STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING ______ B. WING ______	08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	**1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19 monitoring." During an interview on August 15, 2018, at approximately 1:00 PM with Employee #2. She was made aware that there are concerns with coding resident diagnoses. Employee #2 acknowledged the finding.	F 641		
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 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)-	F 656	1. Resident #13 was discharged on and the record cannot be amended retrospectively. 2. Medical records of all current residents with the potential problem concerning constipation were audited by (ADON/DON) to ensure a corresponding care plan with appropriate goals and approaches ~~is~~ was completed. 3. The Interdisciplinary team will be re-educated by DON regarding care plan updates as they relate to resident problems concerning constipation.	8/28/18 10/1/18 10/15/18

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F 656	Continued From page 20 (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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews for one (1) of 19 sampled Residents, the facility failed to develop a care plan to address one (1) Resident problem with constipation. Resident # 15. Findings included... Facility staff failed to develop a care plan to address Resident #15 problem with constipation. Resident #15. During tour interviewed with Resident #15 on August 07, 2018 at 3:41 PM he stated, "I am constipated need something better." He pointed to the bedside table and continued to say, "I went and got some prune juice and hope it goes away." At the time of the interview, a bottle labeled Prune juice half-full was located on the resident bedside table. A review of the Physician's order showed the following orders for Bowel Management:	F 656	4. Audits of care plan updates for residents with problem with constipation will be completed by the DON and/or designee weekly to ensure compliance until three consecutive months of greater than or equal to 95% compliance is achieved. Results of these audits will be reported at the quarterly Quality Assurance Committee meeting, for review and/or further recommendations. 5. Compliance date	10/15/18

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F 656	Continued From page 21 June 4, 2018, directed, "Senna S Tablet 8.6 - 50 mg [Sennosides - Docusate Sodium] 1 tab by mouth every 12 hrs (hours) for Bowel management." June 4, 2018, directed "Bisacodyl Suppository 10 mg Insert 10 mg rectally every 24 hours as needed for Bowel management." June 6, 2018, directed, "Add 1 cup of Prune juice to every meal" A review of Resident #15's care plans showed that a care plan was not developed with goals and approaches to address the resident's problem with constipation. A face-to-face interview conducted with Employee#2 on August 15, 2018, at 3:15 PM. She reviewed the care plan and acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 657	1.The care plan for Resident #15 was revised to include goals and approaches for the resident change in the residents diet order.	9/15/18

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F 657	Continued From page 22 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 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 observations, record reviews and staff interview for one (1) of 19 sampled residents, the facility failed to update the care plan to include goals and approaches to address one (1) resident change in diet. (Resident # 15). Findings included... Resident #15 was admitted on December 22, 2017 with diagnoses to include Hypertension, Hyperlipidemia, Aphasia, and Cerebrovascular Accident. On August 13, 2018, at approximately 12:30 PM, Resident #15 was observed feeding himself. He ate 100% of his diet "Regular diet Puree Texture, honey fluid consistency". According to the clinical record, on June 6, 2018,	F 657	2. Medical records for current residents with diet change was completed by the Dietician to ensure a corresponding care plan concerning goals and approaches is included. 3. The IDT team will be re-educated by DON on care plan updates as they relate to resident with diet changes, all new diet orders will be reviewed by the IDT team on daily basis and Dietician will make sure the care plans are updated with the new changes. 4. Audits of care plan updates will be completed by Dietician on a daily basis to ensure compliance until three consecutive months of greater than or equal to 95% compliance has been achieved. Results of the audits will be reported to the quarterly Quality Assurance Committee meeting for review and/or further recommendations. 5. Compliance date	9/29/18 10/10/18 10/30/18

