employee #26 failed to auscultate the patient ' s stomach with the stethoscope and listen for a whooshing sound to confirm tube positioning in the stomach and to check for G-tube placement prior to the medication administration. 2. Facility staff failed to administer eye drops in accordance with accepted professional standards of quality during medication administration observation for Resident #54. "Place the back of your thumb against the forehead, above the eye receiving the drop Tilt head backward with both eyes open, and look at a point on the ceiling. Pull lower lid down gently to form a pocket for the drop. Position the tip of the eye drop bottle so that it does not come closer than ¾ inch above your lower lid. Squeeze the bottle lightly to allow the drop to fall into the pocket. 10. Close eyes without squeezing them. Keep your eyes closed, and gently blot them with a clean tissue. With eyes closed, gently press on the inner part of the eye for 30 seconds. This keeps the medication in contact with the eye longer." clinicalcenter.nih.gov/ccc/patient_education/pepu	F 281	4. Monitoring of administration of medication via G-tube and eye drops will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported to the Assistant Administrator by the DON who will also present at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	095039		11/14/2017

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F 281	Continued From page 37 bs/eyedrops.pdf During medication administration observation on November 6, 2017, at 9:40 AM, Resident #54 was already lying in bed. Employee #26 was observed to pull on his upper eyelids one at a time, squeezed the eye drops medication bottle, Resident #54 eye drops missed the eyes and ran down his cheeks. A face-to-face interview conducted with Employee #6 and Employee #26 on November 6, 2017, at approximately 9:55 AM. Employee #6 listened to the concerns presented and acknowledged the findings by reporting that staff is a new graduate we will educate her.	F 281		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interview for two (2) of 39 Stage 2 sampled residents, facility staff failed to assist one (1) resident to maintain appropriate grooming; and failed to ensure one (1) resident who was unable to carry out their own activities of daily living receive incontinent care. Residents' #39 and #115. Findings include ...	F 312	**1. Resident #39** had his clothes changed. 2. Clothes of all residents was inspected for stains and holes. Any identified issues were addressed. 3. To prevent future occurrences and to ensure compliance, staff will be re-educated on performance standards for assisting residents with ADLs. The clinical manager/designee is monitoring shower/bath documentation, schedules and grooming. ADL's and personal care will be included in care plan discussions with resident and families. 4. Monitoring of resident grooming, shower documentation, schedules will be added as a nursing quality indicator	11/9/17 11/9/17 12/5/17 Ongoing

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F 312	Continued From page 38	F 312	to ensure compliance. Results of the audits will be reported by the DON to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17.	Ongoing
			1. Resident #115's room has been cleaned, waxed and disinfected. 2. All resident shower schedules were reviewed to ensure that residents' preferences are honored.	11/7/17
			3. To prevent future occurrences, a resident focus meeting was held with the CNAs re: grooming, shower schedules and incontinence care to ensure compliance.	12/5/17
			4. Incontinence care will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly, by the DON, to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will have oversight and correction of identified deficiencies. 5. Corrective action completion date: 12/29/17	Ongoing

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F 312	Continued From page 39 dependent on staff for personal hygiene and bathing. Under Section H: Bladder/Bowel, the resident was coded as always incontinent of urine. Facility staff failed to ensure that Resident #115 received personal hygiene consistent with the resident's needs. During an interview with Employee #2 at the time of 4:15 PM observation. The Employee acknowledged that the resident's incontinent brief was urine soaked and the room smelled of urine.	F 312		
F 313 SS=D	TREATMENT/DEVICES TO MAINTAIN HEARING/VISION CFR(s): 483.25(a)(1)(2) (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview for one (1) of 39 sampled residents facility staff failed to ensure resident receive proper treatment and assistive devices for vision by failing to reschedule an eye appointment.	F 313		

