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	095014	A. BUILDING _____ B. WING _____	08/07/2015

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F 000	INITIAL COMMENTS A Recertification Quality Indicator Survey (QIS) and complaint investigations DC~3043 and DC~3049 were conducted on August 3, through August 7, 2015. The deficiencies are based on observations, record review, resident and staff interviews for 44 sampled 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 D/C - discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) g-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning FU/FL Full Upper /Full Lower ID - Intellectual disability IDT - Interdisciplinary Team INR - International Normalised Ratio L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record	F 000	Stoddard Baptist Global Care at Washington Center for Aging Services (SBGC), is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the Deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
N C Wright	Nursing Home Administrator	9/21/15

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 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 MRR- Medication Regimen Review Neuro - Neurological NP - Nurse Practitioner OBRA - Omnibus Budget Reconciliation Act 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 RAI- Resident Assessment Instrument ROM- Range of Motion TAR - Treatment Administration Record CAA- Care Assessment Area QAA- Quality Assessment and Assurance s/he she/he mm/hg millimeters of mercury	F 000	Continued from page 1	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. The	F 156	**483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES** **F 156** During the survey that ended on 08/7/15 it was identified that the facility staff did not provide the appropriate liability and appeal notice for 3 out of 44 residents. All 3 of the identified residents were notified of the liability and appeal notice, however 2 out of the 3 were not notified within the required time period of 48 hours and the written documentation to support that the 1 resident/responsible party was notified of this notice requirement within the required time period was not located to support this action. There were no negative outcomes to the 3 identified residents/their responsible parties.	

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F 156	Continued From page 2 facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section	F 156	Continued from page 2 **1). Resident # 130** 1. The Resident #130 was notified by Employee #32 of the liability and appeal notice within the required 48 time frame, which was supported by the social service note written by this employee. However the actual copy of the signed notice was unable to be located to support that this requirement was met. No corrective action can be done for the timeframe identified. There were no unfavorable outcomes to Resident #130 as a result of this deficiency. 2. All Medicare residents have the potential to be affected when this regulatory requirement is not met. There were no unfavorable outcomes to the Medicare residents with the potential to be affected. The clinical records of residents with the potential to be affected will be checked for Medicare non coverage and the right to appeal the decision notices to assess the facility's compliance status of meeting this requirement. 3. The social services staff have been educated as of 9-16-15 on this requirement and the revised process for the filing, tracking and distribution of these notices. The Social Services Director/Designee will conduct weekly audits of Medicare residents clinical record for Medicare non coverage and the right to appeal the decision notices	10/7/2015 10/7/2015

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F 156	Continued From page 3 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently 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.	F 156	Continued from page 3 4. A quality assurance program to Monitor the Medicare non coverage and the right to appeal the decision notices under the supervision of the Director of Social Services/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee, effective at the 10/16/15 quarterly Quality Improvement Committee meeting. **2). Resident #240** 1. Resident #240 received the written notice of Medicare Non-coverage on the day of discharge which did not meet this requirement. No corrective action can be done for the timeframe identified. There were no unfavorable outcomes to Resident #240 as a result of this deficiency. 2. All Medicare residents have the potential to be affected when this regulatory requirement is not met. There were no unfavorable outcomes to the Medicare residents with the potential to be affected. The clinical records of residents with the potential to be affected will be checked for Medicare non coverage and the right to appeal the decision notices to assess the facility's compliance status of meeting this requirement.	10/16/15 10/7/15

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for

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F 156	Continued From page 4 three (3) of 44 sampled residents, it was determined that facility staff failed to provide the appropriate liability and appeal notice(s) for three (3) residents. The findings include: 1. A review of the clinical record for Resident #130 revealed. Resident # 130 was admitted to facility on March 25, 2015 with a diagnosis which included Hypertension, CVA, hemiparesis, and dementia. Resident received PT, OT, and Speech Therapy services which ended May 20, 2015 and was discharged to home from facility on May 22, 2015. The clinical record lacked evidence that the Resident was notified of the notice of Medicare non-coverage and the right to appeal the decision. Appeal process were signed, 48 hours prior to discharge indicating that the resident was informed of his/her rights, and benefits for Medicare and Medicaid services. A face -to-face interview was conducted with Employee # 32 on July 7, 2015, at approximately 2:30 PM. Employee #32 was queried regarding the appeal notification process prior to discharge. He/she acknowledged this resident was not given proper notification. The clinical record was reviewed on July 7, 2015. 2. A review of the clinical record for Resident #240 revealed a " Notice of Medicare Non-Coverage letter stating The effective date coverage of current PT and OT services will end March 12, 2015. Resident # 240 was discharged to home from facility on March 13, 2015.	F 156	Continued from page 4 3. The social services staff have been educated as of 9/16/15 on this requirement and the revised process for the filing, tracking and distribution of these notices. The Social Services Director/ Designee will conduct weekly audits of Medicare residents clinical record for Medicare non coverage and the right to appeal the decision notices. 4. A quality assurance program to Monitor the Medicare non coverage and the right to appeal the decision notices under the supervision of the Director of Social Services/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee effective at the 10/16/15 quarterly Quality Improvement Committee meeting. **3). Resident #244** 1. Resident #240 received the written notice of Medicare Non-coverage on the day of discharge which did not meet this requirement. No corrective action can be done for the timeframe identified. There were no unfavorable outcomes to Resident #244 as a result of this deficiency.	10/7/15 10/16/15

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F 156	Continued From page 5 The date signed by resident for receipt of notice is March 13, 2015. The clinical record lacked evidence that all forms related to the appeal process were signed, 48 hours prior to discharge indicating that the resident was informed of his/her rights, and benefits for Medicare and Medicaid services. A face -to-face interview was conducted with Employee # 32 on July7, 2015, at approximately 2:30 PM. Employee #32 was queried regarding the appeal notification process hours to discharge. He/she acknowledged this resident was not given proper notification. The clinical record was reviewed on July 7, 2015. 3. A review of the clinical record for Resident #244 revealed a " Notice of Medicare Non-Coverage letter stating the effective date coverage of current PT, OT, and Speech Therapy services will end February 25, 2015. Resident # 244 was discharged to home from facility on March 3, 2015. The date signed by resident for receipt of notice is March 3, 2015. The clinical record lacked evidence that all forms related to the appeal process were signed, 48 hours prior to discharge indicating that the resident was informed of his/her rights, and benefits for Medicare and Medicaid services. A face -to-face interview was conducted with Employee # 32 on July 7, 2015, at approximately 2:30 PM. Employee #32 was queried regarding the appeal notification process hours prior to discharge. He/she acknowledged this resident was not given proper notification. The clinical record was reviewed on July 7, 2015.	F 156	Continued from page 5 2. All Medicare residents have the potential to be affected when this regulatory requirement is not met. There were no unfavorable outcomes to the Medicare residents with the potential to be affected. The clinical records of residents with the potential to be affected will be checked for Medicare non coverage and the right to appeal the decision notices to assess the facility's compliance status of meeting this requirement. 3. The social services staff have been educated on this requirement and the revised process for the filing on the clinical record, tracking and distribution of Medicare non coverage and the right to appeal the decision notices. The Social Services Director/ Designee will conduct weekly audits of Medicare residents clinical record for Medicare non coverage and the right to appeal the decision notices. 4. A quality assurance program to Monitor the Medicare non coverage and the right to appeal the decision notices under the supervision of the Director of Social Services/ Designated Representative will be monitored and reported monthly to the Quality Improvement Committee effective at the 10/16/15 quarterly Quality Improvement Committee meeting.	10/7/15 10/7/15 10/16/15

