Stoddard Baptist
GLOBAL CARE

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October 16, 2017

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

Dear Ms. Longstreth:

Enclosed are our Plans of Correction for the September 1, 2017 Recertification (Health) Quality Indicator Survey (QIS) and annual 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) 541-6058.

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 _____	Stoddard Baptist 09/01/2017

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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 of Washington, DC from August 25, 2017 through September 01, 2017. Survey activities consisted of a review of 40 resident clinical records during Stage 1; review of 40 sampled residents during Stage 2; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families and facility staff. 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 cc - cubic centimeters cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide COPD - Chronic Obstructive Pulmonary Disease CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue	F 000	Stoddard Baptist Global Care at Washington Center for Aging Services (SBGC), is filling this Plan of Correction in accordance with the Compliance requirements for the Federal and State regulations. This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction does not constitute admission of facts or conclusions cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Denise Chadwick Wright	Nursing Home Administrator	10/16/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) LE- Lower Extremity 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 Neuro - Neurological NP - Nurse Practitioner O2- Oxygen ORIF - Open Reduction Internal Fixation PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth PO2- Pulse oximetry POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party Sol- Solution S/P- Status Post TAR - Treatment Administration Record Tx- Treatment	F 000	Continued From page 1	

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F 000	Continued From page 2 UE- Upper Extremity	F 000	Continued From page 2	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 40 sampled residents, the interdisciplinary team failed to assess one (1) resident's ability to self-administer medications in a safe manner. Resident #78. The findings include: On August 28, 2017 at approximately 10:21 AM Resident #78 was observed opening a dresser drawer in the resident's room and removing the following over-the-counter medications: a. Two (2) bottles of Anebesol b. One (1) bottle of Systane Ultra lubricating eye drop (0.33oz 1 bottle), c. Rolaid 96 chewable tablets, d. Vitron C 60 coated tablets, e. One (1) bottle of Diabetic Tussin 40 ounces f. One (1) container of Aspercreme g. One (1) Vicks Menthol Inhaler for nasal congestion h. Calcium 600mg plus Vitamin D3800 International Units (100 coated tablets), i. One (1) tube of A and D ointment j. One (1) container of Diaderm rejuvenating foot	F 176	Ftag 176 483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE Resident #78 1. The facility conducted an Interdisciplinary Care Team meeting on 8/30/17 with Resident #78 and her responsible party to explain the requirements for the facility's setting to ensure that she is aware of non-prescription and prescription medication requirements in a long term care environment. needs and long-term care regulations. Upon notification, all medications in resident #78's room were removed on 8/28/17. The resident was assessed on 8/28/17 and did not exhibit any side effects of the medications found in the room. 2. A facility-wide check of all residents' rooms was conducted, and no medications were found in the residents' rooms. Resident rooms will be monitored weekly to prevent storage of medications. 3. Licensed nurses and nursing assistants were in-serviced, as part of rounding to check for medications stored in the resident rooms.	0828/17 08/28//17 08/28/17

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F 176	Continued From page 3 cream (4oz. 1 container) During a resident interview on August 28, 2017, at approximately 10:21 AM, Resident #78 was queried about self-administering medications. Resident #78 responded, "Yes I have my own medications that I forgot to take this morning" Resident #78 then self-administered the medications Vitron C, Calcium plus vitamin D and Systane eye drops. The resident further stated, "When I call for medications that are going to help me. They do not have it or they take a long time to get it. Therefore, I buy what I need and take them. In response to how do get he over-the-counter medications, Resident #78 stated, "When I go to Kaiser with my children I pick up what I need and they pay for it." According to the August 2017 Physician's Order Form signed by the physician on July 21, 2017, directed, "Vitron C 1 tab PO [by mouth] daily for anemia, pt. [patient] has in her room, willing to take it by herself. Can keep in room with pt." A review of the August 2017 Medication Administration Records (MAR) showed the physician order for Vitron C. Vitron C medication was administered daily at 9:00 AM. The clinical record lacked documented evidence the other over-the-counter medications were found documented for self-administration use or staff administration on the MAR. A review of care plan dated July 21, 2017,	F 176	Continued From page 3 4. The systemic process that will be implemented to monitor performance and make sure solutions are sustained will entail the Resident Care Managers conducting monthly resident interviews and observations utilizing the CMS QIS form, which will be reported to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	10/16/17

