Stoddard Baptist
GLOBAL CARE
www.stoddardbaptistglobal.org

September 1, 2016

Veronica Longstreth, RN, MSN
Interim Program Manager
District of Columbia Department of Health
Health Care Regulation and Licensing Administration
899 North Capitol Street, NE, 2nd Floor
Washington, DC 20002

Ms. Longstreth:

Enclosed are our Plans of Correction for the July 15, 2016 Recertification (Health) Quality Indicator Survey (QIS) and Licensure survey that was conducted at Stoddard Baptist Global Care at Washington Center for Aging Services.

If any additional information is needed please feel free to contact me at: (202) 541-6068.

Sincerely,

Denise Chadwick Wright

Denise Chadwick Wright
Nursing Home Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING _____ B. WING _____	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Washington Center for Aging Services from July 7, 2016 through July 15, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 43 sampled residents during Stage 2. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram	F 000	SBGC at WCAS, is filing this Plan of Correction In accordance with the compliance requirements for federal and state egulations. 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
Denise Chadwick by proxy	Nursing Home Administrator	8/31/16

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 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 AM Care - morning activities of daily living	F 000	Continued From page 1	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246	**F246** 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/ PREFERENCES	

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F 246	Continued From page 2 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews for three (3) of 43 Stage 2 sampled residents, it was determined that facility staff failed to provide routine showers for one (1) resident who was totally dependent on staff for all personal care needs, and failed to accommodate the residents ' choice to receive showers for two (2) residents. Residents' #9, #68, and #211. The findings include: 1. Facility staff failed to provide routine showers for Resident #9, who was totally dependent. A family interview was conducted on July 8, 2016 at approximately 12:40 PM. In response to the question, " Does the resident receive the same number of baths or showers in a week based on past preferences? " The family member responded, "No. I do not think [he/she] gets showers, we often have to ask for [him/her] to be washed up." A review of the quarterly MDS with an ARD (Assessment Reference Date) of June 10, 2016 revealed, the resident was coded as totally dependent for dressing, toilet use and personal	F 246	1) The routine shower documentation, which is captured in the facility's electronic documentation under ADL documentation did not reflect the shower services provided to the affected residents by the facility staff. (A) The Resident #9 was assessed and given a shower 7/8/16, which has been documented. (B) Resident #68 was assessed and given a shower on 7/8/16. The Resident Care Manager reviewed the shower accommodation preferences with the resident and have documented on the shower schedule and care plan. (C) Resident #211 was assessed and given a shower on 7/8/16. The Resident Care Manager reviewed the shower accommodation preferences with the resident and have documented on the shower schedule and care plan. 2) Resident Care Managers/ Charge Nurses conducted rounds on all nursing units to assess if showers were given as scheduled The Charge Nurses/Nurse Supervisors will validate/verify at the end of each shift and the Resident Care Managers will review daily. Clinical Staff Expectations (all levels licensed and non licensed) have been developed, the review and distribution of these expectations has been initiated.	08-28-16 08-28-16

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F 246	Continued From page 3 hygiene. According to Section I (Diagnoses) the resident was admitted to the facility with diagnoses which included Alzheimer ' s Disease, Non-Alzheimer ' s Dementia and Depression. A face-to-face interview was conducted with Employee #9 at approximately 3:00 PM on July14, 2016. The employee was queried regarding the family member ' s response that the resident did not receive regular showers. The employee stated that the resident received showers on shower days [Days when showers are routinely scheduled to be given]. The employee added that each resident has two-to-three shower days every week. A review of the documentation of the "Showers Sheets" for May, June and July 2016 revealed that the resident received four (4) showers in May: May 01, May 03, May 20 and May 24, 2016. The resident received one (1) shower in June, on June 05, 2016. The resident received no showers between July 01 and July 14, 2016. A face-to-face interview was conducted on July 14, 2016 at approximately 4:20 PM with Employee #9. After review of the aforementioned he/she acknowledged the findings. The record was reviewed on July 15, 2016. 2. Facility staff failed to accommodate Resident #68's choice to receive showers. During a resident interview conducted on July 7,	F 246	Continued From page 3	

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F 246	Continued From page 4 2016 at approximately 3:30 PM, when resident was queried, " Do you choose whether you take a shower, tub, or bed bath? He/she responded, " No, I would like to have a choice of taking showers. " A history and physical dated August 30, 2015 revealed resident ' s diagnoses included: Osteoarthritis and Chronic Osteoporosis. The "Physician's Order" signed July 1, 2016 directed: "Functional Level- Dependent For: ... bathing, Dressing, Eating, Mobility, Continence, Weight Bearing..." According the annual Minimum Data Set (MDS) dated June 2, 2016, Resident #68 was coded under Section F (Preferences for Customary Routine and Activities) as choosing between a tub bath, shower, bed bath, or sponge bath was very important. A review of the unit 's shower schedule book, revealed that the resident was scheduled to have showers on Wednesday and Saturday evenings. A review of the electronic ADL (Activities of Daily Living) flow sheet revealed from June1, 2016 to July 13, 2016, it was documented that the resident had received a total of two (2) showers. Facility staff failed to accommodate Resident #68 choice to receive showers. A face-to-face interview was conducted with Employee #49 on July 14, 2016 at approximately 11:23 AM regarding the aforementioned findings.	F 246	Continued From page 4 3) Licensed Nurses and nursing assistants have been educated on Activities of Daily Living with focus on the electronic ADL documentation. The Charge nurses and Resident Care Managers/Nurse Supervisors were re-educated on how to ensure that the electronic ADL documentation is in compliance on a consistent basis. The Charge Nurses/Nurse Supervisors will validate/verify at the end of each shift and the Resident Care Managers will review daily. Clinical Staff Expectations (all levels licensed and non-licensed) have been developed, the review and distribution of these expectations has been initiated. 4) Residents ADL Care will be monitored on a daily basis and reported to the Quality Improvement Committee on a monthly basis for a minimum of a three month period if for all residents based on the residents' preferences compliance is consistent during this time period, the reporting frequency will be reviewed and if determined appropriate by the QAPI Committee it will be changed to quarterly.	08-28-16 08-19-16

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F 246	Continued From page 5 He/she acknowledged the findings. The clinical record was reviewed on July 14, 2016. 3. Facility staff failed to accommodate Resident #211 ' s choice to receive showers. Resident #211 was admitted to the facility from an acute care hospital on February 4, 2016. According to a history and physical dated February 6, 2016 revealed diagnoses included: ESRD (End Stage Renal Disease), Hypertension, Diabetes Mellitus and Coronary Artery Disease. During a resident interview conducted on July 8, 2016 at approximately 10:23 PM, the resident was queried, " Do you choose whether you take a shower, tub, or bed bath? He/she responded, " No, I would like to have more showers. I have only had two (2) showers since I was admitted. " According to an admission Minimum Data Set (MDS) dated April 11, 2016, Resident #211 was coded under Section F (Preferences for Customary Routine and Activities) as choosing between a tub bath, shower, bed bath, or sponge bath was very important. A review of the unit ' s shower schedule book, revealed that the resident was scheduled to have showers on Wednesday and Saturday evenings. A review of the electronic ADL (Activities of Daily	F 246	Continued From page 5	

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F 246	Continued From page 6 Living) flow sheet revealed that the resident received five showers from February 2016 to July 2016. Facility staff failed to accommodate Resident #211 ' s choice to receive showers. A face-to-face interview was conducted with Employee #31 on July 13, 2016 at approximately 1:05 PM regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on July 13, 2016.	F 246	**Ftag 253** 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 1. (A) Dust has been removed and cleaning has been completed for the 2 out of 44 identified resident bathroom vents identified in rooms #272 and #316 on 8/3/16. (B) The 2 out of 44 soiled bathroom floors identified in rooms #337 and #339 with dark spots were corrected with cleaning/stain removal on 8/3/16. (C) The 5 out of 17 stained chairs located in the solarium on 2 Green were immediately removed and cleaned on 8/3/16. (D) The 5 out of 72 cans of Glucerna nutritional supplements that expired as of June 2016; 2 out of 2 cans of eight ounce Jevity high protein cans of nutritional supplement that were expired as of March 2016 on the 1 of 8 units surveyed all were immediately removed. 2. (A) The Dir. Of Environmental Services/Environmental Services Supervisors/Team Leaders conducted rounds to ensure that the all bathroom vents have been cleaned and dust removed if applicable.	08-03-16 08-03-16
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 on July 12, 2016 between 9:50 AM and 12:30 PM, it was determined that the facility failed to provide housekeeping services necessary to maintain a sanitary environment as evidenced by soiled bathroom vents in two (2) of 44 resident's bathrooms, soiled bathroom floors in two (2) of 44 resident's bathrooms, five (5) of 17 stained chairs located in the solarium of one (1) of eight (8) resident care units surveyed, five (5) of 72 cans of Glucerna nutritional supplements that were expired as of June 2016 on one (1) of eight (8) resident care units surveyed, and two (2) of two (2) eight-ounce cans of Jevity high protein cans of nutritional supplement that were expired as of	F 253		

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F 253	Continued From page 7 March 2016 on one (1) of eight (8) resident care units surveyed. The findings include: 1. Bathroom vents in two (2) of 44 resident rooms (#272 and #316) surveyed were soiled with dust. 2. The floor in the bathroom of resident room #337 and #339 were soiled with dark spots throughout, two (2) of 44 resident rooms surveyed. 3. Five (5) of 17 chairs in the solarium on unit 1 Green were stained, one (1) of eight (8) resident care units surveyed. 4. Five (5) of 72 eight-ounce cans of Glucerna, 1.2 cal, nutritional supplement located in the storage room on unit 3 Green were expired as of June 2016, one (1) of eight (8) resident care units surveyed. 5. Two (2) of two (2) eight-ounce cans of Jevity, 1.5 cal high protein cans of nutritional supplement with fiber located in the storage room on unit 3 Green were expired as of March 2016, one (1) of eight (8) resident care units surveyed. These observations were made in the presence of Employee #5 and Employee #6 who acknowledged the findings.	F 253	Continued From page 7 (B) The Dir. Of Environmental Services/Environmental Service Supervisors/Team Leaders conducted rounds to ensure that all bathroom floors are free of stains. (C) The Dir. Of Environmental Services/Environmental Services Supervisors/Team Leaders reviewed all solarium chairs and had them cleaned as applicable. (Need a worksheet/checklist to support with signatures.) (D) The Materials Management conducted a facility wide check of all of the nutritional supplement storage areas to ensure that there were no other expired nutritional supplements. 3. (A) The Dir. Of environmental Services re-educated the environmental services employees on the daily checklist and proper cleaning of vents,in addition to the regulation, F253 and the importance of ensuring compliance. (B) The Dir. Of Environmental Services/Regional Director of Environmental Services re-educated the environmental services employees on the cleaning of floors, which, which entailed stain/spot	08-03-16
F 272	483.20(b)(1) COMPREHENSIVE	F 272	removal and their removal and their	