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	F 157	**483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **F 157** 1) Resident #91 was assessed by Nurse Practitioner on May 2, 2015. Resident did not exhibit adverse signs related to need for dialysis. She received dialysis 5/4/2015 and 5/5/2015. 2) A review of all dialysis-dependent residents was conducted. No other resident was affected by this deficiency. 9/18/15 3) Nursing supervisor will closely monitor residents' dialysis scheduled appointments. All nursing staff to be in-serviced in proper notification of missed appointments. 10/7/15 4) Monthly audits will be presented at the Quality Improvement meetings. 10/16/15	

Based on record review and staff interview for two (2) of 44 sampled residents, it was determined that facility staff failed to immediately

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F 157	Continued From page 7 notify the physician, responsible party and dialysis center when it was determined that one (1) resident missed a dialysis appointment; and to notify the physician that an ophthalmic solution was not administered as prescribed to one (1) resident. Residents' #91 and 274. The findings include: 1.Facility staff failed to immediately notify the physician, responsible party (RP) and dialysis center when it was determined that one (1) resident missed a scheduled dialysis appointment. According to the "Physician's Progress" Note dated July 22, 2015 revealed that the resident was to receive hemodialysis three time a week. A review of the plan of care was initiated on June 6, 2015 revealed that the resident was to attend dialysis 3 days per week (Tuesdays, Thursday and Saturdays). A review of the Nurses Progress Notes revealed the following: May 2, 2015 [Saturday] at 3:23 PM - "Resident missed dialysis this morning, transportation did not come, supervisor made aware. " May 2, 2015 at 10:37 PM - "Resident remains alert and responsive. Denies pain or distress, Rt [right] arm access site intact, thrill and bruit present... At 6 PM NP (nurse practitioner) and supervisor on unit to assess resident, at 8:20 PM supervisor on unit and informed RP [name] of resident not going to dialysis this AM. Orders	F 157	Continued from page 7 **1)** Resident #274 physician was notified and the order was given to continue the eye drops. The medication was delivered STAT. Administration began on August 4, 2015 at 2 pm. **2)** A review of all residents with eye drops was conducted. No other resident was affected by this deficiency. 9/18/15 **3)** All nursing staff will be in-serviced on Physician order transcription and administration of eye drops. 10/7/15 **4)** The Unit Manager will audit administration of eye drops and report findings to QI Committee quarterly. 10/16/15	

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F 157	Continued From page 8 noted from NP to monitor condition and call MD/NP (medical doctor/ nurse practitioner) if there are any changes in status." A review of [Name of Dialysis Center] log sheet for May 2015 revealed that on May 2, 2015 Resident #91 was coded as " M (NS) " (Missed treatment due to -no show). There was no indication recorded as to why the resident did not show up for his/her appointment. A telephone interview conducted on May 7, 2015 at approximately 11:00 AM with a representative from the dialysis center. He/she acknowledged that the resident did not show for his/her dialysis appointment. The resident ' s scheduled appointment time is 11:00 AM on Tuesday, Thursdays and Saturdays. A face-to-face interview was conducted with Employee #15 on August 7, 2015 at approximately 12:30 PM. He/she acknowledged the findings and stated, " The resident leaves [the unit] at 9:30AM for transportation to pick him/her up to go dialysis appointments. The resident returns to facility around 4:00 PM. " The clinical record lacked evidence that the physician, the resident ' s responsible party and the dialysis center were immediately notified when the resident missed his/her dialysis appointment. According to the nurse ' s note the physician and family were notified on May 2, 2015 at 8:20 PM; however through interview with facility staff the resident was scheduled to leave the facility at 9:30 AM for his/her 11:00 AM appointment. The record was reviewed on August 7, 2015.	F 157	Continued from page 8	

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F 157	Continued From page 9 2.Facility staff failed to notify the physician that an ophthalmic solution was not administered to Resident #274. According to a history and physical progress note dated July 28, 2015 revealed Resident # 274 was admitted to the facility on July 27, 2015 and diagnoses included Glaucoma. A physician order dated July 27, 2015 and signed July 28, 2015 directed, "Atropine Sulfate Ophthalmic Solution USP 1%- [one] eye drop right eye (four times a day) [for] Glaucoma." A review of the July 2015 and August 2015 Medication Administration Record (MAR) revealed the following order: " Atropine Sulfate Ophth (Ophthalmic) sol (solution) USP- 1%-eye drop (right eye) QID (four times a day) for Glaucoma. There was no evidence that the medication had been administered to the resident from July 28, 2015 to August 4, 2015 (missing approximately 30 doses). A physician note dated August 4, 2015 revealed the following: " Informed order for Atropine Sulfate eye drops were sent to pharmacy on admission. Request was not filled. Pharmacy contacted today [and] matter addressed. " Further review of the clinical record lacked evidence that the physician was notified that the medication was not available for administration to the resident. A face-to-face interview was conducted with Employees # 3, #4, #13 and #31 on August 4, 2015 at approximately 11:00 AM regarding the	F 157	Continued from page 9	

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F 157	Continued From page 10 aforementioned findings. After review of the clinical record all acknowledged the findings. The clinical record was reviewed on August 4, 2015.	F 157	Continued from page 10 **483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** **F 166**	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 44 sampled residents, it was determined that facility staff failed to resolved one (1) resident's complaint of lost dentures in a timely manner. Resident #108 The findings include: A face-to-face interview was conducted with Resident #108 on August 5, 2015 at approximately 10:00 AM. At this time resident stated, " I have no teeth. My dentures were stolen from inside the cabinet. Everyone is aware that my dentures were stolen. I saw the dentist few months and am waiting for dentures. As we finished the interview resident restated, " I still need my dentures. " A review of the Physician's Order Sheet for the month of April 2015 directed, " Dental consult as needed. " A "Consult for Dental Appointment" dated April 8, 2015 revealed, "Complete oral exam/oral	F 166	1) Resident #108 was not adversely affected by the deficiency. The Dentist was notified immediately and invoice for resident's denture has been processed. Dental impressions were done. Resident will receive dentures within 2-3 weeks. 2) All other residents with pending orders for dentures were reviewed with the dentist for timely follow up. 3) Unit managers will report Weekly on follow up from dentist for processing of dentures requests. 4) Unit managers will report findings to the QI committee monthly.	10/7/15 9/8/15 10/7/15 10/16/15

