Stoddard Baptist GLOBAL CARE

www.stoddardbaptistglobal.org

December 6, 2018

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

Dear Ms. Longstreth:

Enclosed are our Plans of Correction for the Recertification and Licensure surveys conducted at Stoddard Baptist Global Care from September 19 – September 26, 2018.

If any additional information is needed please feel free to contact me at (202) 541-6058.

Sincerely,

LNHA

Dennis Olaniyi, MSN, BC-RN, LNHA

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 _____	09/26/2018

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 Long Term Care Survey was conducted at Washington Center for Aging Services from September 19, 2018 through September 26, 2018. Survey activities consisted of a review of 38 sampled residents. The following deficiencies are based on observation, record review, resident 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 CFU Colony Forming Unit 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	Stoddard Baptist Global Care (Washington Center for Aging Services) makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 12/6/18

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	F 000		

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
ng- nanograms
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
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
Rap, R/P - Responsible party
SCSA Significant change status assessment
Sol- Solution
TAR - Treatment Administration Record
Trach- Tracheostomy
TV- Television

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F 000	Continued From page 2 TX- Treatment	F 000	**F550 Resident Rights/Exercise of Rights**	12/4/18
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550	1. Resident #116 was immediately provided incontinent care in a dignified manner with privacy. 2. All residents that require incontinent care were identified and found not to be affected by the same deficient practice. 3. Nursing Staff were immediately educated on privacy while providing incontinent care to residents. Additional training of staff continued through 11/29/2018. 4. The nursing leadership team monitors the residents as it pertains to resident's rights including Privacy. This information is a part of the quality program and is presented to the QAPI committee quarterly.	

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F 550	Continued From page 3 free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for (1) one of 38 sampled residents facility staff failed to provide incontinent care in a dignified manner by leaving resident unattended and unclothed (exposed). Resident# 116 Findings included .... Resident admitted to the facility on 8/7/14 with diagnoses which include Hypertension, Vascular Dementia without behavioral disturbance, Adult Failure to Thrive and Contracture of Muscle. Review on 9/21/18 at 2:30 PM of the Annual Minimum Data Set [MDS] dated 7/10/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) resident is scored as "0" which indicate resident is rarely/never understood. Section G [Functional Status] resident is coded as "4' totally dependent on staff for activities of daily living (dressing, toilet use, bathing, and personal hygiene). Observation on 9/21/18 at 2:00 PM showed Resident# 116 lying in bed exposed with privacy curtain partially drawn. Employee# 22 entered the room holding towels and stated I just left for a minute I am changing her diaper, I should have covered her (resident) up, I am sorry. During an interview on 9/21/18 at 2:00 PM Employee# 13, Nursing Supervisor, stated yes, I	F 550		

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F 550	Continued From page 4 see the resident, this is a problem I will take care of it. Review of the nursing care plan, a problem start ate of 2/9/18 "Resident has potential for skin breakdown due to her being incontinent of bowel and bladder; Approach: Maintain resident's dignity and privacy when providing care." Facility staff failed to provide incontinent care with dignity by leaving resident unclothed (exposed) and vulnerable. During a face-to-face interview at the time of the observation on 9/21/18 at 2:00 PM, Employees #13 and #22 acknowledged the finding.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and a family member Interviews for one (1) of 38 sampled residents, facility failed to provide the resident with a replacement television and to place the television in an appropriate position where it can be viewed by the resident. Resident #202. Findings included...	F 558	**F558 Reasonable Accommodations – See page 6**	