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F 272 SS=E	Continued From page 8 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's 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.	F 272	Continued From page 8 Expectations F253 and the importance of ensuring compliance. (C) Dir. Of Environmental Services/Regional Director of Environmental Services re-educated the environmental services employees on the expectations F253 and the importance of ensuring compliance. (D) The Materials Management Manager changed the nutritional supplement stocking and storage process from the Vendor conducting to being conducting by in house staff on a weekly basis. 4. (A) The Dir. Of Environmental Services/Designee will provide the QAPI committee with a monthly report on the status of cleanliness (dust free) of: (A) bathroom vents; (B) bathroom floors; (C) soiled chairs/furnishings. The Materials Management Manager/Designee will report on the nutritional supplement storage (assuring compliance with no expired cans in circulation). All of these areas will be reported on for a minimal of 3 months, if found to consistently be in compliance for this reporting period, it will be changed to quarterly. **F272** COMPREHENSIVE ASSESSMENTS	08-19-16

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 43 Staged 2 sampled residents, it was determined that facility staff failed to accurately code Minimum Data Sets (MDS) for one (1) resident with a pressure ulcer, one (1) resident with a pacemaker; and one (1) resident with a UTI (Urinary Tract Infection). Residents ' #9, #98, and #279. The findings include: 1. Facility staff failed to accurately code the annual and quarterly MDS for pressure ulcer for Resident #9. A review of the resident ' s clinical record revealed that a stage 2 pressure ulcer measuring 3.2 x 2.6 x 0.2 centimeters (cm) was identified on the resident ' s sacrum on May 11, 2016. Documentation on the Wound and Skin Care Progress Note dated June 01, 2016 described the wound as a Stage 3 measuring 2.5 x 2.0 x 0.3cm with 70% granulation, 30% slough and no Eschar. According to the quarterly MDS with an Assessment Reference Date of June 10, 2016 the resident was coded as a " 1 " under the heading of Risk of Pressure Ulcers. Under the heading of Unhealed Pressure Ulcers the resident was coded with a zero (0) indicating that the resident had no ulcers. Under the heading of numbers of ulcers for each stage; Stage 1, Stage	F 272	Continued From page 9 COMPREHENSIVE ASSESSMENTS Resident #9, #98, #279: 1. Quarterly and annual modification was completed for inaccurate coding for the following residents: Resident #9 – Pressure Ulcer 7/14/16 Resident #98 – Pacemaker 7/15/16 Resident #279 – Urinary Tract Infection 7/14/16. There were no unfavorable outcomes as a Result of this practice. 2. Audits were conducted on all MDS for accuracy and coding for pressure ulcers, pacemakers and UrinaryTract Infections (UTI), and none were found incorrect. 3. In-service was provided to the MDS Coordinators on coding pressure ulcers, pacemakers and urinary tract infections and none were found incorrect. 4. MDS Coordinators coding will be monitored monthly by a MDS Consultant Group. The consultant group's report will be reported to the Quality Improvement Committee on a quarterly basis.	7-15-16 7-29-16 8-04-16 8-19-16

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F 272	Continued From page 10 2, Stage 3 and Stage 4 the areas were all left blank indicating that the resident had no ulcers at any stage. A face-to-face interview was conducted with Employee #29 at approximately 11:00AM on July 12, 2016. The employee was queried regarding the absence of coding of the pressure ulcer on the MDS. He/she responded that his/her coding was based on the information from the assessment sheets. The clinical record was reviewed on July 12, 2016. 2. Facility staff failed to accurately code the quarterly MDS for a Pacemaker for Resident #98. A review of the clinical record revealed that Resident #98 had a Pacemaker device implanted on March 27, 2015. A review of the Physician ' s Notes: Physical Examination dated March 3, 2016 and April 27, 2016 revealed under: Cardiovascular that the resident had a " pacemaker. " A review of the Nursing Care Plan, revealed a " Problem start date: 8/12/2015 " Potential for cardiac complications related to dysrhythmias - resident requires use of Pacemaker. A review of the resident ' s quarterly MDS completed May 3, 2016 revealed that the resident was not coded as having a pacemaker under Section I (Active Diagnoses).	F 272	Continued From page 10	

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F 272	Continued From page 11 A face-to-face interview was conducted with Employee #29 on July 14, 2016 at approximately 10:30 AM. He/she acknowledged the findings. The record was reviewed on July 14, 2016. 3. Facility staff failed to accurately code the admission Minimum Data Set (MDS) for a UTI [urinary tract infection] for Resident #279. The hospital discharge/transfer summary dated March 22, 2016 revealed; " During course of admission patient was treated for UTI with completed antibiotic therapy ... " According to the History and Physical form dated April 12, 2016, Resident #279 ' s problems included: " Dementia, Depression, Hypertension and Recent UTI. " A review of the admission MDS (Minimum Data Set) dated April 15, 2016 revealed under Section I (Active Diagnoses), UTI (last 30 days) was not coded. A face-to-face interview was conducted with Employee #29 on July 14, 2016 at approximately 2:00 PM regarding the aforementioned findings. After reviewing the MDS, he/she acknowledged the MDS was not coded for a UTI within 30 days. The clinical record was reviewed on July 14, 2016.	F 272	Continued From page 11	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	**F 279** 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	

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F 279	Continued From page 12 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 43 Stage 2 sampled residents, it was determined that facility staff failed to develop an integrated care plan to include care and services that would be provided by Hospice. Resident #193. The findings include: A review of the resident ' s clinical record revealed that the resident was enrolled in Hospice on October 13, 2015. Review of the clinical record revealed a Hospice Care Plan which addressed areas of care to be performed by Hospice.	F 279	Continued From page 12 1. Resident #193 care plan was revised on 7/18/16 to reflect integration of care and services being provided to the resident by the facility and Hospice Services. There were no unfavorable outcomes to the resident.	8-31-16
			2. All residents receiving Hospice Services care plans were checked to Ensure integration of care and services were being provided between the facility and Hospice.	8/31/16
			3. In-services were provided for the facility staff and Hospice Services with focus on integration of care and services for the residents.	8-28-16
			4. Integration of care of the residents' and care plans for Hospice Services will be monitored monthly and reported to the Quality Improvement Committee quarterly. The next quarterly meeting is scheduled for 9-16-16.	8-31-16
			5. Completion date:	

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F 279	Continued From page 13 A review of the care plan section of the clinical record revealed the facility ' s care plans which were separate and apart from the Hospice care plans. One of the problems identified on the care plan was titled " Hospice. " The care plan was originally created on July 15, 2015. The following notation was documented under " Problem " : " Resident is under Hospice care. Staff continues to make the resident comfortable. Resident has cognitive impairment due to CVA [Cerebral Vascular Accident] and difficulty in decision making. " Under the heading of Goal was written " Hospice Care. " Under the heading of Approach the writer wrote " Hospice Care. " There was no evidence in the care plan of any integration between the services of the facility and the services that were provided by the Hospice Team. A face-to-face interview was conducted with Employee #9 on July 14, 2016 at approximately 4:00PM. When the employee was queried regarding the facility ' s integrated care plan he/she acknowledged that there was none. And explained that the Hospice Team usually participated in the quarterly IDT (Interdisciplinary Team) meetings by telephone. A face-to-face interview was conducted on July	F 279	Continued From page 13	

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F 279	Continued From page 14 15, 2016 with Employee #37 at approximately 11:00 AM. He/she acknowledged participation in the meetings by telephone and that there was no integrated care plan for the provision of care to the resident. " We have our care plan and they have theirs. " The record was reviewed on July 14, 2016.	F 279	Continued From page 14	
F 280 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 43 Stage 2 sampled residents, it was determined that facility staff failed to review and revise the residents care plan	F 280	F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 1. Resident 108 care plan was revised to reflect the family preference for the resident to remain in bed on Mondays and Thursdays. There were no unfavorable outcomes to the resident as a result of this practice. Resident #154 care plan was revised on 7-18-16 to include specific approaches to decrease wandering behavior. 2. All residents care plans were checked if family members requested specific preferences for the resident and residents with wandering behavior care plans were updated to include specific approaches for wandering. 3. Resident Care Managers and Licensed Nurses are being educated to update residents' care plans consistently to meet the individual requests of residents and family members; and wandering behaviors.	8-31-16 8-31-16 8-31-16

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F 280	Continued From page 15 with goals and approaches for the resident's family preference that the resident remain in bed on Mondays and Thursdays for one (1) resident and failed to revise the comprehensive care plan to include specific approaches for one (1) resident's wandering behavior. Residents' #108 and #154. The findings include: 1. A resident room observation was conducted on July 15, 2016 at approximately 10:30 AM. A hand written note was observed on the residents ' wall over the head of the bed and on the residents ' personal dresser indicating the following, " [Resident #108 name] stays in bed on Mondays and Thursdays, no date or signature attached. " A review of the Nursing care plan: Category: ADL [Activity of Daily Living] Functional/ Rehabilitation edited June 8, 2016; the Social Work Care plan: Category: Mood State created April 7, 2016 and the Activity Care Plan and Activity Progress Notes dated July 12 lacked evidence of a category with goals and approaches for the resident to remain in bed on Mondays and Thursdays. A face-to-face interview was conducted with Employee #14 on July 15, 2016 at approximately 11:30 AM. After review of the aforementioned, he/she stated that they (facility) " were aware of the note and that the family posted the note. " Facility staff failed to review and revise the	F 280	Continued From page 15 1. All residents care plans will be monitored monthly and reported to the Quality Improvement Committee quarterly. The next quarterly meeting is scheduled For 9-16-16.	8-31-16

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F 280	Continued From page 16 resident ' s care plan to reflects the resident ' s family preference for the resident to remain in bed on Monday ' s and Thursdays. The record was reviewed on July 15, 2016. 2. Facility staff failed to revise the comprehensive care plan to include specific approaches for Resident #154 wandering behavior. According to a physician ' s progress note dated May 10, 2016 revealed; " Patient tolerated medication, still wandering ... " A review of Resident #154 ' s care plans revealed the interdisciplinary team (IDT) identified the problem area " Wanderer, Potential for Injury " was revised on June 25, 2016. The list of interventions failed to include any specific approaches to address the care and safety for the resident who demonstrated a wandering behavior. Resident #154 was observed on July 7-8, 2016 and July 12, 2016 between the hours of 10:00AM- 3:00 PM, wandering throughout the unit. Staff frequently redirected resident. A face-to-face interview was conducted with Employee # 32 on July 12, 2016 at approximately 2:00 PM who acknowledged the care plan lacked evidence of specific approaches for the resident ' s wandering behavior. The clinical record was reviewed on July 12, 2016.	F 280	Continued From page 16	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	**F309** 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	

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F 309	Continued From page 17 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for six (6) of 43 Stage 2 sampled residents, it was determined that facility staff failed to ensure that each resident received and the facility provided the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by failure to follow physician ' s orders for the use of a left palm protector for one (1) resident, administer Midodrine 10 mg in accordance with physician ' s order for one (1) resident, ensure that one (1) resident had a follow up urologist consult in a timely manner, consistently monitor, assess and develop a pain management plan to treat one resident ' s pain, ensure that the protocol for central line catheter was followed for one (1) resident with a peripherally inserted central catheter (PICC) and to follow physician's orders to administer influenza vaccine to one (1) resident. Residents' #80, 66, 171, 208, 267, and 275. The findings include: 1. Facility staff failed to follow physician ' s orders for the use of a left palm protector for Resident #80.	F 309	Continued From page 17 1. 1. Resident #80 was assessed on 7/13/16 and the palm protector was placed on the resident's left hand as ordered by the attending physician. There were no unfavorable outcomes to the resident as a result of this practice. 2. An audit was conducted on all other residents with orders for palm protectors to ensure compliance. 3. Nursing staff are being in-serviced on resident protective devices. 4. The Resident Care Managers and Charge Nurses will conduct monthly audits of residents with orders for protective devices and the information will be reported to the Quality Improvement Committee quarterly. The next meeting is scheduled on 9-16-16.	7-13-16 8-31-16 8-31-16 8-31-16