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F 166	Continued From page 11 concerns ... "Pt [patient] informs of lost dentures and request more, Nurse informed ... need denture start, if facility cannot find, Condition of teeth, Pt [patient] edentulous. " A face-to-face interview was conducted with Employee #17 on August 6, 2015 at approximately 11:17AM regarding the resident lost dentures. Employee #17 presented the writer with an invoice dated June 17, 2015 from the dental office that revealed a request for payment for new dentures. There was no evidence that the facility staff made prompt efforts to resolve Resident#108 ' s complaint of lost dentures in a timely manner. Another face-to-face interview was conducted on August 6, 2015 at approximately 1:17 PM with Employee #17. He/she acknowledged the findings. The record was reviewed on August 6, 2015.	F 166	Continued from page 11 **483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY** **F241** **1)** Resident #9 face was cleaned immediately. — 8/6/15 **2)** All other residents' concerns were reviewed in an effort to assure that no other residents were affected. — 8/6/15 **3)** All nursing staff will be in-serviced on the importance of documenting how resident concerns are addressed. — 10/7/15 **4)** Unit Managers and charge nurses will monitor all residents for proper grooming. Unit Managers will report findings to QI Committee monthly. — 10/16/15	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 44 sampled residents, it was determined that facility staff failed to ensure that Resident #9's dignity was enhanced as evidenced by	F 241		

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F 241	Continued From page 12 failure to thoroughly perform facial hygiene prior to offering the breakfast meal. The findings include: During the breakfast meal on August 6, 2015 at approximately 09:15 AM Resident #9 was observed eating breakfast with an accumulation of drainage surrounding his/her eyes indicating that resident's face [eyes] had not been thoroughly cleaned. The observation was communicated to Employee #17 who was present at the time and the findings were acknowledged.	F 241	Continued from page 12 **483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES** **F 253 1)** 1. Exhaust vents in resident's shower rooms located on units 3 Blue, 3 Orange, 3 Green, 2 Blue, 1 Green were soiled, five (5) of eight (8) resident care units were cleaned upon notice on 8/6/15. 2. The exhaust vent located in the bathroom of resident room #202 was soiled, one (1) of 48 resident rooms surveyed, which was cleaned upon notice on 8/6/15.	8/8/15 8/8/15
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on August 6, 2015 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled exhaust vents in resident shower rooms located in five (5) of eight (8) resident care units and soiled exhaust vents in one (1) of 48 resident's rooms was missing one (1) vent cover.	F 253	3. Privacy curtains were hanging loose and off the hooks in resident's room #201, #240,#285, #382, #339, five (5) of 48 resident's rooms surveyed, which were rehung properly upon notice on 8/6 /15. 4. Privacy curtains were torn in four (4) of 48 resident's rooms including room #185, #201,#203, and #240 which were replace with untorn curtains on 8/6 /15. 5. One (1) of three (3) privacy curtains in room #209 (bed A) was missing, one (1) of 48 resident rooms surveyed which were were replaced on 8/6/15.	8/8/15 8/8/15

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F 253	Continued From page 13 The findings include: 1. Exhaust vents in resident's shower rooms located on units 3 Blue, 3 Orange, 3 Green, 2 Blue, 1 Green were soiled, five (5) of eight (8) resident care units. 2. The exhaust vent located in the bathroom of resident room #202 was soiled, one (1) of 48 resident rooms surveyed. 3. Privacy curtains were hanging loose and off the hooks in resident's room #201, #240, #285, #382, #339, five (5) of 48 resident's rooms surveyed. 4. Privacy curtains were torn in four (4) of 48 resident's rooms including room #185, #201, #203, and #240. 5. One (1) of three (3) privacy curtains in room #209 (bed A) was missing, one (1) of 48 resident rooms surveyed. 6. Shower curtains were hanging loose and off the hooks in shower rooms located on units 3 Green and 3 Orange. These observations were made in the presence of Employee #24 and/or Employee #26 who acknowledged the findings.	F 253	Continued from page 13 6. Shower curtains were hanging loose and off the hooks in shower rooms located on units 3 Green and 3 Orange which were rehung properly upon notice on 8/6 /15. **2)** All exhaust vents were inspected and cleaned if required; all privacy curtains were inspected and rehung or replaced if determined necessary. Weekly inspections to include: exhaust fans, privacy and shower curtains will be conducted by the Director/Designated Manager (Lead) in an effort to provide and maintain housekeeping and maintenance services in a sanitary, orderly and comfortable interior. **3)** An environmental services competency training program will be initiated on 09/23/15 for the environmental services staff on daily inspections and corrective actions. **4)** A quality assurance program to monitor environmental and engineering rounds was implemented under the supervision of the Director of Environmental Services and Director of Engineering which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor.	9/28/15 9/28/15 10/16/15
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272		

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F 272	Continued From page 14 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for three (3) of 44 sampled residents, it 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's 483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272	Continued from page 14 **483.20(b)(1) COMPREHENSIVE ASSESSMENTS** **F 272** **1)** Resident #105 modification of MDS quarterly to correct inaccurate coding of incontinence was modified on August 7, 2015 and submitted to CMS and accepted. Done 9/10/15 **2)** Audit was done on all MDS for accuracy and coding for incontinence 9/18/15. **3)** In-service was provided to MDS coordinator for incontinence. MDS coordinators will monitor coding of incontinences monthly. **4)** MDS Coordinator will findings to the monthly QI Committee quarterly.	9/10/15 9/18/15 10/7/15 10/16/15

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F 272	Continued From page 15 was determined that facility staff failed to accurately code Minimum Data Sets (MDS ') for one (1) resident under Section H, Urinary continence and Section L, Oral dental status for one (1) resident with missing/absent teeth; and staff failed to identify the location and date of Care Area Assessment for one (1) resident. Residents' #105, 118, and 152. The findings include: 1. Facility staff failed to accurately code Resident #105 ' s quarterly MDS of March 19, 2015 for Incontinence. A review of Resident #105 ' s quarterly MDS with an Assessment Reference Date (ARD) of March 19, 2015 revealed that the resident was coded as always continent under Section H0300, Urinary Continence. A review of the Activities of "Daily Living Reports" for March 2015 revealed that the resident was incontinent during that time. A face-to-face interview was conducted with Employee #21 at approximately 2:30PM and with Employee #13 at approximately 2:35 PM on August 6, 2015. Both employees affirmed that the resident has been incontinent since his/her admission to the facility. Another face-to-face interview was conducted with Employee #7 at approximately 10:15AM on	F 272	Continued from page 15 1) Resident #118 MDS was assessed for missing and absent teeth. Resident was noted to have some dentition. — 8/8/15 2) An audit of all MDS was done for accuracy of coding for missing or absent teeth. No other MDS were found to be deficient. — 9/18/15 3) In-services were provided to MDS coordinators for missing or absent teeth. MDS coordinators will conduct monthly audits for documentation of missing or absent teeth. — 10/7/15 4) MDS Coordinator will findings to the monthly QI Committee quarterly. — 10/16/15	

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F 272	Continued From page 16 August 7, 2015. The employee reviewed the MDS and acknowledged the finding. The record was reviewed on August 6, 2015. 2. Facility staff failed to accurately code Resident #118 ' s annual Minimum Data Set (MDS) for missing/absent teeth. During a face-to-face interview on August 4, 2015 at approximately 10:30AM the resident was asked whether his/her teeth hurt. He/she responded by opening his/her mouth, pointed to the upper and lower gums and stated, " See. I have none. " No teeth were visible. A review of the Resident ' s annual MDS with an Assessment Reference Date (ARD) of May 18, 2015 revealed that the resident was not coded as being edentulous in Section L (Oral/Dental Status). A face-to-face interview was conducted with Employee #7 at approximately 10:15AM on August 7, 2015. The employee reviewed the MDS and acknowledged the finding. The record was reviewed on August 5, 2015. 3. Facility staff failed to identify the location and date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary " of the Annual Minimum Data Set [MDS] for Resident #152.	F 272	Continued from page 16 **1)** Due to ECS software problem, resident #44 Care Area Assessment care areas triggers did not show the location. Unable to correct retrospectively with this software problem. The software was changed to now show location and date of Care Assessments area on the MDS. **2)** Audit was done of all MDS, for Care Area Assessments documentation of location and date. 9/18/15 **3)** In-service was provided to the Interdisciplinary Team on documentation of the location and date of the Care Area Assessments. 10/7/15 **4)** MDS coordinators will report findings to the monthly QI Committee quarterly. 10/16/15	