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F 558	Continued From page 5 As reported to this surveyor on September 20, 2018 at approximately 2:30 PM the resident has a very small television (approximately 13 - 15 inches) which sits on the side of the bed and which she is not able to view when she is in bed. The informant further reported that the resident had a larger television (19 inches) which was purchased by the family when she was first admitted to the facility. According to the informant the original television was accidentally destroyed while an employee was cleaning the resident's room. He could not recollect the date of the incident but he thinks it was a few years ago. The resident was admitted to the facility on April 16, 2007. The admission inventory sheet showed a 19 inch television among the resident's list of possessions. An observation of the room on September 20, 2018 showed A 13 - 15 inch television on a portable tray (television tray) at the side of the resident's bed. The position of the television did not allow the resident to watch the television while lying in bed. After the observation the resident was asked if she liked her television and its location. She responded that it was too small and that she could not watch when she was lying in bed. A face-to-face interview was conducted with Employee #8 at approximately 2:30 PM on September 24, 2018. During the interview I advised the employee of the informant's concern about the situation but would investigate and inform me of the results of her investigation.	F 558	**F558 Reasonable Accommodations Needs/Preferences** 1. Purchased and placed in the resident room. The TV was positioned at a location that meets the needs of the resident. 2. All residents with personal televisions were identified and no other resident was found to be impacted by this practice. 3. Social Services will ensure that all resident's broken personal television is replaced with same size TV. Additionally, a meeting was held with the management team. During the meeting the team was re-educated regarding meeting the needs of the residents. 4. Monitoring the environment of residents is a component of the quality program. This includes ensuring the TV is placed in a location that is viewable for the residents and identification of any resident who has items damaged via staff in the Center. This information is presented in the QAPI committee meeting quarterly.	12/4/18

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F 558	Continued From page 6 During a follow-up face-to-face interview at approximately 11:00 AM on September 25, 2018 the manager stated she was informed that replacement of items are based on original value less depreciation; hence, the reason the resident's 19 inch television was replaced with a 13 inch television. She added that the value of the current television was equal to the value of the television that was destroyed. The manager also added that in order for the television to be mounted on the wall the family would need to bring in the materials (brackets, bolts, screws etcetera). During another face-to-face interview with Employee #1 the employee acknowledged that the facility failed to provide the resident with an appropriate replacement television. However, the employee stated that he was not aware of the situation but now that he is aware he will ensure that the resident receives an appropriate replacement television and that it is in a location that will be satisfactory to the resident and the family.	F 558		
F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for	F 575	**F575 Required Postings – See Page 8**	

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F 575	Continued From page 7 jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to ensure the accuracy of the contact information to include the names, mailing and email addresses for all pertinent State agencies and advocacy groups posted and failed to ensure the posting included a statement that the resident may file a complaint with the State Survey Agency was posted in an accessible and understandable manner. The resident census was 240 on the first day of survey. Findings included ... During tour of the facility on 9/26/18 at 12:00 PM, the "Important Contact Numbers" sign was observed posted on the wall behind the nurses' station in small print. The "Important Contact Numbers" signage contained telephone numbers "to report grievances" to the following organization: the	F 575	**F575 Required Postings** 1. The required state postings were updated and immediately placed on the unit identified in the survey in a manner consistent with the needs of the residents. 2. A review of the other units was conducted and no other unit was found to be impacted by this practice. 3. Social Services will ensure that state agency contact information will be displayed to resident's eye level. Re-education was done with educational sessions completed by 11/29/2018 4. Monitoring the required postings in the facility is conducted monthly by the leadership team. This information is presented by the Social Services department in the QAPI meeting quarterly.	12/4/18

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F 575	Continued From page 8 facility administrator, Department of Consumer and Complaint/Incident Hotline number, Regulatory Affairs, District Ombudsman, and District of Columbia Office of Aging. However, the signage failed to display the correct names and titles of the administrators for the aforementioned organizations. Further inspection of the required posting showed that the font size of the print was very small and not easily seen by individuals in wheelchairs. The facility failed to ensure the posting accurately reflected all State agencies information to include ailing and email addresses, in a font size that is accessible and understandable by individuals in wheelchairs. During a face to face interview on 9/26/18 at 3:00 PM, Employee #10, was shown the required posting of contact information. Employee #10 was in agreement that the font size was too small further stated that corrections would be made to the sign and move to a lower location so it can could be seen by individuals in wheelchairs. During a face-to-face interview at the time of the observation Employee #10 acknowledged the findings.	F 575		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as	F 577	**F577 Right to Survey Results – See Page 10**	