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F 309	Continued From page 19 A review of the July 2016 Physician ' s Orders signed and dated by the physician directed: "Left hand Palm Protector with roll to be applied to hand with PROM [Passive Range of Motion] and hand hygiene wear at all times and remove for AM/PM care." Resident #80 was observed on July 13, 2016 at approximately 10:00 AM and did not have the Palm Protector in place. Employee #33 who was present at the time of the observation, searched the resident's room and was unsuccessful in locating the device. There was evidence that facility staff ensured that Resident #80 wore the left palm protector in accordance with the physician's order. 2. Facility staff failed to administer Midodrine 10 mg (used to treat low blood pressure) in accordance with physician ' s order for Resident #208. The June and July 2016 Physician ' s Orders directed: " Midodrine 10 mg administer one (1) tablet by mouth three [3] times a day on dialysis days as needed for systolic blood pressure less than 120 [mm Hg] (millimeters of mercury) and/or diastolic blood pressure less than 65 [mm Hg] (Hypotension) " Review of the June 2016 Dialysis Communication forms revealed that the resident ' s systolic blood pressure was less than 120 [mm Hg] on the following days:	F 309	Continued From page 18 2. 1. Resident #208 was assessed on 7/14/16 and the medication Midodrine 10 mg. was administered in accordance with the physician order. The order for Midodrine was discontinued. — 7-14-16 2. All physician medication orders and the medication administration records were checked to validate the medication was being given as ordered. — 8-31-16 3. Licensed Nurses are being re-educated on the medication administration of Midodrine in accordance with the physician orders. — 8-31-16 4. Physician orders and medication administration records will be audited monthly and reported to the Quality Improvement Committee quarterly. The next meeting is scheduled on 9/16/16. — 8/31/16	

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F 309	Continued From page 19 June 1, 2016 - 118/no diastolic blood pressure measurement recorded - post dialysis June 3, 2016 - 117/73 [mm Hg] post dialysis measurement June 8, 2016- 108/68 [mm Hg] pre dialysis measurement June 10, 2016- 110/74 [mm Hg] post dialysis measurement June 15, 2016-114/70 [mm Hg] pre dialysis measurement June 17, 2016 - 112/68 [mm Hg] pre dialysis measurement June 22, 2016-117/72 [mm Hg] pre dialysis measurement; 103/71 [mm Hg] post dialysis measurement A review of the June 2016 Medication Administration Record revealed that Midodrine 10 mg was administered on the following dates: June 1, 2016 at 5:00 PM; Reason for administration, systolic BP (blood pressure) less than 120 [mm Hg] June 10, 2016 at 3:00 PM; Reason for administration, SBP (systolic blood pressure) 110/74 mm Hg June 22, 2016 at 5:00 PM; Reason for administration, SBP 103/71 [mm Hg] On the aforementioned dates, the results of taking the medication were documented as " effective " however, there were no blood pressure measurements recorded on the MAR or in the nursing progress notes. There was no evidence that facility staff administered Midodrine 10 mg to the resident on	F 309	Continued From page 19 3. 1. Resident #171 was assessed on 7/13/16. The assigned nurse/employee #23 documented a physician order for an urology consultation with Dr. Michael H. Phillips on 7/27/16 for medical evaluation of neurogenic bladder. There were no unfavorable outcomes to the resident as a result of this practice. 2. All resident medical records were checked for urology follow-up on consultation orders and correction was made if required. 3. Licensed Nurses are being re-educated on physician orders for medical consultations. 4. The Resident Care Managers are responsible for ensuring that audits are being conducted monthly to monitor physician orders for medical consultations and reported to the Quality Improvement Committee quarterly.	7-27-16 8-31-16 8-31-16 8-31-16

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F 309	Continued From page 20 four (4) occasions (June 3, 8, 15 and 17, 2016) when the systolic blood pressure was less than 120 mm Hg in accordance with the physician ' s order. A face-to-face interview was conducted with Employee #4 on July 14, 2016 at approximately 9:46 AM. He/she acknowledged the findings. The record was reviewed on July 14, 2016. 3.The facility staff failed to ensure that Resident #171 had a follow up consultation for a neurogenic bladder. A review of the facility's Consultation form dated May 23, 2016 directed... "(3) Follow up w [with] / [doctors name] for neurogenic bladder.." A face-to-face interview was conducted on July 13, 2016 at approximately at 4:00PM with Employee #23. He /she was queried regarding the follow up physician's visit for Resident #171' s for neurogenic bladder. Employee #23 stated, "I did not write an order for the resident a follow up visit [for neurogenic bladder]." There was no evidence that facility staff ensured that Resident #171 had a follow up consultation with [name of physician] for neurogenic bladder. 4. Facility staff failed to provide care for Resident #267 who had a PICC [peripherally inserted central catheter] line in accordance with physician's orders. A resident observation was conducted on July 15, 2016 at approximately 11:00 AM. Resident #267 was observed lying in [his/her] bed in an isolation room. The resident was observed with a PICC	F 309	Continued From page 20 1. Resident #203 was assessed on 7/13/16.Physician orders were received for 7/13/16 for effective pain medication. The resident Care Manager and Charge Nurses developed a pain management plan that was effective for the resident's pain on 7/13/16. . 2. All residents receiving pain medications were assessed/observed to validate that the pain medications were effective and discussed with the residents and responsible party. 3. All licensed staff are being re-educated On the development of an effective pain management plan for all residents. 4. Resident's pain management will be monitored monthly and reported to the Quality Improvement Committee quarterly.	7/13/16 8/31/16 8/31/16 08/19/16

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F 309	Continued From page 21 line on the right upper arm. The PICC line had a clear dressing that did not have a label to identify the name, date or time that the dressing was applied. A review of the Admission Physician Order Sheet and Plan of Care dated June 23, 2016 revealed that Resident #267 came to the facility on this date from acute care setting with medication order to give Ertapenem 1G [Gram] IV [intravenous] Daily to be given 6 weeks for ESBL [Extended-Spectrum Beta-Lactamase] in urine. A review of the Physician order sheet dated June 23, 2016 directed, "Ertapenem (Invanz) [antibiotic] 1GM IV [intravenous] daily for 6 weeks ESBL [Extended-Spectrum Beta-Lactamase] [in] urine Stop date 7/18/16." NS [normal saline] Administer 1 GM [Gram] (100 ml) IV over 30 minutes at a rate of 200ML[milliliters]/HR [hour] once every 24 hours via PICC line and Flogard pump until 8/4/16 [August 4. 2016] A review of the Central - Line Catheter Protocol revealed that the facility staff failed to follow the protocol as evidence by: Under section " device type " the allotted boxes were left blank Under section " type of infusion " , the allotted boxes were left blank Under section " On admission " the allotted boxes were left blank Under section Flushing Protocol: " 5ml NSS	F 309	Continued From page 21 4. 1. Resident #267 was assessed on 7/15/16. The residents PICC line central catheter dressing was changed per physician orders and labeled to identify the name, date and time of the registered nurse on 7/15/16. There were no unfavorable outcomes to the resident as a result of this practice.	7/15/16
			2. There were no other residents affected by this practice.	7/3116
			3. Registered Nurses are being re-educated on the management of PICC line central catheters.	08/28/16
			4. Monthly audits of PICC line catheters are being conducted and reported to the Quality improvement Committee quarterly.	8/19/16

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F 309	Continued From page 22 [normal saline] before meds, 5ml NSS after meds, 5ml 10units/ml Heparin flush " was checked but the facility reported they do not flush with heparin. Under treatment Protocols " label with name date and time was left blank on PICC line dressing Under change dressing the allotted boxes were left blank indicating not performed or not done. In addition, facility staff failed to measure the upper right arm circumference inches above insertion site and prn every seven (7) days with the dressing change; and failed to measure the external catheter length on admission with each dressing change and prn. A review of Pharmacy Protocol " Appendix 8.3 Central - Line Catheter Protocol form " policy: last reviewed October 1, 2010 that reads, " Purpose: Documentation shall be in accordance with facility policies and procedures and on facility approved forms. Guidelines for use of the form: Each field on the form must be completed in full " ... Facility nursing staff and prescribers are responsible for checking off or writing in orders that are consistent with the current, acceptable standard of care." There was no evidence that facility staff ensured that the protocol for central line catheter was followed as evidence by the allotted boxes for the catheter protocol was left blank indicating not performed or not done. A face-to-face Interview was conducted on July 15, 2016 at approximately at 4:00PM with Employees #4 and #7. After review of the	F 309	Continued From page 22 1.Resident #275 was assessed on 7/15/16. The resident was admitted on 3/9/16 and Received PPD 1-Step (tuberculin skin test 1on 3/24/16). There were no unfavorable outcomes to the resident as a result of this practice. 2.All new resident admissions were checked to validated that residents received PPD 2-Step (tuberculin skin test) in a timely manner. 3. All licensed nurses are being educated on requirement for 2-Step PPD (tuberculin skin test) with focus on timely administration. 4. New resident admissions are being audited monthly to ensure 2-Step PPD (tuberculin skin test) are being administered in a timely manner and reported to the Quality Improvement Committee quarterly.	7-15-16 8-28-16 8-28-16 8-19-16

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F 309	Continued From page 23 aforementioned, both acknowledged the findings. 5. Facility staff failed to follow physician order to administer influenza vaccine to one resident. Resident #66 A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #66 was admitted to the facility on February 18, 2016 with an order that directed " Flu vaccine annually. " A review of the Immunization record revealed that the space allotted for documenting administration of the flu vaccine was left " Blank " indicating the vaccine was not administered. A Face-to-Face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee # 7. He /she acknowledged the findings. The record was reviewed on July 15, 2016. 6. Facility staff failed to administer PPD [Purified Protein Derivative] for Resident #275 in a timely manner. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #275 was admitted to the facility on March 9, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR [chest radiograph] if positive. " A review of the Medication Administration record revealed that PPD 1- step TST [tuberculin skin test] was administered on March 24, 2016 and read March 26, 2016. This was documented on the immunization record as given and negative 15 days ' post physician order.	F 309	Continued From page 23 5. **Resident #66** The flu vaccine was unable to be given to Resident #66 at the time of observation due to the flu season (September 1, 2015-March 31, 2016). All resident immunization records were audited and no deficits were identified. Education was provided to licensed nursing Staff on documentation of immunization records. Immunization records will be audited monthly which will be reported to the Quality Assurance and Performance Improvement Committee on a monthly basis for three months, if there are no compliance issues the reporting frequency will be changed to quarterly.	08/28/16 08/20/16 08/19/16