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F 176	Continued From page 4 showed "Problem" that read, "Resident may keep Vitron C in her room for self-administration." The other over-the-counter medications found at bedside were not included in the care plan for Resident #. During a face-to-face interview with Employee # 17 on August 28, 2017, at approximately 12:00 PM, Resident #78's self-medicating with several over-the-counter medications that were located in Resident #78's dresser drawer was discussed. Employee #17 stated, "[resident name] self-administers own medication. We supervise [resident name] take the medication, [Resident name] will call when ready to take the medication." After reading the list of medications that the resident removed from the dresser drawer in the bedroom, Employee #17 acknowledged the findings. Also, the family was contacted and a meeting was scheduled for the next day. There clinical record lacked documented evidence the Interdisciplinary Care Team (IDT) determined that it was safe for Resident #78 to self-administer medications. Also, during the self-medication observation on August 28, 2017 at approximately 10:22 AM, failed to demonstrate that the facility staff provided direct supervision of Resident #78 during self-administered of medications.	F 176	Continued From page 4	

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F 176	Continued From page 5	F 176	Continued From page 5	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 40 sampled residents, the facility staff failed to promote one (1) resident's dignity when serving a lunch meal on August 25, 2017. Resident# 222. The findings include: An observation on August 25, 2017, at approximately 1:25 PM revealed Resident# 222 and Resident# 135 seated at same dining table. The facility staff served Resident#135 a lunch meal at 1:25 PM, Resident# 222 had not received a lunch meal. At approximately 1:40 PM, the facility staff was asked: "why did Resident#222 not receive a lunch tray"? Facility staff stated, "the feeders are fed last." Facility staff served Resident# 222 a lunch meal at 1:40 PM. During a face-to-face meeting on August 25, 2017, at approximately 2:00 PM, Employee # 17 and Employee# 18 acknowledged the findings.	F 241	Ftag 241 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY Resident #222 1. The facility's Dining with Dignity practice entails that all residents sitting at same table will be served at the same time. Upon notification, resident 222 received a lunch tray and was fed on 8/25/17, after observation was made that the resident had not eaten. The resident consumed 75% of the meal. 2. A facility-wide check of all solariums/dining areas was conducted, and all residents were found to be eating and those requiring assistance were being fed. 3. The facility's practice of feeding all residents at a table at the same time will be reinforced by the licensed nurses. Nursing staff were in-serviced on the importance of promoting dignity for all residents when serving meals which will be reinforced by the charge nurses and managers. Resident Care Managers and charge nurses will monitor the solarium daily during meal time to ensure that all residents at each table are eating or being fed their meals.at the same time. 4. Solarium/dining areas monitoring and resident dignity concerns will be reported to the Quality Assurance and Performance Improvement Committee on 10/20/17 and then monthly thereafter.	08/25/17 08/25/17 09/27/17 10/16/17
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

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F 278	Continued From page 6 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview for one (1) of 40 sampled residents, it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) under Section B [Vision] for (1)	F 278	Continued From page 6	

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F 278	Continued From page 7 resident 's ability to see, in adequate light. Resident# 235. The findings include: On August 30, 2017, at approximately 3:00 PM, a review of the medical record for Resident# 235, reveal resident admitted to the facility on December 11, 2015, with an admitting diagnosis of Type 2 Diabetes Mellitus and Secondary Diagnoses of Essential (primary) hypertension, Legal Blindness. Further review revealed a Minimum Data Set Assessment dated June 16, 2017. The assessment reveals the facility staff documented the number zero (0) in Section B1000 (Ability to see in adequate light with glasses or other visual appliances). This coding indicates the resident has "Adequate Vision; sees fine detail such as regular print in newspapers/books." Further review of the Minimum Data Set Assessment dated June 16. 2017, Section I [Active Diagnoses] reveal the Resident ' s additional active diagnoses as Mild Cognitive Impairment, Legal blindness, as defined in the USA, Anemia in Chronic Kidney Disease. The medical record lacked documented evidence that the MDS coding accurately reflects the	F 278	Continued From page 7 Ftag 278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 1) The MDS Assessment was immediately corrected on 8/31/17. The correction was transmitted and accepted in the CMS portal. 2) A facility-wide check of all residents' MDS was conducted for coding accuracy with a focus on Section B1000. 3) All MDS staff were in-serviced on 8/31/17 for accurate coding of MDS Assessment (focus on section B1000). 4) MDS nurses will conduct monthly audit and report findings to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	08/31/17 08/31/17 1016/17 10/16/17