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F 313	Continued From page 40 Findings included.... On November 13, 2017, at approximately 10:05 AM a resident interview reveals, "They were supposed to make an eye appointment for me, I had the hundred dollars for the glasses, but I spent it, I can't see close up because it's blurry." On November 13, 2017, at approximately 10:30 AM a clinical record review reveal a verbal order with a date of September 4, 2017, appointment scheduled for opth [opthamology] on September 5, 2017, at 9:30 am. On November 13, 2017, at approximately 11:00 AM, a review of the Minimum Data Set [MDS] with a date of August 26, 2017, under Section B 1200 [Corrective lenses (contacts, glasses, or magnifying glass)] the allocated space has a number 1 which indicate Yes. A further review of the record indicate a daily progress note with a date of September 15, 2017, reads "resident missed appointment today because the insurance said he need to pay 20% out of his pocket." On November 9, 2017 at approximately 11:00 AM, a face-to-face interview with Employee# 21, stated that " I make all of the appointments and follow-up appointments, I schedule the appointments two days before so that they can run the insurance, in the resident's case he needed to pay 20% and the appointment was canceled we told his daughter but I did not reschedule another appointment" A face-to-face interview with Employee# 10 [social worker] on November , 2017, at	F 313	1. **Resident #132** has a scheduled Eye appointment. 2. No other resident was affected by this deficient practice. The facility has audited all resident records with vision issues requiring intervention. Appropriate consults will be requested per audit findings. Nursing management, DON, clinical managers, social workers and supervisors will review the ophthalmology appointment logs on each unit daily. 3. To prevent future occurrences nursing staff will be in-serviced regarding vision services, how to obtain consults and coordination of family/resident requests for consultation to attending physicians to ensure appointments are made and residents attend the consults. 4. Coordination of resident treatment, devices and/or services required to maintain hearing/vision will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved.	1/12/18 11/20/17 Ongoing 12/10/17

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F 313	Continued From page 41 approximately 11:30 AM stated that "yes, he was scheduled for an eye appointment, but his insurance would not cover the full amount, the resident would be responsible for 20 %, so the appointment was canceled, we did not reschedule the appointment." Employee #10 acknowledged the findings at the time of the interview	F 313	The audits will be conducted by the unit managers weekly. Results of the audits will be reported monthly to the Assistant Administrator by the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies 5. Corrective action completion date: 12/29/17.	Ongoing
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 39 sampled residents, the facility staff failed to ensure that residents were free from physical abuse as evidenced by Residents' #23 and 101 who experienced one (1) occasion of physical abuse by Resident #122. Findings include... Resident # 122 was admitted to the facility on June 22, 2017. According to the history and physical dated June 23, 2017, Resident #122 has the following diagnoses: exacerbation of multiple sclerosis, bipolar disorder, insomnia, chronic pain disorder, schizoaffective disorder with psychotic features, and narcissistic personality disorder. Review of the medical record on November 14, 2017, showed Resident #122 had altercations with two (2) residents, one on August 14, 2017, and another on November 7, 2017. 1. Facility staff failed to keep the Resident #23 free from abuse when Resident #23 had coffee" thrown in her face by Resident # 122 on August 14, 2017, at 2:50 PM during activities in the common day room. A review of the medical record on November 14, 2017, revealed the following: Nurse's progress note entry, August 14, 2017, at	F 323	1. **Resident# 23 and #101-** An incident report was completed regarding the reported resident to resident physical abuse by **Resident #122**. 2. **Resident #122's** behavior is being monitored by the nursing staff and when behavior has changed, the attending physician is notified, as well as the psychiatrist for evaluation. 3. To prevent future occurrences, in-service training was provided to all department heads and all nursing staff. Daily review of reported resident to resident altercations will be conducted at the daily stand-up meeting to ensure that reported resident to resident altercations have a corresponding incident report on file, and are care planned with appropriate approaches. Efforts to Identify outside resources will continue to identify possible solutions	8/14/17 Ongoing 12/5/17 On-going