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F 657	Continued From page 23 Resident #15 had a Modified Barium swallow test. The Resident on July 28, 2018, had a diet change to "Regular diet Puree Texture, honey fluid consistency" A review of Careplan showed May 23, 2018, speech therapy change diet to "Pureed with nectar consistency" The evidence shows that facility staff did not update the Resident #15 care plan with goals and approaches goals and approaches to address "Regular diet Puree Texture, honey fluid consistency". A face-to-face interview conducted with Employee#2 on August 15, 2018, at 3:15 PM. She reviewed the care plan and acknowledged the findings.	F 657		
F 684 SS=E	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 and staff interview of three (3) of 19 sampled residents, the	F 684	1. Resident #13 has been discharged on 8/28/18 from the facility. Both resident's #13 and #27 were seen by psych services. Resident #13 was seen prior to discharge on 8/28/18 Resident #13 had their pulmonary appointment completed prior or to D/C. Resident #13 was admitted without a PICC x-ray. On 8/15/18 a call was placed to obtain hospital x-ray results. X-ray results obtained the same day indicated no discrepancies between the x-ray results and the assessment findings completed by facility staff.	8/15/18 8/15/18

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F 684	Continued From page 24 facility staff failed to follow the physician's orders to change oxygen humidifying water, failed to ensure that Psych consults was completed, failed to ensure that pulmonary appointment was completed, and failed to assess and measure the external length of the peripherally inserted central catheter (PICC) line and arm circumference for one (1) resident receiving antibiotic therapy. (Residents' #13, #27 and #134) Finding included... 1. Failed to follow physician orders to change oxygen humidifying water. (Resident #13) Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with acute exacerbation, Acute and Chronic Respiratory failure with hypoxia and Shortness of breath. Observation on August 7, 2018, Resident #13 oxygen humidifying bottle was not dated, to indicate when the bottle was last change. A review of the physician's order showed, "Change oxygen humidifying water [every] 24 hour when the water level is low and PRN." A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee # 2 acknowledged the findings. 2. Failed to ensure two (2) residents were seen by the psychologist, in accordance with the attending physician's order. (Residents #13 and	F 684	2. The involved nursing employee was re-educated by DON regarding the failure to follow physician's orders to change oxygen humidifier water. Current residents in-house with oxygen requiring change in humidifier water were reviewed by ADON to ensure compliance of physician's orders. Current in-house resident records have been reviewed by ADON ensuring that all appointments and consultations have been set-up as per physician order. Currently there are no other residents in-house who have a PICC-line. 3. Licensed staff will be in-serviced on the oxygen therapy policy and changing oxygen humidifier water by the DON. The leadership team will monitor through weekly visual inspections for staff compliance to physician orders with further re-education of staff and/or disciplinary action enforced if indicated. The DON and/or designee will complete weekly audits x4 for staff compliance for oxygen therapy to physician order, then monthly x4.	8/7/18 8/15/18 8/30/18 10/14/18

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F 684	Continued From page 25 #27) A. Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with acute exacerbation, Acute and Chronic Respiratory failure with hypoxia and Shortness of breath. On June 20, 2018, Physician order directed Psych consult for medication review and [evaluation] PRN (as needed). Resident #13's medical record showed that Psych consults were scheduled for July 30, 2018, at 2:15 pm and August 6, 2018, at 2:15 pm. However, the results from the consultation were not on the resident's chart. The record lacked evidence that the resident was seen by the psychologist as ordered by the attending physician. A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee #2 acknowledged the findings. B. Resident #27 was admitted to the facility on July 20, 2018 with diagnoses that include joint pain, insomnia, anxiety disorder, major depressive disorder, Hypertension and constipation. A review of the physician's order for August 2018 showed the resident was to receive Pristiq 100 mg one tablet in the morning for Major Depressive Disorder, Quetiapine Fumarate 50	F 684	Results of the audits will be reported monthly at the quarterly quality assurance committee meeting. And correction of any identified deficiencies. Licensed staff will be re-educated by DON/ADON on how to obtain consults and coordination of family/resident requests for consultation to ensure appointments are made. The appointment log binder is located at the Skilled Nursing station. All clinical staff were re-educated on by ADON/DON regarding PICC care protocol to include: A) daily care, assessment, measurement of the external length of the peripherally-inserted central catheter (PICC-line) and arm circumference. B) to use the PICC-line protocol form for daily shift documentation. C) Protocol forms will be audited daily by DON/ADON for compliance.	 10/15/18 8/18/18