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F 577	Continued From page 9 client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility staff failed to ensure the most recent Federal State Survey results and plan of correction was available for review by residents and family members on Unit 1st floor (Orange). The resident census was 240 on the first day of the survey. Findings included ... During tour of the facility on 9/26/18 at 12:00 PM, an observation showed a white binder located at the nursing station with green and white signage "Survey Book please do not remove survey book from this area, request additional copies from Administration, Thank You." A further review of the binder showed Statement of Deficiencies [CMS2567] and Plan of Correction dated	F 577	**F577 Right to Survey Results/Advocate Agency info** 1. The Federal and State Survey Book and Plan of Correction was immediately updated on the unit identified (1 Orange). 2. All other units were checked for most recent Federal, State Survey Books and plan of correction. No other unit was found to be affected by this practice. 3. Administrative staff will ensure that most recent Federal, State survey books and plan of correction are available on all nursing units and other areas as required. The administrative staff members who will be responsible for ensuring the books are updated were re-educated. The training was completed by 11/29/2018. 4. Monitoring the required survey posting in the facility is conducted monthly. This information is presented to the QAPI committee quarterly.	12/4/18

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F 577	Continued From page 10 11/19/14. During an interview on 9/26/18 at 12:30 PM, Employee#10 stated, this need to be updated I will put last year's CMS2567 in the survey book. During a face-to-face interview Employee#10 acknowledged the finding at the time of the observation.	F 577	**F584 Safe/Clean/Comfortable/Homelike Environment** 1. The clogged sink (one), soiled floor in one electrical closet, one pantry, one linen room, soiled ceiling tiles in one pantry, one dayroom, floor tile damaged near one ice machine, antiskid strips, and odor identified in two bathrooms, and one damaged wall were repaired. There were no residents found to be affected by this practice. 2. All resident rooms and common areas were checked as it pertained to sinks, floors, ceiling tiles, floor tiles, antiskid strips, odors (particularly bathrooms) and walls. Any areas identified were corrected as indicated. 3. A preventative maintenance program is established to monitor, inspect and correct areas of concern including: sinks, floors, ceiling tiles, floor tiles, antiskid strips, odors and walls. The Maintenance and Housekeeping Staff were re-educated regarding these requirements. 4. Monitoring the environment as it pertains to safety; clean, comfortable, homelike is done by the Maintenance and Housekeeping leadership team. This information will be reported to the QAPI committee quarterly.	12/4/18
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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F 584	Continued From page 11 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide housekeeping and maintenance services necessary to maintain a comfortable interior as evidenced by: one (1) of one (1) clogged sink; soiled floors were observed in one (1) of one (1) the electrical closet, one (1) of one (1) pantry and one (1) of one (1) clean linen room; soiled ceiling tiles in one (1) of one (1) panty and one (1) of nine (9) dayrooms; floor tile damaged near the ice machine in one (1) of one (1) pantry; antiskid strips were not secure in two (2) of two (2) resident bathrooms; urine odor in two (2) of two (2) resident bathrooms and a damaged wall in one (1) of 38 resident rooms. Findings included ... During observations on the first floor, second floor and third floors on September 26, 2018, between 4:00 PM and 7:30 PM, resident rooms and common areas were observed with the following:	F 584		

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F 584	Continued From page 12 3 green toilet training bathroom had a clogged sink in one (1) of one (1) observed Floors soiled with dust in the electrical closet C332D the storage room C333A, areas of the baseboard located in the dayroom where recessed in one (1) of one (1) observed 3 blue pantry floor was soled beside and behind the ice machine with dust in one (1) nine (9) observed 3 orange clean linen room floor surface was soiled and had paper on the floor in one (1) on nine (9) observed 2 orange 287 dayroom ceiling tile stained in one (1) nine (9) observed 2 orange pantry ceiling tiles stained in one (1) nine (9) observed 3 blue pantry floor tile damaged near the ice machine in one (1) nine (9) observed Rooms 272 and 310 had a urine odor in the resident's bathroom in two (2) of 38 resident bathrooms 3 orange shower room C340 antiskid strips were not secure and the antiskid strips were not secure in toilet room A393C in two (2) of two (2) observed Damaged wall on 3green room #385 residents room in one (1) of 38 resident rooms. During a face-to-face interview on September 26, 2018, at the time of the observations, Employee #4 confirmed the findings.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656	**F656 Develop/Implement Comprehensive Care Plan-** **See page 14**	