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F 272	Continued From page 17 According to Chapter 4 of the MDS 3.0 Users ' Manual, " for each triggered care area, use the " Location and Date of CAA Documentation " column on the CAA summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident ' s record ...written documentation of the CAA findings and decision making process may appear anywhere in the resident ' s record; for example in the progress notes, flow sheets etc ... " A review of Resident #44 ' s annual MDS with an Assessment Reference Date (ARD) of December 22, 2014 revealed the following care areas were selected (e.g. triggered) as areas of concern: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence/Catheter, Falls, Nutritional, Dental Care, and Pressure Ulcers. The record revealed that the location and date of CAA information for the identified care areas were recorded as " CAA 3.0 12/30/14, CAA 3.0 12/23/14, and CAA 3.0 12/26/14. " There was no evidence that facility staff documented the date and location where in the clinical record the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on August 7, 2015 at 3:00 PM. He/she acknowledged the findings. The record was reviewed August 7, 2015.	F 272	Continued from page 17	

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F 280 SS=D	Continued From page 18 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on observation, record review and staff interview for one (1) of 44 sampled residents, it was determined that facility staff failed to revise the comprehensive care plan to manage connectivity concerns affecting the delivery of enteral feeding for Resident #203. The findings include: Facility staff failed to update Resident #203 ' s care plan to include interventions to manage repeated episodes of the enteral formula line separating from the Gastrostomy [feeding;	F 280	Continued from page 18 **483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** **F280** 1. Resident #203's care plan was updated with interventions to manage Gastrostomy tube. The resident was not affected by this practice. 2. A review of all residents with gastrostomy feeding care plans was conducted. None required updates. 3. All nursing staff will be in-serviced on updating care plans. Clinical Care Coordinators will monitor care plans for residents on feeding tubes. 4. Unit Manager will audit care plans and report findings to QI Committee monthly.	10/7/15 10/16/15

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F 280	Continued From page 19 g-tube] tube, affecting the delivery of enteral nutrition. An observation of Resident #203 was conducted on August 7, 2015 at approximately 1:45 PM. The resident was observed lying in bed with the bed linens soiled with enteral formula. The enteral feeding tubing was observed connected to a delivery pump, however disconnected from the resident ' s Gastrostomy site. A face-to-face interview was conducted with Employee #13 immediately after the observation of the binder and the spilled tube feeding liquid. The employee acknowledged that the Gastrostomy tube had become disconnected/separated and caused the feeding to spill into the resident ' s bed on several occasions. The employee also acknowledged that the spillage was often reported by family member(s). A review of the clinical record revealed previous connectivity concerns related to the Gastrostomy and enteral feeding lines as follows: According to a nurse ' s note dated July 19, 2015 at 3:58 PM, " RP [responsible party] called writer about G-tube [leaking] on the floor. Writer went inside the room and found g-tube popped out and feeding on the floor. Writer changed y-connector and told [responsible party] that I need caregiver to help change resident. Writer left resident room to call the care giver and before writer returned the g-tube popped out again and [responsible	F 280	Continued from page 19 1. Resident #203's soiled abdominal binder and bed linens were removed immediately. The Y-connector was changed immediately upon receipt of concern. 2. A review of all residents with feeding tubes was conducted. No other resident was affected by this practice. 9/18/15 3. All staff will be in-serviced on Trouble-Shooting Gastrostomy Tubes. Unit Managers will monitor feeding tubes for spillage. 10/7/15 4. Unit Managers will report findings to the QI Committee monthly. 10/16/15	

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F 280	Continued From page 20 party] said, ' I heard the [pop] and know it was [the] g-tube but I didn't touch it. Writer fixed the g-tube and "Y-connector" [a device that provides a connection between a feeding tube] and it popped again while [responsible party] was still in the resident room. [Responsible party] voiced again that [he/she] heard the [pop]. G-tube intact and patent and flushed. No popping or draining noted. [Responsible Party] said, thank you. " A review of the comprehensive care plan last updated May 12, 2015 lacked evidence of goals and approaches to manage the connectivity concerns identified with Resident #203 ' s Gastrostomy feeding. A telephone interview was conducted with Employee #2 who verbalized that interventions such as hourly enteral feeding monitoring and device modification was implemented to manage the connectivity concerns. However; s/he acknowledged that the care plan was not amended to include the measures.	F 280	Continued from page 20 **483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING F309** **1)** Resident #91 was not affected by this deficient practice. The order for TSH was faxed to Dialysis Center on August 6, 2015. The TSH was done.	8/6/15
			2) All other dialysis-dependent residents' orders were reviewed. None were affected by this deficient practice.	9/18/15
			3) All licensed nurses will be in-serviced on proper lab request completion. Clinical Care Coordinator will monitor all requests for labs at dialysis.	10/7/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	**4)** Unit Managers will audit monthly and report findings to QI Committee monthly.	10/16/15

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, staff

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F 309	Continued From page 21 interview and the review of a complaint for three (3) of 44 sampled residents, it was determined that facility staff failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and/or psychosocial well-being in accordance with the comprehensive assessment and plan of care as evidenced by failure to: obtain diagnostic laboratory tests and ensure Hemodialysis treatment was performed as scheduled for one (1) resident; consistently maintain a Gastrostomy tube to ensure effective delivery of enteral feeding and comprehensively assess one (1) resident with Hypotension [low blood pressure]; and administer ophthalmic solution in accordance with physician ' s orders for one (1) resident with a diagnosis of Glaucoma. Residents' #91, #203 and #274. The findings include: 1A. Facility staff failed to follow through on a physician ' s order to obtain laboratory tests for Resident #91. According to a Physician ' s Interim Order dated June 13, 2015 at 8:00PM, [obtain] " TSH, Free T4 on 6/16/15 [June 16, 2015] @ [at] dialysis center-Dx [diagnosis] wt. [weight] gain ... " A review of the clinical record on August 6, 2015 lacked evidence of the results of the TSH and T4 lab results. A face-to-face interview was conducted with	F 309	Continued from page 21 1. Resident #91 was assessed by Nurse Practitioner on May 2, 2015. Resident did not exhibit adverse signs related to need for dialysis. She received dialysis 5/4/2015 and 5/5/2015. 2. A review of all dialysis-dependent residents was conducted. No other resident was affected by this deficiency. Nursing supervisor will closely monitor residents' dialysis scheduled appointments. 3. All nursing staff to be in-serviced in proper notification of missed appointments. 4. Monthly audits will be presented at the Quality Improvement meetings.	9/18/2015 10/7/15 10/16/15