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F 278	Continued From page 8 resident's condition; Legal Blindness. During a face-to-face interview with Employee# 12 on August 30, 2017, at approximately 3:00 PM, Employee # 12 acknowledged completing Section B1000 [Vision] and stated "yes, he is blind."	F 278	Continued From page 8	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The	F 280		

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F 280	Continued From page 9 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 280	Continued From page 9	

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F 280	Continued From page 10 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to update Resident 247's care plan to indicate that the resident no longer wore dentures. The findings include: During a dining observation on September 1, 2017, at approximately 9:30 AM, Resident #247 was observed eating without natural teeth or dentures. When asked about difficulty chewing and eating, the resident stated, "No. I had some dentures but I lost them when I went to the hospital." On September 1, 2017 at 9:30 AM, a clinical record review showed a care plan for the use of dentures. The clinical record lacked documented evidence the facility staff updated the resident's care plan to reflect changes in the resident's oral status and lose of dentures.	F 280	Continued From page 10 Ftag 280 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Resident #247 1. Resident #247 was assessed on 9/1/17 and the resident condition was stable. The resident's care plan was updated on 9/1/17 to reflect that the resident no longer wears dentures. 2. Facility-wide all residents care plans with dentures were checked and found to be accurate. 3. Resident Care Managers and licensed nurses were in-serviced on updating resident's care plans with focus on oral status care 4. Resident Care Managers and charge nurses will monitor resident care plans with dentures and report findings monthly to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	09/01/17 09/01/17 09/27/17 10/16/17

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F 280	Continued From page 11 During a face-to-face interview with Employee #13 at approximately 10:30 AM on September 5, 2017, the employee was asked about Resident #247's dentures. The Employee stated, "The dentures were lost when the resident was hospitalized in March and the daughter has not decided to replace them. He/she has a diagnosis of Cancer, eats well and has no problems with weight loss." The employee acknowledged that the care plan was not updated to indicate that the resident no longer wears dentures.	F 280	Continued From page 11	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview for one (1) of 40 sampled residents, the facility staff failed to provide routine oral care to one (1) totally dependent resident. Resident #154. The findings include: On August 29, 2017, Resident #154 was observed with a right amputation above the elbow and left arm paralysis.	F 312		

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F 312	Continued From page 12 A subsequent review of the clinical record showed Resident #154 was coded under Section G110 of the Minimum Data Set (MDS) as a four (4) which indicates that the resident is totally dependent on staff for all Activities of Daily Living (ADL). During a face-to-face interview with Resident #154 at approximately 11:30 AM on August 29, 2017, the resident stated, "I have a medical appointment on Thursday. I am going to see my doctor and I would like to have my teeth brushed before I go." The resident was asked whether his/her teeth are brushed when receiving bath in the mornings. Resident # 154 stated "No, and I have an electric tooth brush plugged up by the bathroom sink but they [the Staff] do not use it." The Resident opened his mouth and displayed teeth covered with particles of food. This surveyor checked the bathroom and observed an electric toothbrush plugged into an outlet at the sink. The toothbrush was dry. On August 30, 2017, at approximately 10:30 AM, upon a return visit to the resident's room to inquire whether his teeth were brushed and to determine if the toothbrush was used. The resident informed this writer that his teeth were not brushed. This writer checked the toothbrush and it was dry. Another observation made on August 30, 2017 at approximately 2:45 PM, in the presence of Employee #5 showed that Resident #154's teeth were not brushed and a dry electric toothbrush in the bathroom.	F 312	Continued From page 12 Ftag 312 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #154 1. Resident #154 was assessed and oral care was given on 8/30/17. 2. Facility-wide all residents were checked to ensure that oral care was given with focus on residents that are dependent for oral care. 3. Nursing staff was in-serviced regarding Activities of Daily Living Care with focus on oral care. 4. Resident Care Managers and charge nurses will monitor residents' daily oral care and report findings to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	08/30/17 08/30/17 09/27/17 10/16/17