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F 309	Continued From page 24 A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 15, 2016.	F 309	Continued From page 24 **F 312** 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1 A-B 1. Resident #80 was assessed on 7/13/16 by the physician and charge nurse. The resident's eyes were immediately cleaned and the physician, who was present onsite prescribed treatment which was ordered and administered to the resident's eyes on 7/13/16. The resident's hair was washed and styled in the beauty shop on 7/14/16.	7-13-16
F 312 SS=G	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview for three (3) of 43 Stage 2 sampled residents, it was determined that facility staff failed to ensure that a resident who is unable to carry out activities of daily living [ADL] received the necessary services to maintain good grooming, personal and oral hygiene as evidenced by failure to: consistently provide personal care and grooming for one (1) resident who was observed with unkempt hair and eyelids stuck together with drainage; one (1) resident in need of oral hygiene and one (1) resident observed with excessive facial hair. Residents #80, 9, and 126. The findings include: 1. Facility staff failed to ensure that Resident #80,	F 312	2. All residents that are totally dependent on staff for ADL care were assessed or checked by the Charge Nurse/Resident Care Manager and appropriate care was provided as required. Resident's in need of hair care services have received the appropriate hair care services by the Cosmetologist/ Barber/facility staff. 3. All nursing staff have been re-educated regarding providing ADL care, including hair care/grooming services for all residents and are conducting daily rounds on all residents to assure that all ADLs have been provided. 4. Resident care managers are conducting daily audits on ADL care and will be providing a report to the QAPI Committee on a monthly basis to assure compliance. If	8-28-16 8-28-16 8-19-16

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F 312	Continued From page 25 who was unable to carry out activities of daily living, received the necessary services to maintain grooming and personal hygiene as evidenced by an observation wherein it was determined the resident ' s eyelids were stuck together with excessive eye drainage and his/her hair was unkempt. According to Resident #80 ' s annual and quarterly Minimum Data Sets (MDS) dated February 16, 2016 and May 18, 2016 respectively, revealed: Resident #80 was totally dependent on one (1) staff for hygiene and bathing according to Section G, Functional Status. The resident was coded as severely impaired for daily decision making under Section C, Cognition and under Section B, Hearing Speech and Vision, Resident #80 was coded as rarely/never understands and no speech (absence of spoken words). According to the history and physical examination signed by the physician on February 27, 2016, Resident #80 ' s diagnoses included Advanced Dementia, Generalized Debility, Hypertension and Dysphagia. A. On July 13, 2016 at approximately 10:00 AM, following the completion of AM care (confirmed by the assigned certified nurse assistant), Resident #80 was observed in his/her room lying in bed. The resident's eyes were closed and his/her eyelids were observed to be soiled with drainage. Immediately following the observation, a query was made to Employee #35 [physician] who was present on the unit. Employee #35attempted to examine the resident's eyes, however, he/she was unable to open the resident ' s eyes due to buildup of a yellow crusted substance. Employee #35 stated [he/she] would prescribe an antibiotic	F 312	Continued From page 25 compliance is consistent and determined appropriate by the QAPI Committee the reporting will be reported on a quarterly basis. 2. 1. Oral care is offered on a daily basis to resident #9 who has had a history of refusals, however she received oral care for food particles in the mouth on 7/8, 7/11, and 7/12/16. 2. All totally dependent residents oral care has been checked and oral care has been provided to the residents as required if allowed. 3. Nursing staff (RNs, LPNs, CNAs) are being re-educated on oral health care to residents, which will entail instruction on the recommended oral hygiene care practices in older adults. The education will be conducted by nurse managers, Dr. Rogers (Dentist) and Dr. Lawrence (Dentist) as a part of an intervention to improve oral health outcomes among residents residing in long term care facilities	7-12-16 8-28-16 8-31-16

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F 312	Continued From page 26 treatment for the resident ' s eyes. A review of physician ' s orders revealed Employee #35 wrote the following order: " July 13, 2016 at 11:20 AM, Clean eyelids with Ocusoft [pre-moistened pad to clean eyelids] every shift, then apply Erythromycin Ophthalmic ointment x [times] 10 days for Blepharitis. " A review of the resident's care plan revealed: "ADL Functional /Rehabilitation" [Activities of Daily Living]: care plan, initiated on February 24, 2016, last updated May 25, 2016 revealed that the resident was identified with a "potential for decline in functional [status] and mobility ADLs due to Dementia, Approaches: Assist resident with ADL's...Evaluation: Resident depends on staff for all aspect of ADLs ..." A review of the Medication Administration Record [MAR] for July 13, 2016 revealed the licensed nurse signed the MAR to reflect that 9:00 AM medications were administered as follows: two (2) medications and one (1) supplement administered via gastrostomy tube (GT); one (1) transdermal patch administered topically and blood pressure assessed. Facility staff failed to provide eye care and personal hygiene consistent with the resident's needs. The resident's eyelids were stuck together with drainage. Facility staff completed AM care and medications were administered; however, there was no evidence that clinical staff assessed the buildup of drainage and/or crusting around the resident ' s eyes prior to the surveyor ' s observation. Subsequently, the resident was diagnosed with Blepharitis and prescribed antibiotic medication for the eyes.	F 312	Continued From page 26 4.Resident Care Managers are conducting weekly audits of residents' oral health care and reporting the findings to the Quality Improvement Committee monthly. The next meeting will be held September 16, 2016 3. 1. Resident #126 facial hair was removed on 7/13/16. There were no unfavorable outcomes to the resident as a result of this practice. 2. All residents were checked for facial hair and groomed accordingly. 3. Nursing assistants are being re-educated on ADL care with focus on removal of facial hair on residents. 4.Audits are being conducted weekly to monitor the residents ADL care which entails grooming (facial hair),and hair care. Information is reported to the Quality Improvement Committee monthly.	8-31-16 7-13-16 8-28-26 8-28-16 8-31-16

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F 312	Continued From page 27 A face-to-face interview was conducted with Employee #33 on July 13, 2016 at approximately 1:30 PM. He/she acknowledged that Resident #80 ' s eyes were stuck together with drainage and that licensed staff acted on the physician ' s orders to cleanse the resident ' s eyes and obtain the prescribed treatment. A face-to-face interview was conducted with Employees # 1, 2, and 3 on July 13, 2016 at approximately 4:00 PM regarding the aforementioned observation. The clinical record was reviewed on July 13, 2016. B. Facility staff failed to maintain grooming for Resident #80 who was observed with his/her hair unkempt (untidy/disheveled). A resident observation was conducted on July 13, 2016 at approximately 12:00 PM with Employee #33. The employee repositioned the resident on his/her left side. At this time, Resident #80's hair [towards the back of the head] was observed uncombed, matted and unclean. The clinical record lacked evidence of documentation related to the resident ' s most recent shampoo and/or hair styling. The resident was unable to communicate his/her needs and the staff was required to anticipate the resident ' s needs. According to the care plan "ADL Functional /Rehabilitation " [Activities of Daily Living] dated May 25, 2016, " Resident depends on staff for all aspect of ADLs ... " On July 14, 2016, subsequent to the surveyor ' s observation, Resident #80 was observed in the	F 312	Continued From page 27	

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F 312	Continued From page 28 beauty shop having a shampoo. A face-to-face interview was conducted with Employees' #1, #2, #3, #4, #33, and #36 at the time of the observations. After review of the aforementioned, all acknowledged the findings. 2. Facility staff failed to consistently provide routine oral care for Resident #9 who was totally dependent and was observed with large amounts of food particles around his/her gums and between the teeth. A family interview was conducted on July 8, 2016 at approximately 12:40 PM. In response to the question; " Does the resident receive the help he/she needs in cleaning his/her teeth, the family member responded, " No. [His/her] teeth always have food particles. " The family member then said to the resident, " Show me your teeth. " The resident responded by opening his/her mouth and revealed large amounts of food particles around the gums and between the teeth. " Subsequent observations prior to breakfast on July 11 and 12, 2016 also revealed the food particles caked between the resident ' s teeth and on the gums. A review of the quarterly MDS with an ARD (Assessment Reference Date) of June 10, 2016 revealed, the resident was coded as totally dependent for dressing, toilet use and personal hygiene. According to Section I (Diagnoses) the resident was admitted to the facility with diagnoses which included Alzheimer ' s Disease,	F 312	Continued From page 28	

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F 312	Continued From page 29 Non-Alzheimer ' s Dementia and Depression. A face-to-face interview was conducted with Employee #47 at approximately 2:30PM on July 14, 2016. The employee was queried whether he/she usually brushed the resident ' s teeth when providing daily oral care. He/she responded, " No. When I tried to brush [his/her] teeth they bled and I was told not to brush them. I wipe them but [he/she] does not always open his/her mouth. " A face-to-face interview was also conducted with Employee #9 at approximately 3:00PM on July14, 2016. The employee was informed of the family member ' s statement, the surveyor ' s observations and the staff ' s interview. In response the employee stated, " it is true that [he/she] does not always open [his/her] mouth and allow the teeth to be cleaned. That ' s why we use the sponges. Employee #9 acknowledged the finding. 3. Facility staff failed to provide necessary services to maintain grooming for Resident #126 who requires extensive assistance to maintain his/her grooming was observed with excessive facial hair. On July 8, 2016 at approximately 12:16 PM and July 13, 2016 at approximately 10:00 AM, Resident #126 was observed with gray colored hair covering [his/her] upper lip and chin. According to the Certified Nursing Aide charting, the resident received AM and PM care (personal	F 312	Continued From page 29	

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F 312	Continued From page 30 hygiene/grooming) on July1-13, 2016, however there was no evidence that facility staff shaved the resident while providing AM care. A face-to-face interview was conducted with Resident #126 on July 13, 2016 at approximately 3:30 PM. He/she stated, " Someone use to shave me, I don't know who. I tried to find someone who is regular to remove it (the hair on his/her chin). I asked someone but they never came back. I would like it [the hair on his/her chin] removed. " This interview was conducted in the presence of Employee # 38 who acknowledged the findings.	F 312	Continued From page 30	
F 323 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 43 Stage 2 sampled residents, it was determined that facility staff failed to ensure that the resident environment was as free of accident hazards as is possible; and that each resident received adequate supervision to prevent accidents as evidenced by: failure to utilize appropriate safety measures while providing AM (morning) care to one (1) resident who subsequently sustained a fall and	F 323	**F323** 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. (A) Resident #126 sustained an injury on 7/10/16 while (1) CNA was providing am care at the bedside, which correlated to the rehabilitation screen/evaluation during this incident. Resident#126 was assessed on 7/10/16 and orders were received to transfer the resident to the emergency room on 7/10/16. The facility is unable to correct this experience for the resident, however the careplan has been assisted for the assist of two persons.. (B) Resident #154 wandered into the room of resident #279 without supervision on 6/27/16 and an altercation caused resident #279 to fall and sustain an abrasion .2x.1 on right eyelid which healed in 24 hours. The resident was assessed and orders received to transport the resident per 911 to the emergency room for CT scan which was negative the resident returned on the same day and was seen by the in house physician on the following day. The facility is unable to correct this experience for the residents involved, however the careplan of Resident#154 has been updated to reflect additional approaches to address wandering.	