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F 656	Continued From page 13 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	**F656 Develop/Implement Comprehensive Care Plan** 1. The Care Plans for residents #167 and #108 were reviewed and updated to ensure they were person-centered and addressed activity pursuits and cognitive status. 2. A review of the activity care plans as well as a review of residents who were cognitively intact was conducted to ensure care plans met the resident needs. Care plans were addressed as indicated. 3. The Interdisciplinary team were re-educated regarding care plans ensuring they are person centered and meet the needs of the residents. 4. The Activity Director conducts monthly audits of the resident's preferences. The Social Services Director monitors the BIMS scores of the resident to ensure the care plan addresses their cognitive status. This information is presented at the QAPI Committee meeting quarterly.	12/4/18

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F 656	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to develop and implement an individualized care plan to meet the needs of the resident in two (2) of 38 resident records reviewed (Residents' #167 and 108). Findings included ... A. Resident #167 was admitted with a past medical history including Dementia. Review of the Minimum Data Set (MDS) dated 08/04/18 showed Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive deficit. The surveyor conducted a tour of unit 2 Orange on 09/19/18 at approximately 10:00AM. During the observation Resident #167 was observed seated in a wheelchair in her room facing the hallway. The surveyor conducted another tour on 09/20/18 at approximately 11:00 AM. Resident #167 was again observed seated in a wheelchair in her room, facing the hallway. Later on the in the afternoon at approximately 2:00 PM, the Resident was seen sleeping in her bed. On 09/25/18 at approximately 11:30AM, Resident #167 was again seen seated in her wheelchair, facing the hallway. Review of section F of the MDS dated 02/04/18, showed that listening to music and participating in her favorite activities, is very important. Doing things with groups of people and going outside to get fresh air while the weather is good, is somewhat important. Review of the Activities care plan for Resident #167, last reviewed on 05/08/18 shows that the	F 656		

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F 656	Continued From page 15	F 656		

resident prefers activities that identify with her prior lifestyle. The goal is that the Resident will express satisfaction with her daily routine and leisure activities. However, the activity preferences are not listed, and the approaches are not individualized to meet the needs of the resident.

The surveyor conducted a face to face interview on 09/25/18 at 12:06 PM with Employee #11, Nurse Manager for 2 Orange, regarding the Activity plan for Resident #167. She stated that Resident #167 is non-compliant with leaving her room and from time to time the Activities staff will come by to visit her.

The facility failed to develop a care plan was individualized with goals and approaches to meet the needs of the resident.

The surveyor conducted a face to face interview on 09/25/18 at 12:30 PM with Employee #11, and 25, and they acknowledged the findings.

B. Resident #108 was admitted with a past medical history of Dementia. Review of the Minimum Data Set (MDS), dated 07/10/18 showed a Brief Interview for Mental Status (BIMS) score of 14, indicating she is cognitively intact. She was admitted to 1 Blue, a locked unit designated Dementia unit.

Review of the care plan that addresses her Alzheimer's/Dementia, last edited 07/17/18 showed a goal that the "Resident will be reoriented to person, place and time and resident will be safe in their environment of the next 90 days."The approaches documented were: "1. Reorient resident to person, place and time as

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F 656	Continued From page 16 needed when confusion is noted. 2. Monitor residents whereabout in the facility to ensure safe environment. 3. Remove resident from areas where there is over stimulation that agitated or confuses resident. 4. Document declines in cognitive status in the clinical record. 5. Administer medications as ordered by MD [Medical Doctor] 6. Psych [psychiatric] evaluations as needed." The facility failed to develop an individualized person-centered care plan with goals and approaches to meet the needs of the resident. The surveyor conducted a face to face interview on 09/24/18 at 1:00 PM with Employee #26, Assistant Nurse Manager of 1 Blue. He acknowledged the findings.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview one (1) of 38 sampled residents, the facility failed to ensure that activities met the need	F 679	**F679 Activities Meet Interest** 1. Resident #167's activity preferences were reviewed and care plans were updated to meet the needs of the resident. 2. All residents activity preferences were checked and care plans were updated if indicated. 3. The Activity team was re-educated regarding care plans ensuring they are person centered and meet the activity preferences of the residents. 4. The Activity Director conducts monthly audits of the resident's preferences. This information is presented at the QAPI Committee meeting quarterly.	12/4/18