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F 312	Continued From page 13 Employee #5 acknowledged that the staff failed to provide routine oral care to a resident who is totally dependent on them for all care needs.	F 312	Continued From page 13	
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to provide supervision for eight (8) residents observed in the Activity/Dining Room	F 323		

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F 323	Continued From page 14 unattended for approximately 12 minutes. No employee was observed in the room. Residents #47, #59, 107, 121, 212, 219, 229, and 271. The findings include: On August 29, 2017, at approximately 12:30 pm, eight (8) residents were observed in the second floor Dining Room waiting to be served their lunch. There were no facility staff present in the dining room at the time of the observation. This surveyor remained in the room 10 minutes before initiating the call light. The light was initiated in response to one (1) of the residents calling out for assistance. Two (2) Certified Nursing Assistants and one Registered Nurse (RN) responded to the light in approximately three to four minutes. The residents who were observed in the room were identified as: 1. Resident #47: A review of Section G of this resident's most recent quarterly MDS dated June 02, 2017 revealed that the resident is coded as a four (4) Indicating that he/she is totally dependent on staff for all daily living activities. 2. Resident #59: A review of Section G of this resident's most recent quarterly MDS dated July 26, 2017 revealed that the resident is coded as a three (3) is able to feed self with supervision but	F 323	Continued From page 14 Ftag 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Residents #47, 59, 107, 121, 212, 229 and 271 1. It is the facility's practice to assign solarium coverage for the entire day. Licensed nurses were sent to the solarium immediately on 8/29/17 and the residents were assessed. No complications were identified. A nursing assistant was assigned by licensed nurse to monitor the residents in the solarium. 2. Facility-wide all solariums were checked and the residents were being monitored by nursing in accordance with facility practice. 3. Nursing staff were re-educated regarding supervision of residents in the solariums. The assigned nursing personnel received appropriate counseling. 4. Resident Care Managers and charge nurses will monitor the residents daily in the solariums and report findings to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter. :	08/29/17 08/29/17 09/27/17 10/16/17

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F 323	Continued From page 15 needs extensive assistance for all other daily living activities. 3. Resident #107: A review of Section G of this resident's admission MDS dated June 20, 2017 revealed that the resident is coded as a three (3) and needs extensive assistance from two persons for all daily living activities. This resident fell and sustained a fracture prior to being admitted to the facility on June 13, 2017. This resident was heard calling out, "I want to pee. I don't want to wet myself." 4. Resident #121: A review of Section G of this resident's most recent quarterly MDS dated July 08, 2017 revealed that he/she was coded as a three (3) and needed extensive assistance in mobility from one person and oversight and supervision for all other daily living activities. 5. Resident #212: A review of Section G of this resident's most recent quarterly MDS dated July 03, 2017 revealed that this resident is coded as a three (3) and indicated that he/she needs extensive assistance with two or more persons' physical assistance for all daily living activities. 6. Resident #219: A review of section G of this resident's latest quarterly MDS dated August 15, 2017 indicated that the resident was coded as a	F 323	Continued From page 15	

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F 323	Continued From page 16 three (3) and needed extensive assistance from two (2) persons for transfer, mobility and dressing and needs supervision and oversight for eating. 7. Resident #229: A review of Section G of this resident's most recent quarterly MDS dated July 12, 2017 revealed that this resident needed supervision/oversight for eating and was coded as a three (3) which indicated that the need for extensive assistance for all other activities of daily living exercises. This resident also has a history of falls as documented in the MDS. 8. Resident #271: A review of Section G of this resident's most recent quarterly MDS dated July 16, 2017 revealed that this resident was coded as a three (3) and needs extensive assistance from two (2) persons for bed mobility and transfer and dressing. This resident also has a history of falls as documented in the MDS. Seven (7) of the eight (8) unsupervised residents needed extensive assistance from staff for their daily needs, one resident was totally dependent and three (3) residents have a history of falls. During a face-to-face interview with Employee #19 at approximately 1:00 PM, he employee was stated that a schedule is made daily and staff is assigned throughout the day for periods of 15 minutes each. "The CNA who was scheduled to monitor the room/residents between 12:30 and	F 323	Continued From page 16	