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F 323	Continued From page 31 required transport to a local emergency department for treatment of a complaint of chest pain post fall; and failure to adequately supervise one (1) resident with wandering behaviors who entered the room and engaged in an encounter with another resident who subsequently sustained an injury. Residents' #126, #154 and #279. Additionally, facility staff failed to maintain resident's environment free of accident hazards as evidenced by: frayed call bells in three (3) of 44 resident's rooms, an accessible container of cleaning chemical in one (1) of eight (8) resident units surveyed, and an unsecured surge protector in one (1) of 44 resident's rooms surveyed. Facility staff failed to ensure that Safety Data Sheets were [includes information such as the properties of each chemical; the physical, health, and environmental health hazards; protective measures; and safety precautions for handling, storing, and transporting the chemical] readily available in the Safety Data Sheet Book on each nursing unit. The findings include: 1. Facility staff failed to utilize appropriate safety measures while providing AM/ADL (morning activities of daily living) care to Resident # 126 who sustained a fall during care in the company of a CNA (certified nurse assistant), complained of chest pain at the time of the fall and subsequently required transport to the local emergency department for treatment post fall. According to the Minimum Data Set completed June 15, 2016, Resident #126 was coded as requiring two-person physical assistance for transfers, toilet use, and bathing. The resident	F 323	Continued From page 31 (C) Upon identified of the frayed call bells (3) they were replaced immediately and the unsecured surge protector (1) located in a resident's room was identified as not belonging to the facility was immediately removed and a facility surge protector was put in place. The general cleaning chemical located in 1 of the 8 units surveyed was removed immediately upon location. It was identified as a product used on special cleaning projects. The general cleaning chemical container was immediately removed from the unsecured biohazard room on 8/3/16 by the Director of Environmental Services. The janitor's closet is set up to have cleaning chemicals dispensed through a wall dispensing system located in the janitor's closet which is to be locked at all times. (D) The Micro-kill One and Epiclenz were immediately to the SDS books located on each unit. 2. (A) All residents with the potential to be affected by this practice have been reviewed and updated if applicable to address safety measures. (B) Hourly rounding has been implemented in an effort to minimize accidents with injury. (C) A facility wide check for frayed cords, unsecured surge protectors and unsecured cleaning chemicals was conducted on 7/15/16.	8/3/16 7/15/16

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F 323	Continued From page 32 was coded as not steady, only able to stabilize with staff assistance and impairment to lower extremities on both sides, under Section G Functional Status. Under section H (Bladder and Bowel) the resident was coded as always incontinent of urine and bowel. Review of the nursing progress notes revealed: July 10, 2016 at 9:28 AM, "At 8:30 AM writer received a report from the assigned CNA that resident slid from standing position to the floor while receiving AM care. On assessment resident alert and oriented x2, verbalized chest pain, r [right] 2nd toe skin tear 0.8 x 0.4 x 0.0 cm with minimal active bleeding, pressure dressing applied to R 2nd toe, bleeding stopped, NP (nurse practitioner) called and new order received to send [the resident to the] ER (emergency room) via 911 for chest pain ... " July 10, 2016 at 9:28 PM, "Resident return from the [Hospital Name] at 6:19 PM alert and stable ... " Falls risk Assessment completed June 22, 2016 revealed, "Evaluation Score = 21 (Score of 10 or higher represents a high risk for falls) " According to the "Point of Care History" Activities of Daily Living data competed by the respective Certified Nurse Assistant from July 1-10, 2016, revealed that Resident #126 was coded as having one (1) person physical assistance during transferring and toileting. A face-to-face interview was conducted with the Employee # 39 [staff assigned to care for Resident #126 on July 10, 2016, day of the fall]	F 323	Continued From page 32 3. In an effort to prevent future reoccurrences the engineering team will conduct monthly facility wide call bell inspections on all units, the unit managers/designee will conduct weekly call bell inspection audits and the nursing staff will be re-educated on the reporting of environmental concerns on a daily basis after conducting their daily shift rounds. 4. A preventive maintenance program is In place to monitor and inspect: call bells unsecured surge protectors in resident rooms on a monthly basis, which will be reported to the Safety Committee which meets bimonthly and the QAPI Committee, which meets monthly. The next meeting is scheduled for 9/16/16.	8/31/16 8/31/16

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F 323	Continued From page 33 on July 14, 2016 at approximately 1:30 PM Employee #39 was asked to explain how the incident occurred with the resident ending up on the floor during AM care. " He/she stated, "I washed [his/her] face. The [resident] likes to stand up on the side of the bed and stand. [He/she] holds the rails. On this morning [he/she] was standing facing the window. [He/she] was at the bottom part of the bed. I raised the rail so [he/she] could grab it. [He/she] urinated and [he/she] wanted to step out of it [urine] and [his/her] foot slipped. [His/her] right foot hit the foot pedal on the wheel chair. The wheel chair was behind the resident. [He/she] stepped to the left to get out of the urine, I was standing to the right of the [him/her]. I lowered [him/her] to the floor. I never use a Hoyer lift with [him/her] before because [he/she] can stand. Now, since the incident we use a Hoyer lift..." A follow up interview was conducted on July 14, 2016 at approximately 3:10 PM with Employee #39. He/she stated, "Foot rest were not removed from the wheelchair. If [he/she] had fallen backward [he/she] would have fallen into the chair. No gait belt was used. I wasn't expecting [him/her] to move. [He/she] moved [his/her] leg without me knowing. I was washing [him/her] up. [He/she] can stand. When [he/she] says I want to sit down we let [him/her] sit down. [The resident] doesn't like [his/her] head to be lying flat, [he/she] would rather stand. The old manager knew, I never discussed it with the new manager. " Review of the Care plan section of the resident ' s clinical record revealed that there was no approach or intervention to address the resident ' s choice to have AM care provided while standing	F 323	Continued From page 33	

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F 323	Continued From page 34 at the bed side. In addition, there was no evidence of a Physical or Occupational therapy screening or evaluation to ensure that it was safe for the resident to stand and for how long to have am care provided. Through interview with Employee #39, he/she stated that the resident stepped to the left, there was no evidence that the employee applied the resident ' s shoes and used a gate belt while transferring the resident from a lying position in the bed to then have the resident stand and hold on to the side rail of the bed to have AM care performed. In addition, the employee stated that the resident ' s wheel chair was directly behind the resident, however he/she failed to remove the footrest/legs of the wheelchair prior to transferring the resident. A telephone interview was conducted on July 27, 2016 at approximately 4:05 PM with Employee #27. He/she stated, "I knew [that the resident likes to stand to have AM care provided], that ' s how he/she is, that was his/her request. " In addition, Employee #27 acknowledged the findings. There was no evidence that appropriate safety measures were taken when Employee #39 provided AM care to Resident #126. The resident was transferred with the assistance of one (1) staff from lying in the bed to a standing position at " the bottom part of the bed. " However, the MDS was coded that the resident required the assistance of two (2) persons for transfer. Subsequently, the resident sustained a fall (lowered to the floor). During the assessment of the resident at the time of the fall, the resident verbalized chest pain and required transport to a	F 323	Continued From page 34	

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F 323	Continued From page 35 local emergency department via emergency medical services (911). The record was reviewed on July 15, 2016. 2. Facility staff failed to provide adequate supervision for Resident #154 who had a history of wandering. On June 27, 2016 Resident #154 was placed at the nurse ' s station without supervision, he/she then wandered into Resident #279 ' s room, encountered an altercation with the resident and subsequently Resident #279 sustained an abrasion to the right eyelid. A review of Resident #154 ' s quarterly Minimum Data Set (MDS) dated June 21, 2016 under Section I, Active Diagnoses revealed his/her diagnoses included Alzheimer ' s disease, Dementia and Schizophrenia. Section C, Cognitive Skills for daily decision making revealed the resident was coded as moderately impaired, decisions poor, cues/supervision required. Section E, Behavior was coded as having physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others ...) occurred 1 to 3 days. Section E, wandering (Presence & Frequency)- resident was coded as having behavior of this type daily. A review of the comprehensive care plan for Resident #154 revealed the interdisciplinary team [IDT] identified " wanderer, " as a problem with a goal that the resident ' s safety be maintained, no injury occurs ... " The plan was initiated December 30, 2015 and updated June 25, 2016. The " wanderer" care plan included [but was not limited to] the following:	F 323	Continued From page 35	

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F 323	Continued From page 36 "Problem Start Date: 12/30/2015- Identified wanderer, Potential for Injury r/t [related to] Dementia, Alzheimer ' s manifested by: walking back and forth toward exit. Wanders near exits. Long Term Goal Target Date: March 30, 2016- Safety maintained, no injury occurs, Resident will not leave the unit during the review period. Approach Start Date: December 30, 2015- Provide calm environment. Have photo taken for identification, Check ID (Identification) bracelet. Picture on chart, ensure resident wander guard bracelet is working properly. Staff to walk resident to the front exit door every Wednesday to ensure wander guard is working. If not to notify security for a new bracelet. Monitor resident for elopement every shift. Offer activities. " A review of Resident #154 ' s clinical record revealed the following nurses' notes: "June 19, 2016- 3:59 PM- resident wandering on the unit. Resident takes objects found on the unit (Christmas decorations, cleaning wipes, food from breakfast and lunch trays). Resident behavior unimproved. " " June 21, 2016- 8:27 AM- Resident noted several times pulling lamp and radio from wall outlet and dropping it on the floor. Also took it off again and took it to roommate ' s bed. " " June 21, 2016- 3:54 PM- Resident continue wandering on the unit, touching everything [he/she] can lay [his/her] hand on. Staff continue to be redirect. " " June 23, 2016- 9:43 PM- Resident alert and responsive. Continues to wander in the unit. Dropped keyboard in the nursing station on the	F 323	Continued From page 36	

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F 323	Continued From page 37 floor, keyboard broken. Resident redirected by staff. Refused to be redirected. " June 25, 2016- 10:49 PM- resident continues to wander in the unit touching and pulling everything [he/she] sees. Attempted pulling the assignment board by the nursing station. Redirected by staff. Refused to be redirected. Ate 100% of dinner. Safety precaution maintained. June 27, 2016- 4:16PM- Resident is alert and verbal with intermittent confusion, resident wandered into another resident room and [tried] to take the other resident [Bible] and they started dragging the [Bible] and both residents fell, resident [#154] thoroughly assessed with no apparent injury noted. Resident remain stable at this time. RP (Responsible Party) and MD (Medical Doctor) made aware of resident's fall. V/S (Vital Signs)- 130/70 [blood pressure], 60 [pulse], 18 [respirations] ... " A review of the facility ' s incident report titled, "Incident Report" , documented by nursing staff, dated June 27, 2016, [time of incident: 8:30 AM]. Read as follows: " [Exact Location of Incident: [location recorded], Patient ' s Condition Before Incident: Alert and confused; Was Resident Attended: No; ... Describe Exactly What Happened (What you Saw-Who Reported the Incident-What The Resident Said)- [Resident # 154] went into another resident [room] and was trying to pick up the resident ' s Bible and the resident try to stop [his/her] and they both ended up on the floor. Resident has no apparent injury ... Supervisor Comments and Recommendations: Indicate what contributes to the incident: Resident will be closely monitored for wandering. What action is recommended to prevent similar	F 323	Continued From page 37	