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F 309	Continued From page 22 Employee #15 on August 6, 2015 at approximately 2:00 PM. The employee reviewed the clinical record and acknowledged that the results were not available. A follow-up interview was conducted on August 7, 2015 at approximately 11:00 AM with Employee # 15 regarding the labs ordered for Resident #91. He/she stated that the labs were obtained on August 6, 2015. Facility staff failed to follow a physician ' s order to obtain diagnostic lab tests for Resident #91. The order was not acted upon until the surveyor inquired regarding the results on August 6, 2015. The record was reviewed on August 6, 2015. 1B. Facility staff failed to ensure that Resident #91 received Hemodialysis treatments in accordance with the established schedule [Tuesdays/Thursdays and Saturdays] as prescribed. A review of a History and Physical signed and dated July 22, 2015 revealed Resident #91 's active diagnosis included ESRD -HD (End Stage Renal Disease - Hemodialysis) [three] 3 times a week. A review of the plan of care dated June 6, 2015 revealed that the Resident #91 was scheduled to attend dialysis 3 days per week (Tuesdays, Thursdays and Saturdays).	F 309	Continued from page 22 1) Resident #203 was transferred to the hospital on July 20, 2015 for evaluation of hypotension. She returned on the same day. Retrospectively no corrective action can be done for the action cited. 2) A review of all residents was conducted. No other resident was affected by this practice. — 9/21/15 3) All licensed nurses were in-serviced on proper assessment of residents with hypotension. Clinical care coordinators will monitor assessments for any residents with a diagnosis of hypotension. — 10/7/15 4) Nursing management will audit assessments of all residents with hypotension and report findings to the QI Committee quarterly. — 10/16/15	

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F 309	Continued From page 23 A review of the Nurses Progress Notes revealed the following: May 2, 2015 [Saturday] at 3:23 PM - "Resident missed dialysis this morning, transportation did not come, supervisor made aware. " May 2, 2015 at 10:37 PM - "Resident remains alert and responsive. Denies pain or distress, Rt [right] arm access site intact, thrill and bruit present... At 6 PM NP (nurse practitioner) and supervisor on unit to assess resident, at 8:20 PM supervisor on unit and informed RP [name] of resident not going to dialysis this AM. Orders noted from NP to monitor condition and call MD/NP (medical doctor/ nurse practitioner) if there are any changes in status." A review of [Name of Dialysis Center] log sheet for the month of May 2015 revealed that on Saturday, May 2, 2015 Resident #91 was coded as " M (NS) " (Missed treatment due to -no show). There was no indication recorded as to why the resident did not show up for his/her appointment. A telephone interview was conducted on August 7, 2015 at approximately 11:00 AM with a representative from the dialysis center. He/she acknowledged that the resident did not show for his/her dialysis appointment. The resident ' s scheduled appointment time is 11:00 AM on Tuesday, Thursdays and Saturdays.	F 309	Continued from page 23 1) Resident #203's abdominal binder was removed and feeding tube was reconnected with a new Y-connector. Resident was not affected by the deficient practice. 2) An audit of all dialysis-dependent residents was conducted. No other residents were affected by this practice.	9/18/15
			3) All licensed nurses will be re-educated on management and assessment of residents with G-tubes. Clinical care coordinators will monitor assessments of residents with G-tubes and nursing management team will conduct audits monthly.	10/7/15
			4) Findings will be reported to the monthly QI Committee quarterly.	10/16/15

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F 309	Continued From page 24 A face-to-face interview was conducted with Employee #15 on August 7, 2015 at approximately 12:30 PM. He/she acknowledged the findings and stated, " The resident leaves [the unit] at 9:30AM for transportation to pick him/her up to go dialysis appointments. The resident returns to facility around 4:00 PM. " There was no evidence that Resident #91 received his/her Hemodialysis treatment on Saturday, May 2, 2015 [the scheduled day]. A face-to-face interview was conducted with Employee #15 on August 7, 2015 at approximately 12:30 PM. He/she acknowledged the findings. 2. Facility staff failed to consistently assess and manage Resident #203's Gastrostomy tube [G-tube] to ensure that the connectivity was maintained in order to deliver enteral feeding effectively. Additionally, licensed nursing staff failed to conduct comprehensive nursing assessments when Resident #203 was assessed with repeated episodes of hypotension [low blood pressure]. A. Facility staff failed to consistently assess and manage Resident #203 ' s G-tube. The Physician ' s Order signed and dated [unable to read], directed, " ...Tube feeding with Jevity 1.5 [enteral formula] 70 ml via g [Gastrostomy]	F 309	Continued from page 24 1) Resident #274 physician was notified and the order was given to continue the eye drops. The medication was delivered STAT. Administration began on August 4, 2015 at 2 pm. 2) A review of all residents with eye drops was conducted. No other resident was affected by this deficiency. 9/18/2015 3) All nursing staff will be in-serviced on Physician order transcription and administration of eye drops. 10/7/15 4) The Unit Manager will audit administration of eye drops and report findings to QI Committee quarterly. 10/16/15	

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F 309	Continued From page 25 tube via pump for 18 hours per day or until total nutrient delivered. Downtime: 12 AM - 6AM... " " Apply Abdominal binder for g-tube protection. Remove abdominal binder every shift and monitor for any irregularities and re-apply every shift ... " change feeding (Spike Cap Set/bag) every day " The nurse ' s note dated July 19, 2015 at 3:58 PM reads, " RP [responsible party] called writer about G-tube [leaking] on the floor. Writer went inside the room and found g-tube popped out and feeding on the floor. Writer changed y-connector and told [responsible party] that I need caregiver to help change resident. Writer left resident room to call the care giver and before writer returned the g-tube popped out again and [responsible party] said, ' I heard the [pop] and know it was [the] g-tube but I didn ' t touch it. Writer fixed the g-tube and "Y-connector" [a device that provides a connection between a feeding tube] and it popped again while [responsible party] was still in the resident room. [Responsible party] voiced again that [he/she] heard the [pop]. G-tube intact and patent and flushed. No popping or draining noted. [Responsible Party] said, thank you. " An observation of the resident ' s abdominal binder was conducted on August 7, 2015 at approximately 1:45 PM. At the time the tubing [that connects the feeding to the resident] was noted to be disconnected at the connector site and the enteral feeding had spilled onto the resident ' s bed linens [sheets and draw sheet]. A face-to-face interview was conducted with Employee #13 immediately after the observation	F 309	Continued from page 25	

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F 309	Continued From page 26 of the binder and the spilled tube feeding liquid. The employee acknowledged that the Gastrostomy tube had become disconnected/separated and caused the feeding to spill into the resident ' s bed on several occasions. The employee also acknowledged that the spillage was often reported by family member(s). There was no documented evidence that facility staff assessed the resident ' s GI status [gastrointestional] after occurrences of the Gastrostomy tube separating from the " Y-connector. " In addition there was no documented evidence that facility staff had taken steps to determine why the tubing repeatedly became disconnected. B. Licensed nursing staff failed to conduct comprehensive assessments when Resident #203 was assessed with repeated episodes of " Hypotension " - defined by the American Heart Association as " a blood pressure lower than 90/60 mm/Hg [millimeters of mercury] which may be accompanied with dizziness, lightheadedness, rapid/shallow breathing, fatigue ... " www.heart.org <http://www.heart.org> A review of the clinical record for Resident #203 revealed that he/she sustained approximately three (3) episodes of hypotension between the period of July 14 thru 20, 2015. The resident required transport to a local emergency department to evaluate hypotension.	F 309	Continued from page 26	

