STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0030	A. BUILDING: _____ B. WING _____	11/14/2017

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UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

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L 000	Initial Comments The Annual Licensure 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 3_ sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. 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 DI - deciliter DMH - Department of Mental Health	L 000		Date

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L 000	Continued From page 1 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 2 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: ... 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	L 051	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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L 051	Continued From page 3 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 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.	L 051	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. Correction completion date: 12/29/17	ongoing
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;	L 052		

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L 052	Continued From page 4 (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observations, resident and staff	L 052	**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 resident was affected by this deficient practice 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 11/6/17 12/19/17 Ongoing

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L 052	Continued From page 5 interviews for six (6) of 39 Stage 2 sampled residents, the facility staff failed to respect residents' dignity while dining as evidenced by: 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	L 052	During meal times are treating residents with dignity and respect, serving residents at the same time, and assisting them with meal consumption. Additionally, all residents wearing eyeglasses were identified to ensure proper fit and no missing parts. 3. To prevent future occurrences, all nursing staff will be in serviced on the provision of care that enhances dignity and respect while assisting residents during meal consumption to ensure compliance. Staff was in serviced on respect of resident's dignity while assisting them with meals 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.	Ongoing 11/9/17 12/10/17 and ongoing Ongoing

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L 052	Continued From page 6 Employee #14, CNA stood over Resident #100 while assisting him to eat. 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. 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. 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,	L 052	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 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. The DON will report the results of this monitoring/audit review 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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L 052	Continued From page 7 and #63 seated at a dining table together. The 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	L 052	1. **Resident#132-** glasses were removed immediately. Resident was scheduled for an ophthalmology appointment. 2. No other resident was affected by this deficient practice. Medical records of all records of residents with vision issues requiring intervention were audited. 3. To prevent future occurrences, nursing staff were inserviced on vision services, how to obtain consults and coordination of family/resident requests for consultations to attending physicians to ensure compliance. Nursing management, social workers will review the ophthalmology appointment log on each unit daily	11/13/17 12/19/17 11/7/17 12/5/17 Ongoing

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L 052	Continued From page 8 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. Based on observation and medical record review for 1 of 37 sampled residents facility staff failed to administer prescribed medication as ordered by the treating physician. Resident# 49. Findings include... On November 6, 2017, at approximately 10:00 AM observed Employee #24 [Licensed Practical Nurse] prepare mediications at medication cart for admnistration to Resident# 49. On November 6, 2017, at approximately 10:30 AM, Employee #24 observed to enter Resident# 49 room and begin to administer medications. Resident #49 stated, "what is this for." Resident# 49 was observed to hold a medicine cup with approximately 15 ml (milliliters) of clear fluid. Employee#24 stated: "it is your Prosource your supplement, to help you." Employee# 24 administered the medications. Upon review of the Medication Administration Record [MAR], the medication Lactulose, initialed by Employee #24 indicates Lactulose as administered to Resident#49. A further review of	L 052	4. Coordination of resident treatment, devices and/or services required to maintain vision will be added as a nursing quality indicator to ensure compliance until three 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 DON, and presented at the Quality Assurance committee meeting. The QAC will ensure oversight and correction of any deficiencies. 5. Corrective action completion date: 12/29/17 **1. Resident #49** has prn order for Lactulose and was not harmed by the deficient practice. Prosource was administered as ordered and resident was reassessed to ensure that physician orders were carried out. **Employee #24** employee was counseled regarding failure to administer prescribed medication as ordered by the physician.	ongoing 11/06/17 11/6/17