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F 679	Continued From page 17 of Resident #167. Findings included ... Resident #167 was admitted with a past medical history including Dementia. Review of the Minimum Data Set (MDS) dated 08/04/18 showed Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive deficit. The surveyor conducted a tour of unit 2 Orange on 09/19/18 at approximately 10:00AM. During the observation Resident #167 was observed seated in a wheelchair in her room facing the hallway. The surveyor conducted another tour on 09/20/18 at approximately 11:00 AM. Resident #167 was again observed seated in a wheelchair in her room, facing the hallway. Later on the in the afternoon at approximately 2:00 PM, the Resident was seen sleeping in her bed. On 09/25/18 at approximately 11:30AM, Resident #167 was again seen seated in her wheelchair, facing the hallway. Review of section F of the MDS dated 02/04/18, showed that listening to music and participating in her favorite activities, is very important. Doing things with groups of people and going outside to get fresh air while the weather is good, is somewhat important. Review of the Activities care plan for Resident #167, last reviewed on 05/08/18 shows that the resident prefers activities that identify with her prior lifestyle. The goal is that the Resident will express satisfaction with her daily routine and leisure activities. However, the activity preferences are not listed, and the approaches are not individualized to meet the needs of the	F 679		

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F 679	Continued From page 18 resident. The surveyor conducted a face to face interview on 09/25/18 at 12:06 PM with Employee #11, Nurse Manager for 2 Orange, regarding the Activity plan for Resident #167. She stated that Resident #167 is non-compliant with leaving her room and from time to time the Activities staff will come by to visit her. The facility failed to provide activities to meet the needs and preferences of Resident #167. The surveyor conducted a face to face interview on 09/25/18 at 12:30 PM with Employee #11, and 25, Registered Nurse. The acknowledged the findings.	F 679	**F684 Quality of Care** 1. Resident #65 was assessed immediately and was not found to be impacted. Additionally, it was determined that staff will administer her medications. 2. A review of residents using nasal spray was conducted, no resident was found to be impacted by this practice. 3. All licensed Nursing staffs were educated on proper administration of nasal spray according to professional standard of practice and manufacturer specification. The in-services were completed by 11/29/2018. 4. Medication administration, particularly nasal spray administration reviews are conducted by nursing leadership. This information is presented to the QAPI committee quarterly	12/4/18
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview of one (1) of 38 sampled residents, the facility staff failed to instruct resident proper administration of medication according to professional standards of practice and manufacturer's specification for one (1) of one resident receiving nasal spray. (Resident #	F 684		

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F 684	Continued From page 19 65) Finding included... The facility staff failed to follow professional standards of practice and manufacturers specification for administering Fluticasone nasal spray (indicated for the management of the nasal symptoms of perennial nonallergic rhinitis in adult and pediatric patients aged 4 years and older) during medication administration observation for Resident #65. Resident #65 was admitted to the facility on August 3, 2013, with diagnosis that include Malignant Neoplasm of female breast, Type 2 Diabetes Mellitus, Essential Hypertension, Major Depressive Disorder, Chronic Rhinitis and Allergy. On September 20, 2018 at approximately 10:15 AM, the surveyor observed Employee #20 handed Resident #65 the Flonase nasal spray. Resident #65 self-administered Flonase one spray per nostril. Employee #20 instructed the resident to administer a second dose. The resident administered a second dose of Flonase, one spray per nostril. Employee #20, returned the Flonase to the medication cart. A review of the physician's order dated July 16, 2018 showed "Flonase nasal spray 50 microgram (mcg), 2 sprays to each nostril daily for rhinitis." A face-to face interview conducted on September 20, 2018 at approximately 10:30 AM, Resident	F 684		

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F 684	Continued From page 20 #65 stated she could take her own medication. Manufacturer instructions stated the resident should first blow your nose; close one (1) nostril; tilt your head forward slightly; start to breathe in through your nose, and while breathing, press firmly and quickly down one (1) time on the applicator to release the spray; then breathe out through your mouth. If a second spray is required in that nostril, repeat the process. The medication administration observation failed to support that the resident self-administered the nasal spray in accordance with manufacturer's recommendation to ensure adequate delivery of dose. Furthermore, the facility staff did not provide guidance while observing the resident's self-administration of medication. https://www.rxlist.com/flonase-d6rug.htm#medguide A face-to-face interview conducted on September 20, 2018, at approximately 10:45 AM, Employees' # 20 and #15 acknowledged the findings.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689	**F689 Free of Accidents –** **See Page 22**	