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F 323	Continued From page 38 incidents: When the CNA ' s (Certified Nursing Assistants) are busy doing AM (morning) care, the charge nurse will make sure [Resident # 154] is in sight at all times ... " According to the "24 Hour Nursing Report, " Unit dated June 26, 2016 revealed the following: " Name: [Resident #154], Room - [Diagnosis]: Dementia. Day Remarks: Resident found on the floor in Room 106. No visible bruising or hematomas/lacerations. " Name: [Resident #279], , [Diagnosis]: Dementia. Day Remarks: Resident has a hematoma to the right side of [his/her] head as a result of fall as a result of fall as stated by resident. Resident transported to hospital [hospital named] at 12 noon .... " The "Day Shift Assignment Sheet" dated June 26, 2016 for unit (7:30 AM-4:00 PM) revealed: the on the morning of the incident there was one License Practical Nurse (LPN) and two Certified Nurse Assistants (CNA). The assessments were as follows: Charge Nurse: (assigned LPN), Resident Group I- (assignment split between CNA assigned to Group II and Group III), Group II (assigned CNA), Group III (assigned CNA), Solarium Monitoring: 8:00- I (split); 8:30- II (assigned CNA) A face-to-face interview was conducted with the night CNA assigned to Resident #154 on July26, 2016 at approximately 10:00 AM. He/she stated after Resident #154 was given him/her AM care, he/she escorted the resident to sit at the nurse ' s station. Also, stated, he/she was sitting beside the resident. When her tour of duty ended; he/she left; however, it was a charge nurse at the nurse '	F 323	Continued From page 38	

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F 323	Continued From page 39 s station. Employee #32 was asked about the staffing for the day shift, and what was the unit ' s process for monitoring residents in the solarium. He/she stated, that he/she was re-assigned to another unit to assist with medication administration when the incident happened. There was one charge nurse for days after he/she was re-assigned. Further stated; there is usually three CNA's assigned on day shift. A follow up face-to-face interview was conducted with Employee #9 on July 12, 2016 at approximately 3:00 PM. He/she stated there were only two (2) CNA ' s assigned to the unit. Group I residents had to be split between the two CNA ' s. At the time of the incident, the CNA were doing am in care to other residents. The day charge nurse was at the nurse ' s station and was doing drug reconciliation with the off going night charge nurse. Further stated, there was no one in the solarium monitoring residents. Through record review and staff interview it was determined that facility staff assessed and identified Resident #154 as a wanderer. On June 27, 2016 at approximately 8:30 AM, Resident #154 was placed at the nurse ' s station without supervision. He/she then wandered into the room of Resident #279, and tried to take his/her Bible. This initiated a resident-to-resident altercation that caused Resident #279 to fall and sustain a hematoma to the right side of his/her head. Resident #279 was sent to the emergency room for treatment. There is no evidence that facility staff took reasonable precautions to maintain adequate	F 323	Continued From page 39	

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F 323	Continued From page 40 supervision for Resident #154 who wandered into Resident #279 ' s room encountered a resident-to-resident altercation and subsequently Resident #279 sustained an abrasion to the right eyelid. The record was reviewed on July 12, 2016. 3. Facility staff failed to maintain resident's environment free of accident hazards as evidenced by frayed call bells in three (3) of 44 resident's rooms, an accessible container of cleaning chemical in one (1) of eight (8) resident units surveyed, and an unsecured surge protector in one (1) of 44 resident's rooms surveyed. Observations of the facility made on July 12, 2016 between 9:50 AM and 12:30 PM, were as follows: Call bell cords were frayed in three (3) of 44 resident's rooms surveyed including rooms #200, #240A and #337C. A container of General Purpose (GP) cleaning chemical was observed in an unsecured, easily accessible biohazard room on resident unit 3 Blue, one (1) of eight (8) resident units surveyed. A surge protector was observed unsecured, on the floor of resident room #215, one (1) of 44 resident's rooms surveyed. These observations were made in the presence of Employee #5 and Employee #6 who acknowledged the findings. 4. Facility staff failed to ensure that Safety Data Sheets were [includes information such as the properties of each chemical; the physical, health, and environmental health hazards; protective	F 323	Continued From page 40	

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F 323	Continued From page 41 measures; and safety precautions for handling, storing, and transporting the chemical] readily available in the Safety Data Sheet Book on each unit. The Occupational Safety & Health Administration <https://www.osha.gov/>, Hazard Communication Standard: Safety Data Sheets [SDS]; The Hazard Communication Standard (HCS) (29 CFR 1910.1200(g)), revised in 2012 stipulates, "Employer Responsibilities- Employers must ensure that the SDSs are readily accessible to employees for all hazardous chemicals in their workplace. This may be done in many ways. For example, employers may keep the SDSs in a binder or on computers as long as the employees have immediate access to the information without leaving their work area when needed and a back-up is available for rapid access to the SDS in the case of a power outage or other emergency ..." https://www.osha.gov/Publications/OSHA3514.html During tour of the facility on July 14, 2016 at 12:15 PM it was observed that a container of Micro-Kill One (germicidal alcohol wipes) was placed atop the desk of the nursing station on 3 Orange; and in the day/dining room there were several containers of Epi-clensz instant hand sanitizing wipes. Review of the facility ' s Safe Data Sheets books located on nursing units 1 Blue and 3 Blue was conducted. There was no evidence that safety data sheets for Micro-Kill One and Epi-clensz were available for review and guidance to	F 323	Continued From page 41	

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F 323	Continued From page 42 employees in the event of an emergency. A face-to-face interview was conducted on July 15, 2016 at approximately 10:26 AM with Employee #49. He/she acknowledged the findings.	F 323	Continued From page 42 **F364**	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations made on July 13, 2016 at approximately 1:10 PM and on July 13, 2016 at approximately 1: 40 PM, it was determined that the facility failed to serve foods to residents at the proper temperature as evidenced by food temperatures were tested at less than 140 degrees Fahrenheit (F) for two (2) tested food trays from the steam table service on 2 Green. The findings include: 1. On July 13, 2016 at approximately 1:10 PM the Food temperature logs were reviewed during lunch on unit 2 Green. Staff served hot foods such as spaghetti noodles (130 degrees F) and sliced turkey (115 degrees F). These were tested at less than 140 degrees Fahrenheit. Employee #26 was asked if he/she had informed the dietary supervisor (s) that the aforementioned foods had tested below the recommended temperatures of 140 degrees Fahrenheit (F). Employee #26	F 364	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1 and 2. 1.This practice is unable to be corrected for the residents that may have received their meal at these temperatures. There were no unfavorable outcomes to the residents. 2. The kitchen staff will continue the procedure of taking ray line temperatures prior to food tray distribution service, in addition to conducting random test temperature trays. The kitchen staff serving on units where steam tables are in use will document on the form when the steam table service does not occur vs. leaving the space blank. The temperature of the food will be taken and documented: 1. in the kitchen prior to the assembled food items are transported; 2). upon transfer to the steam table and 3). prior to the last meal being served from the steam table. If temperatures are not maintained the food will be returned to the kitchen for warming at the appropriate temperature.	7/18/16

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F 364	Continued From page 43 answered "no". A review of the food temperature logs from the main kitchen on July 13, 2016 at approximately 3:30 PM revealed that the spaghetti noodles and the sliced turkey were both tested at 180 degrees Fahrenheit before the food carts were delivered to unit 2 Green on July 13, 2016 at approximately 12:45 PM. 2. On July 13, 2016 at approximately 1:35 PM the hot food temperatures tested at less than 140 degrees Fahrenheit (F) from two (2) test food trays. The puree test tray, spaghetti noodles tested at 137.2 degrees F and the puree vegetables tested at 134.9 degrees F and from the regular diet test tray, the cauliflower tested at 136.3 degrees F. The first observation was made during a review of the food temperature log on July 13, 2016 at approximately 1:10 PM with employee #26 who acknowledged the findings. The second observation was made in the presence of Employee #24 who acknowledged the findings.	F 364	Continued From page 43 3. To address others having the potential to be affected by this practice the Dir. Of Food and Nutritional Services (Dir. Of FNS) has instructed the kitchen staff on a protocol that that has been established which entails that if hot food temperatures are not in compliance the food will be reheated to a temperature of 180 degrees prior to leaving the kitchen, and will maintain a holding temperature of 140 degrees during tray distribution. 4. The Food and Nutritional Services Supervisor/Designee will be responsible for going to the assigned unit and taking the temperatures. If temperatures are inadequate, the food item(s) will be removed, heated up and served. The Director of FNS will submit a report on the status of to the Quality Assurance and Performance Improvement Committee on a monthly basis for an initial period of three months, if compliance is sustained for this time period, the QAPI will determine if the reporting time frame can be changed to quarterly.	7/18/16 8/19/16
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 under sanitary conditions	F 371	**F 371** 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	

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F 371	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observations made on July 7, 2016 at approximately 9:00 AM and on July 13, 2016 between 1:00 PM and 2:00 PM, it was determined that the facility failed to prepare foods under sanitary conditions as evidenced by two (2) of two (2) grease fryers that were soiled with leftover food residue, two (2) of four (4) convection ovens that were soiled with burnt food residue, one (1) of one (1) gas stove that was soiled with spilled food stains, a staff member serving foods without a hair net and a beard net and sporadic, inconsistent food temperatures from the steam table service on 1 Green, 2 Green and 3 Green. The findings include: 1. Two (2) of two (2) grease fryers soiled with leftover food residue. 2. Two (2) of four (4) convection ovens were soiled with burnt food residue. 3. One (1) of (1) gas stove was soiled with spilled food stains. 4. Employee#50 was observed without a hair net and a beard net while serving food for lunch in the solarium on 2 Green on July 13, 2016 at approximately 1:10 PM. 5. The steam table logs for unit 1 green, 2 green	F 371	Continued From page 44 1-5 1. The facility is unable to correct the findings for the time of observation, however the Dir. Of Food and Nutritional Services/Designee will monitor the use of the soiled kitchen equipment (grease fryers, convection ovens and gas stove). Education and ongoing inservice training will be provided to the Food Servie staff on the importance of wearing head/hair coverings to protect the food items from hair during meal serving/distribution. Steamtable logs where applicable will reflect days that the service may not have occurred versus leaving it blank. 2. Random checking the facility's cooking equipment will be conducted to ensure that it is clean and free of debris. Appropriate head/hair coverings will be assigned on the units with steam tables in use prior to service as a part of the daily uniform. The steamtable temperature logs will be audited by the Dir. Of Food and Nutritional Services/Designee. 3. Education of food service staff on Ftag 371 and the deficient practices has been conducted.	7/18/16 7/18/16 7/18/16