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F 323	Continued From page 43 2:50 PM, " At approximately 2:50 PM while participating in activities with fellow residents and an activity staff member, coffee was poured on resident by one of the fellow residents." A review of the Care Plan section of Resident #23 ' s clinical record revealed no evidence of interventions to address the altercation which occurred on August 14, 2017. A face-to-face interview was done on November 13, 2017, at 10:00 AM with Resident #23. When questioned about the incident, she stated, "I was shocked when [Resident #122] threw the coffee in my face because I told [Resident #122] that he does not live on this floor. I was glad the coffee was cold. [Resident #122] did apologize to me and I don't feel afraid of [Resident #122]." A review of the clinical record lacked evidence that facility staff implemented interventions to ensure that Resident #23 was free from future physical altercations. A face-to-face interview was conducted with the Employees' #1, #2, and #3, on November 14, 2017, at approximately 11:00 AM. When questioned, they acknowledged there were no interventions in place to prevent future occurrences of this incident. 2. Facility staff failed to keep the Resident #101 free from abuse when he had water" thrown in his face by Resident # 122 November 7, 2017, at 3:40 PM during activities in the common day room on the 6th floor.	F 323	(#3 cont'd) Discharge planning for **resident #122** is ongoing Resident is seen by the psychiatrist monthly and as needed for impulsive/aggressive behavior. To ensure safety for other residents and to address resident's sporadic behavior: Staff has been assigned to monitor dayroom. Hourly rounding will be conducted by unit staff to identify resident location and activity. Unit Staff is also assigned to monitor Healing Garden. Security monitors the front entrance of the building, closely monitors via camera, the areas that resident frequents for quick response (CEO's office, Administrator's office, front entrance of the building, healing garden and unit). Security also frequently rounds on the unit to identify unusual activity. A standing MD order will be written for refusal of medication. Unit Manager/designee and Director of Recreation Therapy/designee are to be notified. Resident will then be redirected from group therapy to an	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing

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F 323	Continued From page 44 A review of the medical record on November 14, 2017, revealed the following: Nurse's progress note entry, dated November 7, 2017, showed the facility staff entered the day room at about 3:40 PM where Resident # 101 and Resident #122 engaged in a verbal altercation and Resident #122 poured drinking water onto Resident #101. A review of the Care Plan section of Resident #101 and Resident #122's clinical records revealed no evidence of interventions to address the altercation, which occurred on November 17, 2017. During an interview with Resident #101 on November 13, 2017, at 10:00 AM, the resident stated, Yes, [Resident #122] poured the water, but I'm okay and don't have a problem with him and I'm not afraid of him. A review of the clinical record lacked evidence that facility staff implemented interventions to ensure that Resident #101 was free from future physical altercations with Resident #122. During a face-to-face interview with the Employees' #1, 2, and, 3 on November 14, 2017, at approximately 11:00 AM, they acknowledged there were no interventions in place to prevent future occurrences of this incident.	F 323	individually structured activity in the Healing Garden. This Plan has been discussed with resident, who has agreed. Signed agreement will be placed in medical record. The Director of Recreation Therapy /designee will meet with resident daily to identify any concerns/needs Resident will be referred to anger management class 4. Behavior monitoring of residents with challenging behaviors will be added as a nursing quality monitor for review at daily stand up meetings to ensure that all residents are free from physical abuse from other residents and to ensure compliance. Results of the audits will be reported monthly to the Assistant Administrator by the DON who will also report to the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	Ongoing
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3)	F 371	5. Corrective action completion date: 12/29/17	

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F 371	Continued From page 45 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to store foods under sanitary conditions as evidenced by: (1) of (1) wrapped beef tenderloin was stored beyond the expiration date; (1) of (1) undated wrapped boneless pit ham and (1) of (1) turkey breast was undated; (1) of (1) container of squid storage beyond expiration date, (1) of (1) undated wrapped meat and (1) of (1) piece of unwrapped frozen biscuit inside reach-in freezer. Also, in the dry storage area, (1) of (1) box of thickened apple juice had an expired date and (2) of (2) boxes of Similac soy isomil infant formula was stored beyond the expiration date.	F 371	1. No resident was harmed by this deficient practice. All food not stored under sanitary conditions was removed 2. The leadership team is conducting weekly documented visual inspections to ensure safety and sanitation 3. To prevent future occurrences, staff will be in-serviced and trained on proper storage, dating & labeling of food items to ensure compliance. This training will also address expiration dates, how and when to discard these items. The Leadership team will monitor through weekly documented inspections. 4. Storage of foods under safe and sanitary conditions will be added as a dietary quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly to the Assistant Administrator by the Director/designee and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure	11/9/17 Ongoing 12/29/17 Ongoing