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F 684	Continued From page 26 mg one table in the evening for Major Depressive Disorder and Cymbalta 60 mg one capsule two times a day for Depression. A physician's order dated July 23, 2018, at 4:00 PM stipulated, "Psych consult for medication review when available" At the time of this review August 14, 2018, the psychologist has not reviewed the resident's medication. The record lacked evidence that the resident was seen by the psychologist as ordered by the attending physician. A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee #2 acknowledged the findings. 3. Facility staff failed to ensure that pulmonary appointment was completed. (Resident #13) Resident #13 admitted on June 6, 2018, with a diagnosis that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Acute and Chronic Respiratory Failure with Hypoxia and Shortness of Breath. On June 13, 2018, Physician's order directed, "Please schedule Appt [pulmonary appointment]" A review of the resident medical record showed pulmonary appointment scheduled for July 30, 2018, at 2:25 pm. However, the medical record showed the appointment was not completed.	F 684	4. All Audit tools for reviewing staff compliance to: following physician orders related to changing oxygen humidifier water, obtaining and arranging psych consults, obtaining and arranging outside physician appointments and correct management of a PICC line will be reviewed weekly x4 weeks at the risk meeting with resulting staff re-education and/or disciplinary actions for non-compliance. Results will also be presented monthly x3 to QAPI meeting, for review and/or further recommendations as indicated. 5. Compliance Date	 10/15/18

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F 684	Continued From page 27	F 684		

A face-to-face interview conducted on August 15, 2018, at 3:15 PM, Employee # 2 acknowledged the findings.

4. Failed to assess and measure the external length of the peripherally inserted central catheter (PICC) line and arm circumference for one (1) resident receiving antibiotic therapy. (Resident #143)

Resident #134 was admitted to the facility on July 27, 2018, with diagnoses which included Complete Traumatic Amputation at Knee Level, End Stage Renal Disease, and Infection of Obstetric Surgical Wound. Also, the resident was admitted to the facility with a Peripherally Inserted Central Catheter (PICC) line located in the right upper arm.

Physician's order dated July 28, 2018, directs:

"IV (intravenous) PICC line dressing changed Q (every) week. Document length of external catheter if indicated. Document arm circumference one time a day every Friday for care ..."

Ciprofloxacin in D5W (5% dextrose in water) solution 400 mg/200/ml use 200 ml intravenously every 12 hours for infection until 8/28/18."

Review of the clinical record lacked evidence that facility staff recorded the length of the external catheter and the residents arm circumference on admission to obtain a baseline and weekly thereafter.

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F 684	Continued From page 28 During a face-to-face interview on August 10, 2018, at approximately 1:00 PM, Employee #2 acknowledged the findings.			
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 by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by a remote bed controller cord that was frayed in one (1) of 17 resident rooms. Findings included... During observations throughout the facility on August 10, 2018, wires from a remote bed controller electrical cord were frayed and exposed in resident room #213, one (1) of 17 resident rooms surveyed. The uncovered, exposed electrical wires created a potential electrical shock hazard to residents, staff and visitors. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	F 689	1. The resident in room# 213 was not harmed. Remote bed controller cord that was frayed was repaired by plant operations director. 2. All remote bed controller cords in all residents' rooms were checked and corrected as needed by plant operations director. 3. Building services and clinical staff were re-educated by plant operations director on safety issues and requirements of functional remote bed controllers. Staff were also educated on the repair request process by plant operations director to ensure timely repairs are completed. 4. Remote bed controller cords will be added as an indicator for the building services department to be monitored during weekly scheduled surveillance rounds. Results of the audits will be reported to the administrator monthly and at the quarterly Quality Assurance Committee meeting for review and recommendations if indicated. 5. Compliance date	8/30/18 8/18/18 8/30/18 8/30/18 10/15/18
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812 SS=E	Continued From page 29 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to prepare, distribute and serve foods under sanitary conditions as evidenced by cooked foods that were stored beyond their expiration date in the walk-in refrigerator or the reach-in refrigerator, cooked and/or ready-to-eat foods that were not labeled or dated in the walk-in refrigerator, a scoop that was improperly stored inside a flour bin, one (1) of one (1) soiled can opener, three (3) of three (3) missing knobs from the steam table on the second floor, two (2) of three (3) broken garbage disposals, missing slats from the walk-in freezer air curtain, raw foods that were inappropriately thawed in the walk-in refrigerator and improper monitoring of food temperature on the steam table.	F 812	1. All cooked foods that was stored beyond the expiration date in the walk-in refrigerator or the reach in refrigerator was discarded immediately after being identified during the survey. Cooked and or ready to eat foods that were not labeled or dated in the walk in refrigerator were all discarded immediately after being identified during the survey. A scoop that was improperly stored inside a floor bin was removed immediately after being identified during the survey. One solid can opener was removed immediately after being identified during the survey. Three missing knobs from the steamer table on the second floor has been replaced. The broken garbage disposals has been replaced with new ones. Missing slats from the walk-in freezer air curtain has been replaced. Raw foods that were inappropriately thawed in the walk-in refrigerator has been thrown away immediately after being identified during the survey. The improper food monitoring of food temperature on the steam table has been corrected. A new dietary manager has been hired who is in charge and present at the food establishment during all hours of operation. 2. A review was conducted by plant operations director and Dining room manager no other component of the steamer was impacted by this practice. A review of the resident meal and holding temperatures and other all other identified issues was conducted by Dining room manager and no other issues were identified or impacted by this practice.	8/23/18