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F 371	Continued From page 45 and 3 green revealed that the food temperatures were not tested daily during the months of May, June and July, 2016 The steam table temperature logs from units 1 Green, 2 Green and 3 Green were presented by Employee #24 and reviewed in his/her presence and the following issues were noted: a. Food temperature logs for unit 1 Green reported food temperature were completed a total of 12 times in May 2016, and zero times in July 2016. b. Food temperature logs for unit 2 Green food temperatures were completed once in May 2016, 24 times in June, 2016 and three (3) times in June and July 2016. c. Food temperatures logs for unit 3 Green food temperatures were completed seven (7) times in May 2016, six (6) times in June 2016 and zero times in July 2016. d. The Food temperature logs did not clearly identified if the times the food temperatures were completed were for breakfast, lunch or dinner meals. These observations were made in the presence of Employee #24, Employee #25 and /or Employee #26 who acknowledged the findings.	F 371	Continued From page 45 4. The findings of random checks/audits/observations will be reported to the Quality Assurance and Performance Improvement Committee on a monthly basis until determined by the committee to change the frequency of reporting.	8/19/16
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 46 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that facility staff	F 441	Continued From page 46 **F441** 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) SBGC has revised their Infection Control Program which entails CDC and APIC guidelines for LTC to enhance the effectiveness of our infection control program in an effort to prevent the spread of infection. A) The tracking and trending of infections as evidenced in the line listing has been revised to reflect corrections to the April, May and June 2016 data that correlates to the monthly summary report and entails the proper data under the categories on the listing as follows; Signs and Symptoms – McGreer criteria is being utilized; Chext Xray results section includes the actual chest xray results; Culture date and results includes the actual cuture results; Treatment end date, which a column has been added to entail the date for resolution or follow up diagnostic tests/cultures. Root cause analysis for facility infections Has been initiated for UTIs for residents as evidenced via the initiation of the use of brainstorming and fishbone diagrams. B).The facility is unable to correct the initial lack of administering the 2 step TST for Resident #40 and Resident #272.	9/2/16

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F 441	Continued From page 47 failed to maintain an Infection Control Program that tracked and trends infections in the facility; to ensure that two (2) of 11 residents' received the purified protein derivative (PPD) using the two-step tuberculin skin test (TST), to administer the PPD for one (1) resident in a timely manner, and to ensure that one (1) resident on isolation had his/her own dedicated medical devices in his/her room. Residents' #40, #267, #272, #275 The findings include: 1. Facility staff failed to maintain an Infection Control Program that tracked and trends infections in the facility. On July 13, 2016 at approximately 11:24 AM, during an interview with the Infection Control Nurse, the surveillance lists were reviewed. Review of the facility's infection control surveillance list from April to June 2016 revealed the following: The line listing for April 2016 categorized the 32 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility included nine (9) facility acquired urinary tract infections, two (2) respiratory infections, three (3) skin infections, four (4) wound infections and one (1) eye infection. The line listing for May 2016 categorized the 25 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility	F 441	Continued From page 47 C) The facility is unable to correct the time period that the PPD was given to Resident #275, however a policy was developed and training has been provided to address the administration of TB for residents on admission and annually. D) The facility upon identification of the isolated observation of no hand towels and dedicated medical devices being in Resident #267's room was immediately corrected. The process that has been implemented to prevent recurrences of this nature entails that the stocking of the room being checked during rounds conducted by the off going and incoming shift. 2). A review of all resident's PPD chest xrays/ 2 step TST have been provided/administered. Newly admitted residents effective 8/24/16 have been given the 2 step TST. 3).The systemic changes that have been initiated and implemented include, however are not limited to: 1). Establishment of TB policy which entails 2 step TST administration upon admission for all new residents; Education on this policy and for the licensed staff on the administration of the 2 step TST. Also, an Infection Control Preventionist with an Infection Preventionist (IP) certification has been hired with an anticipated start date of 09/6/16.	8/24/16 9/2/16

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F 441	Continued From page 48 included five (5) facility urinary tract infections, two (2) Clostridium difficile, four (4) respiratory infections, two (2) skin infections, three (3) wound infections and one (1) eye infection. The line listing for June 2016 categorized the 14 residents listed as having infections that were community acquired. However according to the facility ' s monthly summary report the facility recorded that 14 infections listed were in facility acquired infections. The listing included five (5) urinary tract infections, two (2) of which were identified with ESBL (Extended-spectrum beta-lactamases), one (1) respiratory infection, four (4) skin infections. In addition, the surveillance sheets for April, May, and June 2016 revealed: Under the section - Signs & Symptoms diagnoses were listed instead of signs and symptoms. Under the section " CXR (chest x-ray) and results " the information record was N/A (not applicable), however two (2) residents were identified with Pneumonia, one (1) upper respiratory infection and one (1) Bronchiectasis. Under the section " Culture date and results " the information recorded was N/A or dates. However, the facility identified infections that included, urinary tract infections, wound infections, and Clostridium difficile. Under the section " Treatment end date " the information recorded was dates that the treatment ended, however there was no date for the resolution the infection or follow up diagnostic	F 441	Continued From page 48 The facility's TB program has been re-engineered to entail: District of Columbia Department of Health Chest Clinic; APIC and CDC standards and best practices. 4). The Infection Control Committee will begin meeting monthly effective 9/2/16 for 3 months to ensure the following, however not limited to are in place: 1). Infection Control Program is in place with tracking and trending of infections; 2). root cause analysis; 3). monitoring of the 2 step PPD administration will be conducted by the Resident Care Manager/Assistant Resident Care Manager/Nurse Supervisor within the 24 hour period upon admission, which will be reviewed by the Infection Control Nurse within a 24-72 hour period to ensure compliance; 4). the stocking of the isolation carts and rooms for proper medical devices and hand towels will be inspected by the Resident Care Manager /Nurse Supervisor/ Infection Control Nurse. If there is consistent compliance found the meeting frequency will change to meeting quarterly. The Infection Control Committee will report to the Quality Assurance Performance Improvement meeting on a monthly basis monthly for 3 months if compliance is consistent the reporting frequency to the QAPI Committee will change to quarterly.	8/19/16

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F 441	Continued From page 49 tests or cultures. The surveillance forms lacked consistent documentation to determine whether the infections were acquired in-house or in the community; if a culture, a diagnostic test or laboratory test was ordered, the results and name of the identified organism; if signs and symptoms were assessed and observed; and was there any follow-up cultures. There was no evidence that the facility trends/tracks/ and performs root cause analysis for the list of the facility's infections. In addition, there was no evidence that facility staff were re-educated/trained on areas of improvement from the surveillance data consistently. A face-to-face interview was conducted with Employee #7 and 4 on July 15, 2016 at approximately 4:30 PM. They acknowledged that findings. 2. Facility staff failed to ensure that two (2) of 11 resident ' s PPD were administered using the 2 - steps TST baseline. Residents' #40 and #272 2A. A review of Residents #40 immunization records revealed there was no indication that the 2 - steps TST baseline was administered. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident	F 441	Continued From page 49	

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F 441	Continued From page 50 #40 was admitted to the facility on January 28, 2016 with an order that directed " PPD 2 step 0.1ml 5tu Intradermal, administer one week apart, obtain CXR if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on February 1, 2016 and read February 2, 2016. This was documented on the immunization record as given and negative. There was no indication on the record that PPD 2 - step was administered. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 18, 2016. 2B. A review of Resident #272 immunization records revealed there were no indication that the 2 - steps TST baseline was administered. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #272 was admitted to the facility on March 3, 2016 with an order that directed " PPD 2 step 0.1ml 5tu Intradermal, administer one week apart, obtain CXR if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on March 4, 2016 and read March 6, 2016. This was documented on the immunization record as given and negative. There was no indication on the record that PPD 2 - step was administered. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employees #4 and # 7. They acknowledged the	F 441	Continued From page 50	

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F 441	Continued From page 51 findings. The record was reviewed on July 18, 2016. 3. Facility staff failed to administer PPD for Resident #275 in a timely manner. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #275 was admitted to the facility on March 9, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR [chest xray] if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on March 24, 2016 and read March 26, 2016. This was documented on the immunization record as given and negative 15 days ' post physician order. A face-to-face Interview was conducted on July 15, 2016 at approximately 3:00PM with Employee #4 and # 7. They acknowledged the findings. The record was reviewed on July 15, 2016. 4. Facility staff failed to ensure that one resident on isolation had his/her own dedicated medical devices in his/her room. Resident #267. A review of Resident #267 record revealed him/her was on contact isolation for ESBL in urine. On July 15, 2016 at approximately 3:00 PM an observation of Resident #267's room, (who was in isolation) was conducted. At this time it was observed that there were no dedicated medical devices such as, blood pressure cuff and	F 441	Continued From page 51	

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F 441	Continued From page 52 stethoscope stored in the isolation room. In addition, there were no hand paper towels at the sink that was located in the isolation room. At the time of the observation Employee #49 was queried concerning the resident's lack of dedicated medical devices and disposable paper towels in the isolation room. After this query dedicated medical devices were placed in the isolation room. A face-to-face Interview was conducted on July 15, 2016 at approximately at 3:00PM with Employee #49. He/she acknowledged the findings.	F 441	Continued From page 52	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on July 13, 2016 at approximately 12:10 PM, it was determined that the facility failed to maintain essential equipment in safe operating condition as evidenced by a broken pressure gauge from the dishwashing machine. The findings include: The booster heater pressure gauge to the dishwashing machine was broken and the incoming water pressure could not be determined.	F 456	**F 456** 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION 1.The booster heater pressure gauge to the Dishwashing machine was replaced upon observation by the Engineering team. 2. A service contractor came out to check the booster heater on 8/24/16 and a final rinse solenoid valve remaining open was identified to be leaking water. The vacuum scaler was leaking. This part was ordered on 8/24/16 and upon delivery the vendor will install. 3. A preventative maintenance program will entail the monitoring of kitchen equipment. 4. The preventative maintenance findings of concern will be reported to the Quality Assurance Performance Improvement meeting on a monthly basis.	7/13/16 8/24/16 8/19/16 8/19/16

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F 456	Continued From page 53 This observation was made in the presence of Employee #25 who acknowledged the finding.	F 456		
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 facilities. This REQUIREMENT is not met as evidenced by: Based on observations made on July 12, 2016 between 9:50 AM and 12:30 PM, it was determined that the facility failed to maintain resident's call bells in good working condition as evidenced by a non functioning call bell in one (1) of 44 resident rooms surveyed. The findings include: The call bell in resident room #219 failed to initiate an alarm when tested, one (1) of 44 resident rooms surveyed. This observation was made in the presence of Employee #5 and Employee #6 who acknowledged the finding.	F 463	**F463** 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH 1. The call bell in resident room #219 that failed to initiate when tested was immediatelyreplaced. 7/12/16 2. Facility wide the call bell system in all resident's rooms, bathrooms, nursing units and solariums have been inspected to confirm that they are functioning properly. 7/18/16 3. A preventative maintenance program is now in place to monitor and inspect the call bell system on a monthly basis. 8/19/16 4. The Dir. Of Engineering will provide the QAPI 7/31/16 committee with a monthly inspection report on the call bell system's operation, it will be reported on a monthly basis for 3 months, if there are no compliance issues after the 3 month period, the reporting period will be changed to quarterly. 8/19/16	
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;	F 514	**F 514** 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE	