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F 371	Continued From page 46 Findings include ... (1) of (1) wrapped beef tenderloin had a label of "10/24, good through 10/27" was found inside the kitchen's walk-in refrigerator #2. (1) of (1) undated wrapped boneless pit ham and (1) of (1) undated wrapped turkey breast was observed inside walk-in refrigerator # 2 (1) of (1) container of squid was observed on the floor with a preparation date of 10/25 (1) of (1) undated wrapped meat inside reach-in freezer # 1 (1) of (1) piece of unwrapped frozen biscuit inside reach-in freezer # 1 During the tour of the dry storage area on November 9, 2017 at approximately 12:30PM, the following were observed: (1) of (1) box of thickened apple juice had an expiration date of 10/2/2017 (2) of (2) boxes of Similac soy isomil infant formula had an expiration date of 11/1/2017 During the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, Employees #16 and #17 acknowledged the findings.	F 371	The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	
F 372 SS=D	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4)	F 372		

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F 372	Continued From page 47 (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to properly dispose of garbage (food waste) refuse as evidenced by a meat and paper disposed of in the same receptacle in one (1) of one (1) observation. The observation was made on November 6, 2017, at approximately 9:15 AM in the presence of Employee #16. Findings include ... 1.During the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, food and trash were mixed in a trash receptacle outside walk-in refrigerator #2. The items consist of chopped pink meat, paper and plastic inside the trash receptacle. 2.During the kitchen tour observations on November 6, 2017 at approximately 9:15 AM, it was also observed that the food trash container was mixed with regular trash outside walk-in refrigerator #2. Employee #16 acknowledged the findings at the time of the observation.	F 372	1. The deficient practice was corrected immediately. 2. No resident was harmed by this deficient practice. "The Trim Tracks Food Waste Observation" program has been implemented and is being championed by the Executive Chef and the Patient Services Manager to ensure that residents will not be affected. 3. To prevent future occurrences, and to ensure compliance, staff will be in-service and trained on proper disposal of waste. The Director will monitor by conducting weekly documented reviews of this process. 4. Disposal of waste will be added as a dietary quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly by the Director to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	12/10/17 12/10/17 Ongoing Ongoing
F 406 SS=D	PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES CFR(s): 483.65(a)(1)(2) (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and	F 406		

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F 406	Continued From page 48 rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, for one (1) of 39 Stage 2 sampled residents, the facility staff failed to assure that Resident #2 receive necessary specialized rehabilitative adaptive devices to assist with eating meals independently. Findings include... An observation on November 6, 2017, at approximately 12:15 PM showed Resident #2 with a fork in his right hand attempting to eat his meal having difficulty scooping the food onto the fork. On November 7, 2017, at approximately 12:30 PM , the facility staff served Resident #2 the meal at the bedside. Again, the resident could not pick up the food with the fork. The food slid off the standard plate onto the tray. Resident put the	F 406	1. **Resident #2** has been evaluated by occupational therapy. 2. An audit of all residents in need of specialized rehabilitative adaptive devices to assist with eating meals independently was done to ensure that the resident was referred to and evaluated by occupational therapy. 3. To prevent future occurrences and to ensure compliance, all nursing staff has been re-educated to ensure that all residents in need of adaptive devices should be referred to occupational therapy for screening and evaluation, as one of the approaches to be documented in the resident's care plan.	12/5/17 12/5/17 12/5/17