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L 052	Continued From page 9 the MAR reveal the following prescribed morning (9:00 AM) medications: - Amlodipine 5 mg 1 tablet by mouth one time a day for HTN [hypertension] - Aspirin 81 mg 1 tablet by mouth one time a day for prophylaxis - Remeron 7.5 mg by mouth one time a day stimulate appetite/depression - Ergocalciferol capsule 50000 unit give 1 capsule by mouth one time a day every Thur for Vitamin D deficiency until 12./14/2017 - Spironolactone 25 mg give 1 tablet by mouth one time a day for HTN - Prosource two times a day for supplement On November 6, 2017, at approximately 10:40 AM, Employee#24 was observed to search the medication cart for Prosource. Employee # stated "I thought I gave the Resident Prosource, I did not know that it was Lactulose." A face-to-face interview with Employee # 7 [Nursing Supervisor] on November 6, 2017 at approximately 11:00 AM, "the Prosource is not in the cart we have to call down, and they bring it to the floor, " Upon further review there was no documented harm to the Resident. Employees # 7 and #24 acknowledged the findings at teh time of the interview.	L 052	2. No other resident was affected by this deficient practice, as evidenced by audit of other residents that have physician orders for Prosource and Lactulose. 3. Licensed nurses were inserviced on medication pass and following physician orders. Staff competency was developed, to ensure the administration of medications in accordance with professional standards. Medication pass monitoring will be conducted by the clinical manager/designee monthly 4. Monitoring of medication pass will be added as a nursing quality indicator to ensure compliance. Results of the monitoring will be reported monthly to the DON, who will provide results to the Assistant Administrator and present quarterly at the QA committee. QAC will ensure oversight and corrections of any identified deficiencies.	11/7/17 11/9/17 Ongoing
L 106	3219.8 Nursing Facilities Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced.	L 106	5. Corrective action completion date: 12/29/17	

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L 106	Continued From page 10 This Statute 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.	L 106	1. The deficient practice was corrected immediately. 2. No other resident was affected by this deficient practice. 3. To prevent future occurrences, and to ensure compliance, staffs will be in-serviced and trained on proper disposal of waste. "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 resident safety. 4. Director of food services will conduct a weekly audit of the process. Disposal of waste will be added as a dietary quality indicator to ensure compliance until three 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 QAC meeting. The QAC will ensure oversight of any identified deficiencies 5. Corrective action plan completion date: 12/29/17	11/6/17 11/6/17 12/10/17 Ongoing 12/29/17
L 206	3232.4 Nursing Facilities 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. This Statute is not met as evidenced by:	L 206		

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L 206	Continued From page 11 Based on record review and staff interview for one (1) of 39 Stage 2 sampled residents, facility 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, 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.	L 206	1. **Employee#2** will be re-educated on the facility "Resident abuse, neglect, exploitation and misappropriation of property" policy as well as state reporting regulatory requirements. **Employee#6** will be re-educated on the facility "Resident abuse/neglect, exploitation, mistreatment of residents or misappropriation of property" (SNS 51) policy as well as state agency reporting regulatory requirements. **Employee # 10 is no longer employed at the facility** **Employee #11 will be re-educated on the facility "Resident abuse/neglect, exploitation, mistreatment of residents or misappropriation of property"(SNS 51) policy as well as state agency reporting regulatory requirements.**	11/9/17 11/12/17 11/12/17

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	HFD02-0030	A. BUILDING: _____ B. WING _____	11/14/2017

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L 206	Continued From page 12 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." 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	L 206	2. No other resident was impacted by the failure to report an alleged abuse to the state agency in accordance with the facility policy. 3. To prevent future occurrences, all reportable facility incidents will be sent to the administrator/designee in his/her absence for review and reported to the state agency within the required regulatory time frames. All staff will be re-educated on the abuse/neglect, exploitation, mistreatment of residents or misappropriation of property (SNS 51) policy as well as state agency reporting regulatory requirements.	Date Ongoing Ongoing

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L 206	Continued From page 13 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. 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.	L 206	4. Compliance monitoring will be conducted by the clinical manager/designee. Monitoring will be added as a quality indicator and reviewed daily during the stand-up meetings until 3 months of greater than or equal to 95% compliance is achieved. Results of the audits will be reported monthly to the Assistant Administrator and presented at the quarterly Quality Assurance committee meetings by the DON. The Quality Assurance committee will ensure oversight and correction of any identified deficiencies. 5. Completion date: 12/29/17	Date Ongoing
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating	L 306		

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L 306	Continued From page 14 signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute 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	L 306	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	11/6/17 11/6/17 11/6/17

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L 306	Continued From page 15 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 the call light.	L 306	5. Corrective action completion date: 12/29/17.	
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on an observation on November 8, 2017, at approximately 10:00 AM, the facility 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	L 410	**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. No other resident was affected by this deficient practice. The Director of Environmental Services will make rounds on all resident rooms to ensure that a sanitary, orderly and comfortable interior is maintained.	11/8/17 11/8/17 11/10/17

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L 410	Continued From page 16 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 Employee #6 at approximately 11:00 AM on November 9, 2017, were acknowledged.	L 410	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. 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	12/5/17 Ongoing