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F 812	Continued From page 30 The facility also failed to ensure that a PERSON IN CHARGE is present at the food establishment during all hours of operation. Findings included... 1. During observations and record review on August 7, 2018, at approximately 9:30 AM various cooked food items were stored beyond their 'used by' date: A quarter pan of collard greens as of August 6, 2018 A pan of meatballs as of August 1, 2018 A pan of tuna salad as of August 2, 2018 A pan of egg salad as of July 30, 2018. 2. Food items were not labeled or dated in the walk-in refrigerator: A pan of cooked sweet peppers A pan of turkey bacon An open pack of chicken breast Ham covered in plastic wrap A pan of slice sausage. 3. A scoop was stored on top of the flour in one (1) of one (1) flour bin. 4. Metal shavings were observed on one (1) of one (1) commercial manual can opener. 5. Three (3) of three (3) knobs from the three-pan open well steam table were missing. 6. Two (2) of three (3) garbage disposals in the main kitchen were not functioning.	F 812	A new Director of dining services is actively reviewing, developing and implementing dining training to address, expiration dates, how and when to discard items, place a work order and maintain safety and sanitary condition of the kitchen 3.A meeting with the ED, NHA and kitchen leadership was conducted to discuss identified issues. The dietary staff were re-educated dining room manager on appropriate and required holding temperature. The dietary staff and nursing staff were reeducated by dining room manager and DON regarding meal service and tray delivery. Dietary staff will be in-serviced and trained by Dining room manger on proper storage, dating and labeling of food items. This training will also address expiration dates, how and when to discard these items, and on how to place a work order. 4. A review of meal services will be conducted monthly. The leadership team is conducting weekly documented visual inspections to ensure safety and sanitation. The kitchen manager/designee will review that the temperature holding forms are completed daily and will notify Dining room Director if consistent unacceptable temperatures are recorded	8/30/18 10/15/18

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	095021	A. BUILDING ____ B. WING ____	08/15/2018

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F 812	Continued From page 31 7. Two (2) slats were missing from the air curtain in the walk-in refrigerator. 8. Raw food such as chicken was stored for thawing on the second shelf of the walk-in refrigerator above a container of carrot salad and a container of three-bean salad. 9. Staff failed to monitor the holding temperature for one (1) food item on the steam table on August 9, 2018 at approximately 12:30 PM. During a face-to-face interview on August 7, 2018, at approximately 10:30 AM and on August 9, 2018, at approximately 10:30 AM, Employee #8 and/or Employee #9 acknowledged the findings. Facility failed to adhere to the U.S. Food and Drug Administration (FDA) 2013 Food Code Chapter 2, Subpart 2-101. Food Code 2013 Recommendations of the United States Public Health Service Food and Drug Administration 2-101.11 Assignment. (A) Except as specified in (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation. (B) In a FOOD ESTABLISHMENT with two or more separately PERMITTED departments that	F 812	The results of all audits related to holding temperatures, food storage and disposal, and repair of broken equipment will be presented at the QAPI quarterly committee meeting for review and/or further recommendations as indicated. 5. Compliance date 1. No specific resident identified. The Dining leadership team: Director of Dining services, Dining Room Manager and Executive Chef currently do have their server certification along with the required DOH food safety manager's examination and certification. 2. The new Director of Dining services hired on 8/1/18 is actively reviewing, developing, and implementing dining leadership support schedule that will ensure full coverage at all limes within the Dining Department. 3. The Food Services Director/designee will conduct monthly environmental rounds, record audits, monitor staff daily to ensure compliance and food delivery as ordered and required, and document findings. Performance will be reported to quarterly QAPI meeting for review and/or further recommendations. 4. Compliance date	10/15/18 10/15/18