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F 689	Continued From page 21 by: Based on observation, record review and staff interview for one (1) of 38 sampled residents facility staff failed to provide care in accordance with physicians' order and professional standards of care as evidenced by a resident fall. Resident # 33. Findings included ... Facility staff failed to maintain safety to prevent a resident fall by failing to raise the bed side rails when providing incontinent care. Resident # 33 admitted to the facility on 6/12/10 with diagnoses which include Unspecified Dementia without Behavioral Disturbance, Chronic Kidney Disease, Dysphagia, and Hypertension. Review on 9/24/18 at 10:00 AM of the Quarterly Minimum Data Set [MDS] dated 6/18/18 showed Section C [Cognitive Patterns] Brief Interview for Mental Status (BIMS) resident is scored as "0" which indicate resident is rarely/never understood. Section G [Functional Status] resident is coded as "4' totally dependent on staff for activities of daily living (dressing, toilet use, bathing, and personal hygiene). Section H [Bladder and Bowel] Resident is coded as "3" which indicate, always incontinent of bladder and bowel. Section J [Health Conditions] J1700 Fall History on Admission/Entry or Reentry is coded as "1" which indicate resident had a fall during the last month; J1900 Number of Falls since Admission/Entry or Reentry Prior Assessment is	F 689	**F689 Free of Accident Hazards** 1. Resident #33 was reassessed, and is without injury and/or accidents, unable to retrospectively correct. 2. All residents who utilize side rails to enhance turning and re-positioning were checked. No other resident was found to be impacted by this practice. 3. The nursing staff was re-educated regarding the use of side rails and importance of elevating them while doing ADL care. The training was completed by 11/29/2018. 4. The nursing leadership team monitors ADL care including use of side rails when indicated. The information is provided to the QAPI committee quarterly.	12/4/18

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F 689	Continued From page 22 coded as "1" No injury (no evidence of any injury is noted on physical assessment by the nurse or primary care clinician). Review of the nursing care plan showed "Resident at risk for falling; approaches "assess resident frequently to assure that resident is positioned correctly on the bed, keep call light in reach at all times, observe frequently and place in supervised area when out of bed, provide incontinent care as needed." Review of the physician order dated 5/2/18 showed "Both side rails up while in bed to enhance turning and repositioning every shift." On 9/24/18 at 11:30 AM a review of the nurses note dated 5/3/18 showed "Resident has fallen while the Certified Nursing Assistant (CNA) and family member were changing the resident, CNA rolled the resident to her side, and she (resident) had fallen to the floor, there were no visible injuries, and the CNA stated the position of the side rails was down, the CNA was provided education that the side rails must be up when providing care." On 9/24/18 at 1:00PM observed resident lying quietly in bed and the ½ side rails were raised, secured to the bed and functioning as intended. During an interview with Employee#15, yes, I am aware of the resident's fall but there was no injury. During an interview on 9/24/18 at 1:30 PM Employee#24 stated I received training on safety precautions to prevent falls, it takes two staff to provide incontinent care I should have asked staff	F 689		

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F 689	Continued From page 23 for help and put the side rails up. During an interview on 9/24/18 at 4:00 PM, Employee# 23 stated I was here and Employee #24, CNA called for help I met the resident on the floor, there were no visible injuries, we got the resident on the bed and sent her (resident) to [hospital name]. During an interview with Employee#15, yes, I am aware of the resident's fall but there was no injury. A review of the medical record showed on resident was transferred to [Hospital name]. A further review of the medical record showed resident did not sustain an injury following the fall (5/3/18). Facility staff failed to maintain safety to prevent a resident fall by failing to raise the bed side rails when providing incontinent care. During a face-to-face interview on 9/24/18 at 5:00 PM Employee #15 acknowledged the finding.	F 689	**F690 Bowe/Bladder Incontinence** 1. Resident #197 was assessed and catheter care was provided by the licensed nursing staff member immediately. 2. A review of residents with Foley Catheter care was conducted and no other resident was found to be affected by this practice. 3. The Licensed Nursing Staff were re-educated on Foley Cather Care, this included a review of the Policy and Procedure on Catheter Care and on Urinary Tract Infections. The training was completed by 11/29/2018. 4. Residents with Foley Catheter care and Catheter care is done by the leadership team. This is presented to the QAPI committee quarterly.	12/4/18
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		