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F 514	Continued From page 54 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient 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 four (4) of 43 Stage 2 sampled residents, it was determined that facility staff failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized as evidenced by failure to: The physician failed to document in that one (1) resident had a Pacemaker, to ensure that the status of one (1) resident's oral treatment plan was included in the clinical record, failed to document the rationale for the administration of Normal Saline intravenously for one (1) resident, and for one (1) resident failed to document the administration of a PPD on the immunization record sheet. Residents' # 98, 154, 281 and 254. The findings include: 1. The physician failed to document in that Resident #98 had a Pacemaker on the History and Physical form.	F 514	1. A). The pacemaker was unable to be added to the 6/22/16 physician history and physical, however on 8/17/16 an updated History and Physical was completed to reflect the pacemaker on this form. B). Resident #154 was seen by Dentist as evidenced in the dentist Progress note that was obtained on July 12, 2016 from the dentist to add to the resident's clinical record. Per the dentist there were no mouth lesions present at the time of her visit(s). This practice is unable to be corrected for Resident #154. C). The Nurse Practitioner's progress notes entailed the rationale for the normal saline order for Resident #281, however because the medical order has been discontinued the practice cannot be corrected timely for Resident #281. However, an addendum to the medical order for Resident # 281 is in place as of 8/31/16. There were no unfavorable outcomes. D) Facility is unable to correct the missing PPD on the immunization record for resident #254.	8/31/16

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F 514	Continued From page 55 A review of the clinical record revealed that Resident #98 had a Pacemaker device implanted on March 27, 2015. A review of the Physician ' s Notes: Physical Examination dated March 3, 2016 and April 27, 2016 respectively revealed under: Cardiovascular that the resident had a " pacemaker. " A review of Resident #98 ' s Physician ' s Order signed by the physician [date June [unreadable] directed the following, " Pacemaker F/U [Follow up] in Six months on June 1, 2016. The Original order date December 2, 2015". A review of the resident ' s History and Physical form dated December 2, 2015 lacked evidence that the physician documented that the resident had a pacemaker device. A face-to-face interview was conducted with Employee #27 on July 12, 2016 at approximately 11:00 AM. After review of the clinical record, Employee #27 acknowledged the findings. 2. The dentist failed to ensure that the status of Resident #154 ' s oral treatment plan was included in the clinical record. A physician interim order dated May 4, 2016 at 4:00 PM directed; "... Dentist consult for mouth lesion ... "	F 514	Continued From page 55 2.A).The RCMs have conducted monthly pacemaker audits to ensure that the physician History and Physical entails documentation to reflect these applicable residents have a pacemaker device. 8/31/16 B). The unit clerks have conducted monthly dental consults to ensure that no other residents have been affected by this practice. 8/31/16 C). All medical orders written for IVs will be reviewed by both the NP and RCM to ensure that rationales for normal saline are appropriately documented . 8/31/16 D) Facility is unable to correct the missing PPD on the munization record for resident #254. 3. A). The Medical Director has communicated with the medical team their expectations as medical staff and a review of Ftag 514 was reviewed with the specific medical team members involved in the practice identified in this citation. 8/31/16 4. The following reports will be reported to the Quality Assurance Performance Improvement Committee on a quarterly basis: A). The Resident Care Managers will include in their monthly report the findings of the audits conducted which entails that the rationale is in place for pacemaker devices; B). Dentist will send a weekly summary to the facility's Director of 8/31/16	

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F 514	Continued From page 56 A review of the dental treatment notes in the clinical record revealed the most recent dental examination was December 9, 2015. The clinical record lacked evidence of a dental evaluation subsequent to December 9, 2015. There was no additional documentation related to the status of oral examination/treatment for the resident. Employee #32 was queried regarding the status of the aforementioned order for the dentist to evaluate Resident #154 ' s mouth lesion. He/she responded that the dentist had evaluated the resident. A telephone interview was conducted with the Dentist on July 12, 2016 at approximately 3:30 PM regarding the aforementioned finding. He/she stated ...stated he/she saw the resident in May [2016] and no mouth lesion(s) were seen. The dentist failed to document the status of the oral treatment plan for Resident #154, particularly as it relates to the status of any mouth lesions. On July 12, 2016 at approximately 4:00 PM, Employee #3 obtained an updated dental note and included it in the clinical record. The clinical record was reviewed on July 12, 2016. 3. Facility staff failed to document the rationale for the administration of Normal Saline intravenously for Resident # 281. A review of the " Interim Order Form " dated [May 25, 2016] at 4:10 PM, " 1) IV (intravenous) NS (normal saline) at 100 ml/h (hour) x [times] 1 (one) L (liter), then NS at 80 ml/h x 1 (one) L ... "	F 514	Continued From page 56 Nursing (Interim) that entails: all consult requests, residents seen by the dentist and scheduled appointments in an effort to reconcile/verify that no resident consults/requests have been missed which will be summarized in a report;C). The night shift charge nurse conducts 24 hour chart audits in an effort to ensure that all orders are written correctly,	

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F 514	Continued From page 57 A review of the Infusion Medication Record for May 2016 revealed, " NS IV at 100 ml/hr x 1 L." After review of physician ' s order and the Infusion Medication record, there was no evidence that an indication for treatment was documented for the use of normal saline. A face-to-face interview was conducted with Employee # 23 on July 14, 2016 at approximately 3:44 PM. After reviewing the record, he/she acknowledged the findings. The record was reviewed on July 14, 2016. 4. Facility staff failed to document the administration of a PPD [Purified Protein Derivative] on the immunization record sheet for Resident #254. A review of the " Admission Order Sheet and Physician Plan of Care " revealed that Resident #254 was admitted to the facility on February 23, 2016 with an order that directed " PPD 1 step 0.1ml 5tu Intradermal, obtain CXR (Chest X-ray) if positive. " A review of the Medication Administration record revealed that PPD 1- step TST was administered on February 24, 2016 and read March 27, 2016. A review of Resident #254 immunization record revealed that the space allotted for the documentation of the PPD was left " Blank. A face-to-face Interview was conducted on July 15, 2016 at approximately at 3:00PM with Employee # 4 and #7. They acknowledged the findings.	F 514	Continued From page 57	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 58	F 520	Continued From page 58	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices.	F 520	F520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET 1).SBGC's quality assessment and assurance committee meets on a monthly basis to identify issues, develop and implement appropriate plans of action to correct identified quality deficiencies. Subcommittees that are in place to focus on specific areas include: the Infection Control Committee, which currently meets on a quarterly basis and the surveillance report is reviewed by the Infection Control Coordinator and Dir. Of Quality Assurance and Performance Improvement on a monthly basis; the Falls committee which meets on a monthly basis; Safety Committee which meets on a bimonthly basis. SBGC is unable to implement corrective actions to address the areas identified: 1) ADL Care (oral care, grooming, personal hygiene); 2) Accidents with injuries sustained are taken seriously and 3) Infection Control surveillance report, tracking and trending of infections within the facility and use of two-step tuberculin skin test (TST). However, an enhanced corrective plan is addressed under #3.	08/19/16

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	095014	A. BUILDING _____ B. WING _____	07/15/2016

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F 520	Continued From page 59 The findings include: During the recertification survey, the following areas of concern were identified: Actives of Daily Living (ADL)- Care- Facility staff failed to provide routine oral care for one (1) resident who was totally dependent on staff for all personal care, ensure that one (1) resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene; failed to provide consistent routine oral care for one (1) totally dependent resident who was observed with large amounts of food particles around the gums and between the teeth and to provided necessary services to maintain grooming for one (1) resident who required extensive assistance to maintain his/her grooming was observed with facial hair. CFR 483.25(a)(3), F312 CFR 483.25(h), F323, Accidents- Facility staff failed to ensure that resident was free from accidents as evidenced by the employee's failure to utilize appropriate safety measures while providing AM (morning) care to one (1) resident, subsequently the resident sustained fall resulting in a skin tear to his/her second toe and was sent to the emergency room for complaint of chest pains; failed to provide adequate supervision for one (1) resident who had a history of wandering. On June 21, 2016 the resident was placed at the nurse's station without supervision, he/she then wandered into another resident's room (Resident #279), encountered an altercation with another resident and subsequently the Resident #279 sustained an abrasion to the right eyelid. Cross reference CFR 483.25(h), F323	F 520	Continued From page 59 2). A focus on all totally dependent Residents; facility accidents with a focus on safety and a revised infection control program has been conducted. Interventions entail: licensed staff, including managerial staff to enhance their rounds in an effort to ensure that the residents have received their ADLcare (personal hygiene, grooming and oral care) has been provided as evidenced by audits conducted effective 08/24/16; safety rounds and safety education for interdisciplinary team members; and a revised TB program with education for staff across multiple disciplines. 3). The systemic changes that have been initiated and implemented include, however are not limited to: 1). A change to the Quality Assurance and Performance Improvement meeting to entail more brainstorming and problem solving; Also, A daily nursing unit huddle process has been initiated for all shifts which requires signatures of the assigned staff; 2). A CN A shift report; 3). Written Clinical Staff (licensed and non-licensed) expectations, 4). A revised skin and ADL sheet, which entails compliance reports/ rounding to assure that all ADL care has been documented prior to the end of the shift by Charge Nurse/Nurse Supervisor, which is reviewed daily by the Resident Care Manager/Assistant Manager; and	8/31/16 9/2/16

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F 520	Continued From page 60 Infection Control- Facility staff failed to maintain an Infection Control Program that tracked and trends infections in the facility; to ensure that two (2) of 11 residents' received the purified protein derivative (PPD) using the two-step tuberculin skin test (TST), to administer the PPD for one (1) resident in a timely manner, and to ensure that one (1) resident on isolation had his/her own dedicated medical devices in his/her room. Cross reference CFR 483.65 A face-to-face interview was conducted on July 15, 2016 at approximately 4:40 PM with Employees #2, #3, and #5 regarding the facility ' s Quality Assessment and Assurance (QAA) program. It was stated that the falls committee meets every month. The committee noted that most falls occur during change in shift. During change of shift someone is available to monitor residents at risk. March [2016] was the highest month since then our falls have decreased. It was further stated that [Resident #154] wanders into another resident ' s room resulting in Resident #279 sustaining an injury and going to the hospital. The new plan is to closely monitor the resident; however, it is not defined in the care plan. Facility staff stated that Infection Control committee reports monthly on infections within the facility that are community and in facility acquired. The facility acknowledge the concerns with the surveillance program within the facility.	F 520	Continued From page 60 5). Skin sheets 6). A Product review committee, for the review and approval all new/discontinued products/ equipment. 7). Education has been conducted in an effort to maintain safety for all residents, which entails fall prevention with injuries and an overall safety program. Establishment of TB policy which entails 2 step TST administration upon admission for all new residents; Education on this policy and for the licensed staff on the administration of the 2 step TST. Also, an Infection Control Preventionist with an Infection Preventionist (IP) certification has been hired with an anticipated start date of 09/6/16. The facility's TB program has been re-engineered to entail standards and best practices in accordance to the District of Columbia Department of Health Chest Clinic; APIC and CDC standards and best practices. The Infection Control Program has been revised which entails: Updated policies; the use of two-step TST; new bleach product wipe (Microkill with bleach) to use as a standard for surface/equipment disinfectant; (resident/ employee symptom assessment tool; and updated signage for isolation areas.	

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F 520	Continued From page 61 It was determined that the Quality Assessment and Assurance Committee failed to recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents; and developed and implement appropriate plans of action to correct identified quality deficiencies.	F 520	Continued From page 61 4). The plan to monitor the performance of the systematic changes discussed above will entail reporting to the Quality Assurance Performance Improvement Committee which was initiated in the meetings held on 07/22/16 and 08/19/16. Meetings will be held on a monthly basis for a minimal of three months starting with the September meeting, if consisted compliance is identified during this period of time the reporting period will change to quarterly.	08/19/16