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F 323	Continued From page 17 12:45 PM was attending to another resident but someone should have replaced [him/her]" The employee acknowledged the finding.	F 323	Continued From page 17 Ftag 371	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on an observation made on August 25, 2017, at approximately 9:00 AM, the facility failed to store food in a safe and sanitary manner in a large side-by-side refrigerator.	F 371	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY 1. There was raw chicken in the thawing stage in the side-by-side refrigerator in the facility kitchen which was immersed in an ice bath with seasoning to be later fried for the dining service. This item was immediately discarded on the same day it was observed and questioned by the surveyor. 2. All other items were checked in the refrigerated units and foundto be in compliance with food regulations. 3. The FNS staff was educated and reminded that raw food with blood component is to be stored on the bottom shelf of the refrigerated unit so that any drippings will not affect other food items therein. The FNS management staff will closely monitor the storage of raw food in all refrigerated units on a daily basis. Any dietary employee that is non-compliant with proper storage will be counseled and disciplined appropriately.	08/25/17 08/25/17 10/16/17

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F 371	Continued From page 18 The findings include: 1. On the second shelf of the refrigerator, several pieces of chicken observed immersed in liquid, covered with saran wrap and dated August 22, 2017. 2. The following items stored on the shelf below the chicken were as follows: a. One (1) opened packet of hot dogs, dated August 21, 2017, b. One (1) full packet of hot dogs undated and unlabeled; c. One (1) full packet of potatoes (French Fries) d. One (1) opened packet of French Fries (both undated and unlabeled) were all stored on the shelf below the chicken. 3. One (1) opened packet of bagels dated August 18, 2017. 4. One (1) opened container of garlic butter no date. 5. One (1) container of mashed potato mix dated July 01, 2017 6. A container of chicken base dated August 23, 2017. 7. A container of ground cinnamon dated August 01, 2017. During a face-to-face interview with Employee #16 immediately after the observation, the employee stated that perishable items could be	F 371	Continued From page 18 3. (cont.) A new form has been implemented for management staff rounding to check and document proper placement of food in the cold units. 4. The staff rounding will be reported to the Quality Assurance and Performance Improvement Committee meeting on October 20, 2017 and then on quarterly basis thereafter.	10/16/17

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F 371	Continued From page 19 stored for "three days after opening." The observations made in the presence of Employee #16 were acknowledged.	F 371	Continued From page 19	
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations made on August 30, 2017, at approximately 10:40 AM, the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) dishwashing machine that failed to maintain a minimum final rinse temperature of 180 degrees Fahrenheit during several consecutive wash cycles. The findings include: One (1) of one (1) dishwashing machine failed to reach and maintain a final rinse temperature of 180 degrees Fahrenheit on August 30, 2017, at approximately 10:40 AM. During several, consecutive wash cycles, the final rinse temperature gauge was at or below 164 degrees Fahrenheit. A stack pump was added to the dishwashing	F 456	Ftag 456 483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION 1. The dish machine in the main kitchen operation was inspected and failed to maintain the proper rinse temperature of 180 degrees Fahrenheit for the rinse cycle. The corrective action involved the Food Service Director making an emergency call to Ecolab to discuss the urgent situation that warranted immediate attention. The Ecolab representative arrived at the facility on 9/1/17 within 15 minutes and installed a stack pump. This was used as a temporary measure utilizing chlorine as a disinfectant until the hot water booster heater could be adjusted. 2. There were no negative effects on the resident or staff population regarding this issue. The Engineering Department was made aware of the issue and started making the necessary adjustments on the booster heater for proper hot water temps. 3. The Engineering Department has implemented a preventive maintenance program to monitor, inspect and log all temperatures of the dish machine once per day. The FNS staff will continue to use test strips as part of the monitoring process in place. Staff were in-serviced about monitoring the temperature of the dish machine.	09/01/17 10/16/17 10/16/17