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F 690	Continued From page 24 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff and resident interview of one (1) of 38 sampled residents, the nursing staff failed to evaluate and address catheter care for a resident with an indwelling catheter and recurrent urinary tract infections (Resident #197). Findings include ... The Washington Center for Aging Services policy entitled "Catheter Care - Suprapubic", undated, stipulates that the purpose of catheter care is to reduce infection and promote good hygiene. The procedure of catheter care included " ...cleanse	F 690		

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F 690	Continued From page 25 the skin around the catheter and the entire visible length of the catheter with soap and water. Be sure all drainage is removed from skin and catheter ..." The policy describes that the type and amount of drainage should be noted, if present. Resident #197 was admitted to the facility with a diagnosis of Parkinson's Disease and a history of Prostate Cancer with a suprapubic catheter placement. Review of the medical record showed that Resident #197 had multiple urinary tract infections (UTI's) beginning in 03/2017 when he was placed on isolation for an Extended Spectrum Beta-Lactamase (ESBL) infection in the urine. Additionally, he was treated for a UTI 03/2018, and in 08/2018, was again placed on isolation for ESBL in the urine. Review of the physician orders report for September, dated 07/29/18, directed that nursing staff perform catheter care. The surveyor conducted a face to face interview with Employee #25, Charge Nurse, 2 Orange, in the presence of Employee #11, Unit Manager 2 Orange, on 09/25/18 at 11:08 AM regarding catheter care. When asked what the procedure was for catheter care, she stated that the nurse observes the drainage bag and checks the urine for sediment, color, and blood. When the surveyor asked if cleaning the catheter was considered catheter care, she stated no, cleaning the catheter is considered an Activity of Daily Living (ADL) and is performed by the Certified Nursing Assistant (CNA). When asked how the resident's frequent UTI's were being addressed related to catheter care, she could offer no further insight.	F 690		

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F 690	Continued From page 26 The surveyor conducted a face to face interview on 09/26/18 at 2:45 PM with Employee #27, Infection Control Nurse Practitioner, in the presence of Employee # 1, Administrator, and Employee 28, Infection Preventionist, regarding how the Infection Control department was addressing the recurrent Catheter Acquired Urinary Tract Infections (CAUTI's) for Resident #197. She stated that they provided education for staff regarding hand hygiene. When asked if training was provided to staff regarding catheter care, she stated no. The above employees acknowledged the findings.	F 690		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review, personnel training record and staff interview of one (1) of 38 sampled residents, the facility failed to develop a Dementia Care Program and ensure the competency of staff, to address the needs of residents diagnosed with dementia and housed on the secure dementia unit (Residents #108) Findings included ... Resident #108 was admitted with a past medical history of Dementia. Review of the Minimum Data Set (MDS), dated 07/10/18 showed a Brief Interview for Mental Status (BIMS) score of 14,	F 744	**F744 Treatment/Service for Dementia** 1. Resident #108 was reassessed to determine her needs as it pertained to Dementia. The Nursing Care Plan was updated to ensure that it was person centered and met the resident's specific needs. 2. A review of the residents on the Special Care Unit was conducted. Person Centered Care plans are in place to meet the needs of the residents diagnosed with Dementia and/or Dementia Related Conditions 3. The nursing staff on the Special Care Unit were re-educated regarding the Dementia care program with the updates already developed. The staff will continue to be educated as the program continues to evolve. In-service training was completed by 11/29/2018. 4. A review of residents who are diagnosed with Dementia (10%) is conducted by the nursing team monthly. The information is submitted to the DON and/or designee and is presented in the QAPI meeting quarterly and more frequently as indicated.	12/4/18

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F 744	Continued From page 27	F 744		

indicating she is cognitively intact. She was admitted to 1 Blue, a locked unit designated Dementia unit.