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F 309	Continued From page 27 The record included the following documentation relative to episodes of Hypotension: Nurse ' s notes: July 14, 2015 at 4:12 PM " V/S [vital signs] 87/60 [blood pressure], 79 [pulse]; 16 [respirations]; 97.9 [temperature]. Seen by the NP [nurse practitioner named] for low blood pressure ...lab done. Result shows no infection as per NP. New order for extra water flush to 200 ml every 2 hours x [times] one day for hypotension and Sodium chloride 1 g [gram] per g-tube [Gastrostomy-tube] bid [twice daily] x2 doses for low blood pressure. RP [responsible party named] was on the unit and NP updated [him/her] about resident low blood pressure and labs result and new order. " SIC July 22, 2015 at 4:02 PM " Resident is stable. G-tube intact and patent. Feeding and medication well tolerated. Low blood pressure at 84/55. NP was notified. No distress or agitation noted this shift. " July 20, 2015 at 4:19 PM " Resident is stable. G-tube is intact and patent. Medication administered as ordered. No agitation noted this shift. Resident has low blood pressure [blood pressure recorded on medication administration record 85/60]. NP was notified. " Physician ' s interim order	F 309	Continued from page 27	

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F 309	Continued From page 28 Physician ' s order dated July 20, 2015 at 5:01 PM read: " Send pt [patient] to ER [emergency room] [hospital name] for eval [evaluation] of hypotension. " There was no evidence that licensed nursing staff comprehensively assessed Resident #203 to determine his/her hemodynamic status once he/she was noted with Hypotension. The documentation in the nursing entries lacked evidence as to whether or not the resident demonstrated adverse signs and symptoms of Hypotension [examples listed above in Hypotension definition] and the documentation was inconsistent with acceptable standards of practice as it relates to a comprehensive assessment of hemodynamic status. The findings were acknowledged during a telephone interview with Employee #2. 3. Facility staff failed to administer an ophthalmic solution to Resident #274 in accordance with physician ' s orders. According to a history and physical progress note dated July 28, 2015 revealed Resident # 274 was admitted to the facility on July 27, 2015 and diagnoses included Glaucoma. A physician ' s order dated July 27, 2015 and	F 309	Continued from page 28	

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F 309	Continued From page 29 signed July 28, 2015 directed; " Atropine Sulfate Ophthalmic Solution USP 1%- eye drop right eye (four times a day) [for] Glaucoma. " A review of the July and August 2015 Medication Administration Records (MAR) lacked evidence of nurses initials in the allotted spaces [indicative that the medication was administered] on July 28, 29, and 30 and August 1-4, 2015. A total of 30 doses were omitted. On the reverse side of the MAR under the heading " PRN, STAT and Medications not administered, " nursing staff documented the following: " 7/31/15 -6AM- Atropine Sulfate-not available- not given. " There was no further documentation to indicate why the Atropine Ophthalmic Solution was not administered. A face-to-face interview was conducted with Employees' # 3, #4, #13 and #31 on August 4, 2015 at approximately 11:00 AM regarding the aforementioned findings. After review of the clinical record all acknowledged the findings. The clinical record was reviewed on August 4, 2015.	F 309	Continued from page 29 **483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **F323** **1)** The flat aluminum-like pan and the trash receptacle upon observation was filled with sand on 8/6/15. There were no unfavorable outcomes as a result of this finding.	8/6/15
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**2)** An order for two safe smoker receptacles was placed on 8/10/15 and upon arrival these receptacles will be put into use and the existing receptacles will be removed.	10/5/15

This REQUIREMENT is not met as evidenced

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F 323	Continued From page 30 by: Based on observations and staff interview, it was determined that facility staff failed to ensure that the facility was free of potential accident hazards as evidenced by failure to ensure the safe disposal of smoking materials in adequate receptacles in the designated smoking area for residents' that reside in the facility. The findings include: According to National Fire Protection Association (NFPA) 2000 Edition,19.7.4..."3) Ashtrays on noncombustible material and safe design shall be provided in all areas were smoking is permitted. 4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking in permitted." On August 6, 2015 at approximately 4:25 PM in the presence of Employee #24 the facility ' s designated smoking area was observed. At this time one (1) of one (1) flat aluminum-like pan was observed on the metal outdoor table in the designated smoking area. There were no residents observed smoking at the time of the observation; and there were no cigarette wastes (i.e. butts) observed in the flat aluminum-like pan. One (1) of one (1) open top trash receptacle with a clear plastic liner was also observed in the designated smoking area. Employee #24 acknowledged that the flat aluminum-like pan and the trash receptacle were not adequate for safe disposal of cigarette waste. He/she stated, " Security is always present when the residents are	F 323	Continued from page 30 **3)** The order for safe smoker receptacles was placed on 8/10/15, however until the safe smoker receptacles arrive the receptacles filled with sand will ensure a safe practice. **4)** A quality assurance program to monitor accident hazards/supervision/devices requirements has been implemented under the supervision of the Director of Engineering/Designee which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor. A report will be provided at the next Quality Improvement meeting effective 10/16/15.	10/5/15 10/16/15

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F 323	Continued From page 31 smoking. I will order one [an approved cigarette receptacle] it will be here tomorrow. " Facility staff failed to ensure that the designated smoking area was equipped with adequate receptacles for the safe disposal of cigarette waste. The receptacles (aluminum pan and the open top trash can with a plastic liner) utilized for the disposal of cigarette waste failed to meet safe disposal requirements.	F 323	Continued from page 31 **483.25 (i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** **F325** **1)** The Physician order for Ensure Plus for resident #161 was corrected immediately and the supplements were purchased the same day. Ensure Plus is being served with meals as ordered began on August 5, 2015 The resident was assessed and was not affected by the deficient practice. **2)** A review of all residents with orders for nutritional supplements was conducted. No other residents were affected by this deficient practice.	9/21/15
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview for one (1) of 44 sampled residents, it was determined that the facility failed to ensure that Resident #161 was administered eight (8) ounces of Ensure Plus at each meal in	F 325	**3)** All licensed staff and nutritionists were educated on transcriptions of orders for nutritional supplements. Orders will be reviewed daily by Clinical Care Coordinators.	10/7/15

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F 325	Continued From page 32 accordance with the physician's order. The findings include: A physician's order dated July 14, 2015 directed, "D/C [discontinue] Med Pass [fortified nutritional shakes] and sugar free med pass orders (secondary) to resident's request for Ensure Plus [nutritional supplement] " Contact family to bring Ensure Plus from home..." The Interim Physician's Order dated July 16, 2015, directed: "Supplement clarification 1. Administer Ensure Plus 8 ozs (ounces) po at each meal (per resident's request) rather than between meals. 2. Family responsible for bringing product" A review of the Medication Administration Record from July 14, 2015 to August 5, 2015 revealed that Ensure Plus had not been administered to Resident #161. A face-to-face interview was conducted on August 4, 2015 at approximately 4:00 PM with Employee #28. He/she was asked about the above orders and whether the resident's family member had been contacted [to bring the Ensure plus]. Employee #28 revealed that the resident contacted the [family member] a while ago [date and or time not specified] and [family member] would bring the Ensure Plus to the facility.	F 325	Continued from page 32 4) The nursing management team will monitor documentation of orders for nutritional supplements. Findings will be reported to the monthly QI Committee meetings quarterly.	10/16/15