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F 812	Continued From page 32 are the legal responsibility of the same PERMIT HOLDER and that are located on the same PREMISES, the PERMIT HOLDER may, during specific time periods when food is not being prepared, packaged, or served, designate a single PERSON IN CHARGE who is present on the PREMISES during all hours of operation, and who is responsible for each separately PERMITTED FOOD ESTABLISHMENT on the PREMISES. "Person in charge" means the individual present at a FOOD ESTABLISHMENT who is responsible for the operation at the time of inspection. During observations on August 7, 2018, at approximately 10:00 AM, a PERSON IN CHARGE was not present at the facility. During a face-to-face interview on August 7, 2018, at approximately 10:30 AM, Employee #8 acknowledged the findings.	F 812		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865	1. No specific residents were identified. 2. All resident's care programs are under continuous review and updates geared not only to improve resident care but to prevent deficient practice from occurring and correcting then if and when they happen.	

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F 865	Continued From page 33 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an effective, comprehensive, data-driven quality assurance performance improvement (QAPI) program as evidenced by: the failure to present the State Agency with a QAPI plan documenting evidence of an ongoing program to addresses all systems of care and full range of services provided to include contracted services. The failed practice has the potential to affect all residents who reside in the facility. The facility census was 24. Findings included... During interview on August 14, 2018 at approximately 3:30 PM, Employees #1, #2, #4 and #7 stated there was not a quality assessment for dietary services from September 2017, to June 2018. In June 2018, dietary services did an audit. The manager identified the following focus areas: diet orders with labels, diet texture, temperature sheet, sanitization, and dietary staff training. Through interview, it was determined that facility staff did not re- evaluate the corrective measures implemented to determine if performance goals were achieved. Employees #1, 2, and 4 made the following	F 865	3. The new administrator hired on August 24th, 2018 is actively reviewing, developing and implementing an effective, comprehensive data-driven quality assurance performance improvement (QAPI) program. The facility is re-establishing a formal QAPI program to collect and analyze data relative to resident quality care, to address all systems of care and full range of services provided to include contracted services. 4. Any deficient practice found in the facility will be reported to the administrator daily at the stand-up meeting. The QAPI committee meeting will occur monthly with the facility team and at a minimum quarterly including the Medical Director. Formal minutes of each meeting will be maintained including areas reviewed and improvement projects initiated as a result of problems identified. The (NHA) will be the keeper of this QAPI Committee material. 5. Completion date	10/15/18

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F 865	Continued From page 34 comments for their respective area(s): Weight loss is reviewed at the meeting. However, food preferences are not discussed. The number of complaints is reviewed. However, grievances are not reviewed. The disrepair of the laundry room had not been discussed at the quality meeting or infection control. During the face-to-face interview on August 15, 2018, Employees #1, #2 and #4 acknowledged the facility failed to implement a quality assurance and performance improvement program.	F 865	1. The Laundry room was cleaned immediately after being identified during the survey. The ceiling tile and the wall damage has been repaired and ceiling tile has been replaced. The staff will be in-serviced on the importance of adhering to infection prevention control program and policy. To include system for prevention, identifying, reporting, investigating and controlling infection and communicable diseases for all Residents, staff, volunteers, visitors and other individual providing services under a contractual agreement.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	2. Environmental rounds, preventive maintenance service checks will be conducted weekly to ensure timely identification of any issues. 3. Plant operations will be notified when deficiencies are found and corrective actions will be taken. All housekeeping services staff had been reeducated by Housekeeping Director for the need to have all linens covered in accordance with infection control standard practice. The laundry room will be inspected daily by Housekeeping Director to ensure cleanliness and all linens are covered as required.	8/23/18 8/23/18