Review of the care plan that addresses her Alzheimer's/Dementia, last edited 07/17/18 showed a goal that the "Resident will be reoriented to person, place and time and resident will be safe in their environment of the next 90 days."The approaches documented were: "1. Reorient resident to person, place and time as needed when confusion is noted. 2. Monitor residents whereabout in the facility to ensure safe environment. 3. Remove resident from areas where there is over stimulation that agitated or confuses resident. 4. Document declines in cognitive status in the clinical record. 5. Administer medications as ordered by MD [Medical Doctor] 6. Psych [psychiatric] evaluations as needed."

During a tour of unit 1 Blue, conducted on 09/24/18 at 2:20 PM, the surveyor observed two Certified Nursing Assistants (CNA) throwing a beach ball to Residents seated in the day room. The surveyor conducted a face to face interview on 9/24/18 at approximately 2:30 PM with Employee # 29, Certified Nursing Assistant, regarding training she received on dementia care. She stated that she has not had any formal training.

The surveyor conducted a face to face interview on 09/24/18 at 2:45 PM, with Employee #30, Certified Nursing Assistant regarding Dementia training. She stated that the staff was sent offsite to complete training.

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F 744	Continued From page 28 Review of Continuing Education Unit (CEU) certificates for staff showed that Employee #30 completed six hours of training on Alzheimer's Disease and Dementia Care. Employee #29, did not complete training. The facility failed to develop a Dementia Care program to meet the needs of residents housed on a Dementia Care unit. The surveyor conducted a face to face interview on 09/26/18 at 9:21 AM with Employees #3, Director of Clinical Operations, and Employee #1, Administrator. Both acknowledged that the facility had no formal Dementia Care Program at the time of survey.	F 744		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	**F842 Resident Records** 1. A review of resident #33 was conducted. Falls risk assessment was updated. Unable to retrospectively correct assessment. 2. The residents with falls were identified, assessed, and appropriate falls risk assessment scoring was documented if needed. 3. The nursing staff were re-educated immediately on completion of falls risk assessment scoring. Additional training was completed through 11/29/2018. 4. The Nursing leadership team monitors the Fall Risk scores monthly. This information is presented at the QAPI committee quarterly.	

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F 842	Continued From page 29 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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	F 842		

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F 842	Continued From page 30 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 record review and staff interview for one (1) of 38 sampled residents facility staff failed to accurately document a fall assessment to reflect the resident's current status. Resident# 33. Findings included ... Resident admitted to the facility on 6/12/10 with diagnoses which include Anemia, Essential Hypertension, Chronic Kidney Disease, Incontinence without Sensory Awareness and Acquired Absence of Unspecified Leg above the Knee. Review on 9/22/18 at 1:00 PM of the Quarterly Minimum Data Set [MDS] showed Section G0400 [Functional Limitation Range of Motion] lower extremity (hip, ankle, knee, foot) impairment on both sides; G0600 [Mobility Devices] wheelchair is selected as normally used. A review of the physician note (Initial or Progress) dated 7/13/18 showed "Dementia-Advanced, Hypertension, Peripheral Vascular Disease, Bilateral Above Knee Amputation," Resident with multiple problems, completely dependent for all activities of daily living, she (Resident) did have a reported fall in May with no injuries." Review of the care plan showed "Resident is limited in physical mobility related to bilateral above the knee amputation."	F 842		

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F 842	Continued From page 31 Review of the Fall Assessment dated 5/3/18 showed "Description: Fall Risk, Ambulation/Elimination Status is scored as "4" which indicates resident is ambulatory/incontinent. Fall Risk Score-Score of 10 or higher represents a high risk for falls. The Fall Risk is scored as "13.0" which represents a high risk for falls. During an interview 9/22/18 on at 2:00 PM Employee# 15 stated this score is not correct, the resident has a bilateral amputation and is not ambulatory. Facility staff failed to accurately calculate the Fall Risk Score and code the Fall Risk Assessment to reflect the resident's current status as a bilateral amputee. During a face-to-face meeting on 9/22/18 at 3:00 PM Employee# 15 acknowledged the finding.	F 842		