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F 325	Continued From page 33 A face-to-face interview was conducted on August 5, 2015 at approximately 3:30 P.M. with Resident #161. He/she stated, "My [family member] said [he/she] was going to bring the Ensure but I haven't seen [he/she]." A face-to-face interview was conducted with Employee #2 and Employee #28 on August 5, 2015 at approximately 4:00 PM. Employee #2 stated, "The resident has a right to refuse the Med Pass and the facility will make sure that [he/she] gets the Ensure Plus." Employee #28 said the [he/she] would personally go to the drugstore to purchase the Ensure Plus. There was no evidence that the resident sustained untoward affects (e.g. weight loss) as a result of not receiving the supplement. The record was reviewed on August 5, 2015. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 325	Continued from page 33 **483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** **F 329** **1)** Unable to retrospectively correct for the deficient practice. Resident #44 was not affected by the deficient practice, but the nursing staff will be re-educated. **2)** All residents with orders for antipsychotic medications were reviewed and corrections made if necessary. — 9/18/15 **3)** All licensed nurses will be in serviced on resident drug regimen to ensure they are free from unnecessary drugs. — 10/7/15 **4)** The nursing management team will monitor documentation for antipsychotics and report the findings to the monthly QI Committee quarterly. — 10/16/15
F 329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	Continued From page 34 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 44 sampled residents, it was determined that facility staff failed to document the rationale for the administration of Haldol (antipsychotic medication) for one (1) resident. Resident #44. The findings include: A review of the May 2015 Physician ' s Orders signed and dated May 15, 2015 directed, " Haldol Lact (lactate) Inj (injection) 5mg/1 ML inject 0.4mls (2MG) Intramuscularly every six hours as needed for agitation. " A review of the May 2015 Medication Administration Record revealed that Resident # 44 received Haldol Lact (lactate) Inj (injection) 5mg/1 ML inject 0.4mls (2MG) Intramuscularly every six hours as needed for agitation at 1:30	F 329	Continued from page 34	

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F 329	Continued From page 35 PM on May 1, 2015. A review of the reverse side of the Medication Administration record lacked a reason for the administration of the medication, and the result/effectiveness of the medication post administration. A review of " Psychoactive Medication Monthly Flow Record " revealed that on May 1, 2015 Resident #44 was coded as having no behaviors. A review of the " Nursing Notes " dated May 1, 2015 lacked documentation of the resident having behavioral episodes, the intervention utilized and outcomes. There was no evidence that facility staff documented the resident's behavior to justify the reason to administer the "as needed Haldol" and failed to record the effectiveness post administration of the medication. A face-to-face interview was conducted on August 6, 2015 at 9:45 AM with Employee #10. He/she acknowledged the findings. The record was reviewed on August 6, 2015.	F 329	Continued from page 35 **483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE SANITARY** **F371** 1) 1. Food temperatures from newly installed steam tables located in the dining room of units 1 Green and 2 Green are not monitored and have never been monitored. The temperature of the food for the newly installed steam tables was taken prior to leaving the kitchen area. As of 8/4/05 food temperature logs for steam tables was implemented. 2. One (1) of one (1) ice machine on unit 2 Orange was soiled and upon observation 3. Three (3) of nine (9) six-inch hotel pans, one (1) of nine (9) four-inch hotel pans and two (2) of eight (8) eight-inch hotel pans in the main kitchen were dented. An order was placed on 9/10/15 to replace the identified dented hotel pans. The expected delivery date for the replacement hotel pans is 9/15/15. **2)** 1. Food temperature logs for the delivery of all resident food is in place. Food 09/28/15 temperatures are reviewed by the Director of Food and Nutritional Services on a daily basis.	9/15/15 9/28/15
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 36 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on August 3, 2015 at approximately 9:30 AM and on August 6, 2015 at approximately 11:05 AM, it was determined that the facility failed to serve food under sanitary conditions as evidenced by the lack of food temperature monitoring from steam tables located in the dining room of units 1 Green and 2 Green, a soiled ice machine on unit 2 Orange and dented hotel pans in the main kitchen. The findings include: 1. Food temperatures from newly installed steam tables located in the dining room of units 1 Green and 2 Green are not monitored and have never been monitored. 2. One (1) of one (1) ice machine on unit 2 Orange was soiled. 3. Three (3) of nine (9) six-inch hotel pans, one (1) of nine (9) four-inch hotel pans and two (2) of eight (8) eight-inch hotel pans in the main kitchen were dented. These observations were made in the presence of Employee #23 who acknowledged the findings.	F 371	Continued from page 36 2. Ice machines on all units have been inspected by the Director of Engineering/ Designee on 9/21/15. 3. The condition of all hotel pans/ kitchen equipment will be inspected for replacement/repair. **3)** An in-service will be provided to the Food and Nutritional services and Engineering staff on the relevance of food sanitary conditions and the regulatory requirements. This training will be initiated on 9/21/15 . **4)** A quality assurance program to monitor Food procurement, storage, preparation, serving and sanitary requirements was implemented under the supervision of the Director of Food and Nutritional Services and Director of Engineering which will be monitored and reported on a monthly basis to the Quality Improvement Committee for at least one year, prior to the committee determining to discontinue this monitor effective 10/16/15.	9/28/15 10/16/15

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F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 44 sampled residents, it was determined that pharmacy services failed to ensure that an ophthalmic medication was delivered to the facility and available to be administered to the resident. Resident #274 The findings include: A review of Resident #274 ' s record revealed a physician ' s order signed July 28, 2015 at 8:55 AM directed: " Atropine Sulfate Ophthalmic Solution USP 1%- eye drop right eye (four times a	F 425	**483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH** **F 425** 1) Resident #274 was not affected by this deficiency. The Physician was notified and a STAT order for the ophthalmic solution was immediately faxed to the pharmacy. The medication was received on August 4, 2015 and administration began at 2 pm. 2) All residents' orders for ophthalmic solutions were reviewed. No other residents were affected by this deficient practice. 3) Pharmacy will reinforce procedure to manually check off each written order as they are processed and reviewed. Pharmacy will reinforce process for communication to the facility and documentation of reasons for new orders not being processed and dispensed such as needed clarification and non-availability as well as follow up required for nursing staff.	9/18/15 10/7/15