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F 456	Continued From page 20 machine by Ecolab at approximately 11:45 AM on August 30, 2017, to circumvent low final rinse temperature issues and to enable the facility to use chlorine as a disinfectant. Dishes disinfection occurred after test strips confirmed that the disinfectant solution was at a minimum of 50 Parts per Million (PPM). The observations made in the presence of Employee #22 were acknowledged.	F 456	Continued From page 20 4. .This issue will be reported during the Quality Assurance and Improvement Committee on 10/20/17 and quarterly thereafter	10/16/17
F 463 SS=D	483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH (g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area - (2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain call bells in good working condition as evidenced by defective call bells in two (2) of 28 resident's rooms. The findings include: During an observation at 10:40 AM, on August 28, 2017, Resident #78 initiated his call light to request assistance with incontinence care. The facility staff responded after approximately 10 minutes to answer the call light. During a face-to-face interview with Employee#17	F 463	Ftag 463 483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Resident #78 1. Resident #78's call light was corrected by Engineering on 8/28/17. 2. All call lights were checked and all were working correctly. 3. The Engineering Department has a system in place to check all resident call lights. Employees were educated to consistently email requisition to the Engineering Department immediately if resident's call lights do not function properly. 4. Engineering will report all findings quarterly the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	08/28/17 08/28/17 09/01/17 10/16/17

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F 463	Continued From page 21 on August 28, 2017, at approximately 1:00 PM regarding resident concerns of not getting the help he/she needed for toileting. The employee acknowledged the findings and reported, "We had a problem with the call light, and we can hear the call light ring but have to check several rooms until we find which room is calling. We called Engineer found out the bulb was out." They presented the blown bulb to the surveyor. During a subsequent face-to-face interview with Employee #20 on August 31, 2017, at approximately 11:00 AM. the employee stated that the visual indicator usually illuminates above the door of the resident room accompanied by a sound from the nurses' station when the call bell was activated. Employee #20 further added that when the call bells activate the visual indicator and the audible alarm should be seen and heard by staff, but the bulb was found to be out in the resident room. Employee #20 acknowledged the finding. 2. On August 30, 2017, at approximately 3:30 PM, during tour two (2) of three (3) call bells in resident room #240 failed to alarm when initiated. The call bells were intended for use by bed B and c in Room #240. Employees #20 and 21 were present at the time of observations and acknowledged the findings.	F 463	Continued From page 21 FTag 463 483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Room 240 1. Call bell system in room 240 was corrected. 2. All call lights were checked and all were working correctly. 3. The preventive maintenance program has been enhanced to monitor and inspect all call bells weekly which entails checking call bell cords, call bell panel and call bell lights in resident's rooms. 4. The Director of Engineering will report to the Quality Assurance and Performance Improvement Committee on 10/20/17 and quarterly thereafter.	08/30/17 08/30/17 09/01/17 10/16/17
F 514	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional	F 514		

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F 514	Continued From page 22 standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on the review of one (1) of 40 sampled resident, the facility failed to accurately transcribe a physician's telephone order for Resident #8. The findings include: A review of Resident #8's clinical record revealed	F 514	Continued From page 22	

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F 514	Continued From page 23 a physician order dated November11, 2016, that included: "Foley Catheter 16 FR(French) 10 cc (balloon size) ... change catheter monthly..." On August 19, 2017, review of the Treatment Administration Record (TAR) dated September 1, 2017, revealed, a d/c (discontinue) foley catheter as a prescribed order." The clinical record lacked documented evidence that the physician wrote an order to discontinue the foley catheter. During a telephone interview with Employee #14 on September 1, 2017, at 11:00 AM, the employee was questioned about the foley catheter order. Employee #14 stated, "I did receive a verbal order to discontinue the Foley catheter and wrote in on the TAR, but forgot to write it on the physician order form". Employee # 2 acknowledged the findings after a record review at approximately 11:30 AM on September 1, 2017.	F 514	Continued From page 23 Ftag 514 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE Resident #8 1. The facility is unable to correct this deficiency. 2. All other residents with orders for Foley catheters were checked and no discrepancies were found. 3. Charge nurses were in-serviced regarding accurate follow through on physician orders with focus on Foley catheter in a timely manner. 4. Residents with physician orders for Foley catheters will be monitored monthly to ensure the attending physician orders are being followed consistently. Report to the Quality Assurance and Performance Improvement Committee on 10/20/17 and monthly thereafter.	09/01/17 09/01/17 09/27/17 10/1617