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F 880	Continued From page 35 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	4. The Director of Housekeeping will make rounds daily on all resident laundry and laundry rooms to ensure that a sanitary, orderly and all linens are covered at all times. Documentation will be completed and results monitored during weekly scheduled surveillance rounds. Results of the audits will be reports to the Administrator monthly and at the quarterly QAPI Committee Meeting for review and/or further recommendations. 5. Compliance date	10/15/18

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F 880	Continued From page 36 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, the facility staff failed to ensure that resident laundry was processed in an environment free from dust. The facility census was 24. Findings include... During tour on August 10, 2018, at approximately 12:50 PM, linen was observed uncovered on the folding table to include pads and sheets. Ceiling tiles were missing and wall damage was noted in the laundry room. During a face to face interview on August 10, 2018, 4:51 PM, Employee #3 stated that the laundry room missing ceiling tiles and wall damage was due to the three- compartment sink flood in April of 2018. Employee #3 stated the laundry room has been this way since the incident in April 2018. When queried about clean-up process following the flood, Employee #3 stated that it was clean up by an outside company. During a face to face interview on August 14, 2018, Employee #1 and 2 stated that they we were not involved in the incident with the laundry. In addition, water damage to the walls and ceiling tiles in the laundry was not included as a part of the infection control process. The failure to ensure ceiling tile were in place and	F 880		

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F 880	Continued From page 37 wall damage was repaired exposed the uncovered linen to potential dust contamination. Employee #1 acknowledged the findings.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain essential equipment in safe operating condition as evidenced by a remote bed controller cord that was frayed in one (1) of 17 resident's rooms. Findings included... During observations throughout the facility on August 10, 2018, wires from a remote bed controller electrical cord were frayed and exposed in resident room #213, one (1) of 17 resident rooms surveyed. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	F 908	1. The resident in room# 213 was not harmed. Remote bed controller cord that was frayed was repaired by plant operations director. 2. All remote bed controller cords in all residents' rooms were checked and corrected as needed by plant operations director. 3. Building services and clinical staff were re-educated by plant operations director on safety issues and requirements of functional remote bed controllers. Staff were also educated on the repair request process by plant operations director to ensure timely repairs are completed. 4. Remote bed controller cords will be added as an indicator for the building services department to be monitored during weekly scheduled surveillance rounds. Results of the audits will be reported to the administrator monthly and at the quarterly Quality Assurance Committee meeting for review and recommendations if indicated. 5. Compliance date	10/15/18
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:			

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F 921	Continued From page 38 Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced a broken entrance door in one (1) of 17 resident rooms, a warped carpet in one (1) of 17 resident rooms, and a damaged wall in one (1) of 17 resident rooms. Findings included... During an environmental tour of the facility on August 10, 2018, between 9:30 AM and 11:00 AM, the following were observed: 1. The closet door to resident room #202 was hanging off its hinges, one (1) of 17 resident room surveyed. 2. The carpet in resident room #214 was buckled and frayed and there was a hole in the wall, one (1) of 17 resident's rooms. 3. Ceiling tiles were missing above laundry cart and wall damage in laundry room. During a face-to-face interview on August 10, 2018, Employee #3 acknowledged these findings at the time of observation.	F 921	1. No resident was harmed by this deficient practice. Room #202, the broken closet door noted at the time of the survey was repaired. Room #214 the warped carpet in the resident's room at the time of the survey was replaced. A damaged wall in room #214 noted at the time of the survey was repaired. 2. All closet doors, carpet and walls were inspected by Plant operations Director and corrections were made as required. Laundry room was cleaned. The ceiling tile and the wall damage has been repaired and ceiling tile has been replaced. 3. All environmental services staff have been re-educated by Director of Environmental Services on the repair request process to ensure timely repairs. Make weekly rounds and re-educating on how to place a work order. 4. Residents' room observation audit will be completed by Environmental Services on weekly basis and results of the audits will be reported to the Administrator and presented by the Director of Environmental Services at the quarterly Quality Assurance Committee meeting for review and/or further recommendations as indicated. 5. Compliance date	8/30/18 8/30/18 10/15/18