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F 406	Continued From page 49 fork down. A staff member came around at this time and offered him a sandwich. The resident agreed to have the sandwich and ate it without difficulty. Review the medical record on November 9, 2017, showed a MDS (Minimum Data Set) Comprehensive assessment dated August 23, 2017. In Section G. Eating- was coded as supervision with eating which means oversight or encouragement and cueing with set up help only. There was no indication that resident had been assessed for his ability to eat independently without additional device help. During a face to face interview with Resident # 2 at approximately 1:15 PM on November 7, 2017, he stated that sometimes he has trouble getting it to his mouth and using his fingers and hand to eat sandwiches is easier. During a face-to-face interview on November 9, 2017, at approximately 10:00 AM with Employee #25, she stated the resident had been on rehabilitation service in August 2017 for grooming but was no longer on service. When asked if the resident had been evaluated for use of fork or an adaptive dish to help him with his meals, she stated "No." Employee #25 acknowledged the findings. The clinical record lacked documented evidence	F 406	4. Assessment audits to identify, determine resident needs for specialized rehabilitative adaptive devices and to assist with eating meals independently, will be added as a nursing quality indicator to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Rehabilitation consults will be generated as needed. Results of the audits will be reported monthly to the Assistant Administrator and presented at the quarterly Quality Assurance committee meeting by the Director of Rehabilitation. The QAC will ensure oversight and correction of any identified deficiencies 5. Corrective action completion date: 12/29/17	Ongoing

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F 406	Continued From page 50 that facility staff assessed Resident # 2 to determine his highest practical level of function and psychosocial well-being, to facilitate eating, prior to the observations and subsequent interviews.	F 406		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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;	F 441	1. **Resident # 28** was not harmed by the deficient practice. Resident was educated on hand hygiene and sanitizer use prior to eating. Employee #6 was re-educated on hand hygiene procedures to be followed by staff involved in direct resident contact and proper sanitary set-up of resident's food. 2. No other residents affected by this deficient practice. Hand hygiene observation rounds were made by the ICP to ensure that staff were following professional standards and facility policies and procedures.	12/5/17 Ongoing

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F 441	Continued From page 51 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a 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 observation and staff interview, facility staff failed to ensure proper hand hygiene practice for one (1) resident during a dining observation. Resident #28.	F 441	3. To prevent future occurrence, all nursing staff were in serviced on Hand hygiene , with return demonstration to ensure compliance and that proper hand-washing protocol, professional standards are consistently followed. 4. Employee hand-washing practice/audits will be added as an Infection Control quality indicator to ensure compliance. Results of the audits will be reported monthly to the DON and presented at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	12/5/17 Ongoing

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F 441	Continued From page 52 Findings include ... "Evidence supports the belief that improved hand hygiene can reduce health-care-associated infection rates. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of multiresistant organisms and has been recognized as a substantial contributor to outbreaks." http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf#page=19 During a dining observation conducted on November 7, 2017, at approximately 12:15 PM, Resident #28 was observed to use both hands to roll his wheelchair into the day room/dining area. Staff brought his lunch and placed it before him but did not offer him hand sanitizer to cleanse his hands. Resident #28 observed eating his lunch. The Surveyor stated to the resident, "You are late getting lunch." The resident responded, "I was outside." A face-to-face interview was conducted with Employee #6 on November 7, 2017, at approximately 12:50 PM concerning residents not offered the opportunity to perform hand hygiene prior to eating lunch. Employee #6 acknowledged the finding.	F 441		
F 463 SS=D	RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH CFR(s): 483.90(g)(2) (g) Resident Call System	F 463		

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F 463	Continued From page 53 The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to maintain call light in good working condition as evidenced by the call light failure to produce an visual or audible sound to alert the staff in one (1) of 39 resident's rooms. Resident #54 Findings include... During an interview at approximately 2:36 PM on November 6, 2017, with Resident #54, the call light was initiated. At approximately 3:30 PM the interview ended, however, the staff did not respond to the call light. The surveyor spoken with the facility staff located at the front desk, to report the call bell issue.The facility staff stated that the bell did not ring and the light outside room 729 did not come on. In reponse to the call bell light failure, the front desk asked another staff member to go back to room 729 and put the call light on again. The call light failed to illuminate or produce an audible sound. The staff sent a report to the maintenance supervisor. During a face-to-face interview with Employee #6 on November 8, 2017, at approximately 2:10 PM regarding the call light not working. She acknowledged the finding and maintenance fixed	F 463	1. **Resident # 54** was not harmed by the deficient practice. Call-lights in room 729 were repaired to give both audible and visual signal. 2. Call-lights in all resident room and bathing areas were checked and corrected as needed. 3. To prevent future occurrences, Building services and clinical staff were re-educated on the safety issues and requirements of functional alarms and call-bells. Staff was also educated on the repair request process to ensure timely repairs 4. Call lights will be added as a quality indicator for the Building Services department and will be monitored during weekly scheduled surveillance rounds. Results of the audits will be reported to the Assistant Administrator monthly and at the Quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies.	11/7/17 11/7/17 11/9/17 ongoing