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F 425	Continued From page 38 day) [for] Glaucoma. " A review of the Medication Administration Record for July 2015 and August 2015 revealed that the facility identified that the Atropine Sulfate Ophthalmic Solution was to be administered at 6AM, 10AM, 2PM and 6PM. Review of the July 2015 and August 2015 Medication Administration Records (MAR) revealed that Resident #274 was not administered the medication from July 28, 2015 through August 4, 2015. The reason written on the reverse side of the July 2015 MAR was " Not available. Not given. " A total of 30 doses were not administered to Resident #274. A face-to-face interview was conducted with Employees # 3, #4, #13 and #31 on August 4, 2015 at approximately 11:00 AM regarding the aforementioned findings. After review of the clinical record all acknowledged the findings. A telephone interview was conducted with Employee #32 on August 4, 2015 at approximately 11:06 AM regarding the aforementioned findings. He/she stated the physician orders for the resident ' s admission medications were faxed and received by the pharmacy at 10:56 PM on July 28, 2015. Further stated, " The medications should have been dispensed and delivered to the facility in accordance to the delivery schedule agreed upon by the facility and pharmacy. There was no documentation in the system as to why the medication was not sent. So, it was overlooked or missed. I will refer this incident to the Quality Department. "	F 425	Continued from page 38 4) Pharmacy consultant will monitor medication delivery processes. Nursing management will report findings to the monthly QI Committee quarterly.	10/16/15

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F 425	Continued From page 39 There was no evidence that the pharmacy ensured that an ophthalmic medication was delivered to the facility and available to be administered to the resident. The clinical record was reviewed on August 4, 2015.	F 425	Continued from page 39 **483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	**F 431** **1)** The alcoholic beverage bottles were immediately labeled with the resident's name and room number and safely stored on 8/3/15. **2)** All residents' orders were reviewed. No resident was affected by this practice. 9/18/15 **3)** The nursing staff has been re-educated on proper labeling and storage of ordered alcoholic beverages. 10/7/15 **4)** Nursing management will monitor labeling and storage of alcoholic beverages and report the findings to the monthly QI Committee quarterly. 10/16/15	

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F 431	Continued From page 40 be readily detected. This REQUIREMENT is not met as evidenced by: During a medication storage tour on August 3, 2015 at approximately 10:55 AM, it was determined that facility staff failed to label two (2) of two (2) opened bottles of alcoholic beverages, that were stored in the medication room in an unlocked storage cabinet on one (1) of eight (8) residential care units. The finding include: The facility ' s policy , " Resident Alcohol Beverages " Policy No: NSD04-164, stipulates, " ... 2. All alcohol beverages will be labeled with the resident ' s first and last name and room number and stored in the medication room or the refrigerator on the nursing units. " On August 3, 2015 at approximately 10:55 AM an observation of the medication room was conducted. At this time two (2) of two (2) unlabeled and opened 3 liters and 1.5 liters bottles of Livingston Cellars Burgundy Wine was observed on the 3rd shelf of an unlocked cabinet located in the medication room on Unit 2 Blue. The observation was made in the presence of Employee #2, Employee #29 and Employee # 30. All acknowledged the findings.	F 431	Continued from page 40 **483.70 (c) (2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION** **F 456 1)** 1. Two (2) of two (2) blades from the buffalo chopper were chipped and dented and needed to be replaced. There were no negative outcomes to the residents as a result of this deficiency. The blades from the buffalo chopper were ordered on 8/10/15 and have been put into use as of 8/14/15. 2. One (1) of seven (7) steam table lid covers did not have a handle. There were no negative outcomes to the residents as a result of this deficiency. The replacement steam table lid was ordered as of8/17/15 and has been placed into use.	8/14/15
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		

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F 456	Continued From page 41 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on August 3, 2015 at approximately 9:30 AM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by two (2) of two (2) chipped and dented blades from the buffalo chopper, one (1) of seven (7) steam table covers with a missing handle and one (1) of two (2) reach-in refrigerator with a torn door gasket. The findings include: 1. Two (2) of two (2) blades from the buffalo chopper were chipped and dented and needed to be replaced. 2. One (1) of seven (7) steam table lid covers did not have a handle. 3. The door gasket from one (1) of two (2) reach-in refrigerators was torn. These observations were made in the presence of Employee #23 who acknowledged the findings.	F 456	Continued from page 41 3. The door gaskets of two (2) reach in refrigerators in the kitchen were torn and replaced on 09/21/2015. There were no negative outcomes to the residents as a result of this deficiency. **2)** All essential equipment in the kitchen including the buffalo chopper blades, steam table lid and refrigerator door gaskets will be checked and assessed on 09/28/2015 to determine if repairs/ replacements are required. **3)** An in-service was provided for all Food and Nutritional Services and Engineering staff regarding the ongoing inspections of all Essential equipment the kitchen and specific to the Engineering staff they gained additional knowledge on the essential equipment throughout the facility. **4)** A Preventative Maintenance Program will be implemented effective 09/30/15 to to monitor and inspect essential equipment, to include, however not be limited to kitchen equipment such as (buffalo chopper blades, pans and steam table lid covers, which will be inspected by the Director of Food and Nutritional Services and refrigerator gaskets will be inspected by Director of	9/28/15 9/30/15 10/16/15
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463		

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F 463	Continued From page 42 facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on August 6, 2015 at approximately 2:15 PM, it was determined that the facility failed to maintain call bells in good working condition as evidenced by call bells that failed to alarm when tested in two (2) of 48 resident's rooms. The finding include: Call bells in resident rooms #105 and #112 did not activate when tested in two (2) of 48 resident's rooms. These observations were made in the presence of Employee #24 and/or Employee #26 who acknowledged the findings.	F 463	Continued from page 42 Engineering) refrigerators in the facility monthly, which will be reported effective10/16/15 quarterly to the Quality Improvement Committee. **483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH** **F463** **1)** Call bells for residents in rooms #105 and #112 were immediately replaced. **2)** A review was conducted of call bells in all other residents' rooms. None were found to be inactive. **3)** All staff were re-educated on checking call bells for proper functioning. Unit clerks will conduct testing of call lights weekly. **4)** Nursing management team will report findings to the monthly QI Committee quarterly.	9/18/15 10/7/15 10/16/15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514		

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F 514	Continued From page 43 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) for 44 sampled residents, it was determined that facility staff failed to ensure that facility staff accurately documented the amount of water administered to Resident #203. The findings include: The Physician ' s Interim Order dated July 14, 2015 at 3:00 PM, directed, " Extra water flush to 200 ml every 2 hours x [times] one day for hypotension... " A review of July 2015 Medication Administration Record revealed, " Extra water for one day may increase water flush to 200 ml 2qh [every two hours] x [times] one day for hypotension " . The hours recorded for the administration times were 11-7 [shift]; 7-3 [shift] and 3-11 [shift]. On July 14 and 15 nurses ' initials were observed allotted spaces indicating that water flushes were administered every shift. There was no documented evidence that facility staff administered water flushes every two hours [twelve times in 24 hours] as ordered by the	F 514	Continued from page 43 **483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE** **F514** **1)** Resident #203's feeding pump was set to deliver the extra water as ordered. The fluid was given to the resident through the feeding tube. **2)** A review of all residents with feeding tubes was conducted. No other residents were affected by the deficient practice. — 9/18/15 **3)** All nursing staff will be re-educated on correct documentation of extra amounts of water ordered for residents with feeding tubes. The clinical care coordinators will monitor orders for extra water for residents. — 10/7/15 **4)** The nursing management team will report findings to the monthly QI committee quarterly. — 10/16/15	

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F 514	Continued From page 44 physician. On September 3, 2015 at approximately 11:00 AM, a telephone interview was conducted with Employee #3. He/she stated that the resident received the fluids every two hours and acknowledged the findings.	F 514		