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F 463	Continued From page 54 the call light.	F 463	5. Corrective action completion date: 12/29/17	
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514		

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F 514	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of one (1) of 39 Stage 2 sampled residents, the facility failed to ensure a Licensed Practical Nurse and Registered Nurse signed and verified that an admission assessment was completed for Resident #144. Findings included... 1.Facility failed to ensure a licensed practical nurse and registered nurse signed and verified that an admission assessment was completed for Resident #144. Resident #144 admitted on November 3, 2017 at 6:10 PM with diagnoses to include Cerebral Vascular Accident (CVA) with right sided weakness, Hypertension, Bipolar Depression, Seizure Disorder, Vascular Dementia. Review of Resident #144's Resident Admission Evaluation showed the admission evaluation form was left blank for the oral status assessment, inoculation (pneumonia and flu vaccination) assessment, nutrition assessment, side rail recommendations and the use of devices (e.g. cane, walker), indicating the aforementioned assessments were not completed by a nurse on admission. In addition, pages one (1) and two (2) of the Admission Evaluation form lacked the name and signatures of the licensed practical nurse and registered nurse responsible attesting to the form completion.	F 514	1. The involved nursing employees were counselled for failure to accurately verify that an admission assignment was completed and signed for **Resident #144**. 2. Medical records of residents admitted in the last 6 months were reviewed to determine if an assessment was done upon admission to the unit, completed and signed by a registered nurse. 3. To prevent future occurrences, nursing staff was in-serviced to ensure that all residents admitted are assessed by an RN upon admission and to ensure compliance. Daily audit of medical records of new admissions will be completed by the Admissions Coordinator, to ensure assessments are accurately documented to depict findings according to actual sequence of events during admission and documented by an RN. 4. Auditing the medical record for new admissions will be added as an admissions quality to ensure compliance until three months of greater than or equal to 95% compliance is	11/8/17 11/9/17 11/9/17 Ongoing Ongoing

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F 514	Continued From page 56 Employee #2 on November 13, 2017 at 3:40PM acknowledged the findings.	F 514	Achieved. Results of the audits will be reported monthly to the Assistant Administrator and presented by the Admissions Coordinator at the quarterly Quality Assurance committee meeting. The QAC will ensure oversight and correction of any identified deficiencies. 5. Corrective action completion date: 12/29/17	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 520		

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F 520	Continued From page 57 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the quality assessment and assurance committee meeting sign-in sheets and staff interview, the facility staff failed to ensure a Director of Nursing Services was present at one (1) of three (3) quality assessment and assurance committee meetings. Findings include ... The facility staff failed to ensure a Director of Nursing Services was present at one (1) of three (3) quality assessment and assurance committee meetings. A review of the quality assessment and assurance committee meeting sign-in sheets revealed that on April 26, 2017 a Director of Nursing Services did not sign the sheet indicating they were not in attendance. During a face-to-face meeting with Employee #3 on November 14, 2017 at approximately 3:31 PM. She stated during this time the facility did not have a Director of Nursing Services and acknowledged the findings.	F 520	1. A new Director of Nursing was hired in June. DON attendance at Quality Assurance Committee meetings has been addressed with the administration. 2. DON/designee attendance at Quality Assurance Committee meetings has been addressed with SNF Administrator. Assistant Administrator will ensure DON attendance. 3. To prevent future occurrences, meeting schedules will be coordinated with the Director of Nursing or designee, who will ensure DON attendance. 4. DON attendance at all QA and Assurance Committee meetings will be monitored and reported to the Director of Hospital Quality/Administrator for appropriate follow up as indicated. 5. Corrective action completion date: 12/29/17	11/14/17 Ongoing Ongoing Ongoing