UniqueResidential
CARE CENTER
A VMT Managed Facility

We Stick Our Neck Out for Quality

May 6, 2018

Veronica Longstreth
Program Manager
Health Care Facilities Division
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

Dear Ms. Longstreth,

Enclosed is the Plan of Correction for our Recertification and Annual Licensure surveys that was completed on April 6, 2018 at Unique Residential Care Center.

The facility continues to be dedicated and committed to quality care. If additional information is needed, please do not hesitate to contact me at (202) 535-2011.

Sincerely,

Regina Kim

Regina Kim, LNHA, MSG
Administrator

CC: Tonoah Hampton, MSN, RN
Supervisory Nurse Consultant

Direct: 202.535.2116 / **Main:** 202.535.1100 / **Fax:** 202.842.1366
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING _____ B. WING _____	04/06/2018

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UNIQUE RESIDENTIAL CARE CENTER	901 FIRST STREET NW WASHINGTON, DC 20001

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F 000	INITIAL COMMENTS An unannounced recertification survey was conducted at Unique Residential Care Center from April 2, 2018, through April 6, 2018. Survey activities consisted of a review of 43 residents' clinical records. The following deficiencies are based on observation, record review, and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long-Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CT- Computerized Tomography 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 EMS - Emergency Medical Services (911) G-tube Gastrostomy tube	F 000	Unique Residential Care Center make its best efforts to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute and admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the statement of deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State Laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Regina Tim	Administrator	5/6/2018

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 HSC Health Service Center HVAC - Heating ventilation/Air conditioning IAC- Internal Auditory Canal 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 MRI- Magentic Resonance Imaging Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy @- at	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		

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F 584	Continued From page 2 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; §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.	F 584		

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F 584	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and staff confirmations, the facility failed to provide housekeeping and maintenance services necessary to maintain a comfortable interior as evidenced by soiled bathroom vents in five (5) of 53 resident rooms, two (2) of two (2) sofas and one (1) of two (2) sofa chairs that were stained in one (1) of eight (8) resident lounge and two (2) of eight (8) hoppers that did not flush when tested in two (2) of eight (8) soiled linen rooms. Findings included... Observations on April 3, 2018, between 9:50 AM and 12:30 PM and on April 4, 2018, between 9:35 AM and 10:35 AM showed: 1. Bathroom vents soiled with dust in five (5) of 53 resident rooms. 2. Two (2) of two (2) sofas and one (1) of two (2) sofa chairs located on 4 south soiled in several areas. 3. Two (2) of eight (8) hoppers, one (1) located on 4 North and one (1) on 2 North failed to flush when tested. The observations made, in the presence of Employee #10, were acknowledged.	F 584	1. On 4/4/2018 the bathroom vents were cleaned in the 5-resident rooms. 2. The two sofas and 1 sofa chair on 4-South was removed and new sofas will be replaced once the new furniture arrives. 3. The two hoppers located on 4-North and 1 hopper on 2-North has been repaired. As part of maintenance schedule done on a weekly basis the hoppers will be checked on the maintenance check-list. An audit was done on 4/4/ 2018 to examine any other occurances with soiled sofas, soiled vents and hoppers and no other occurance were found. On a daily basis the vents, sofas and hoppers will be checked as part of the daily maintenance check-list audits. 4.Facilities Director will report findings at the QA meetings monthly for the next 3 months to monitor process towards improvement.	4/4/18 5/19/18 5/19/18 5/19/18
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		

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F 656	Continued From page 4 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		

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F 656	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident interview for one (1) of 43 sampled residents, facility staff failed to initiate a care plan with goals and approaches for one (1) resident who refused to wear his upper and lower dentures. Resident #61. Findings included... Facility staff failed to initiate a care plan with goals and approaches for one (1) resident refusal to wear upper and lower dentures. During an interview with Resident #61 conducted on April 4, 2018, at approximately 12:50 PM, when asked about dental the resident as he pointed to his upper and lower denture on the side table next to the television and stated, "I would like to wear my dentures sometimes." The clean upper and lower dentures were observed in a clear plastic bag on the top of the resident's bedside table. A review of the "Dental Consultation progress notes" revealed documentation that Resident #61 was last seen by the dentist on September 15, 2017. The dentist documented concerns that resident was not wearing his dentures. On April 4, 2018, at approximately 1:10 PM after resident had lunch the Certified Nursing Assistant (CNA), picking up the lunch trays was observed asking the resident, "Mr. (resident name) do you want to wear your dentures. The resident responded no, not now."	F 656	1. Resident# 61 care plan for refusal to wear upper and lower dentures was initiated with approaches on 4/4/2018. 2. Audits of residents with history of refusal of wearing dentures were reviewed to identify other residents that require updated care plans for refusal of wearing dentures. Follow up will be completed to ensure all residents refusal care plans are updated. 3. Nurse Managers were re-educated on 4/13/18 on the policy and procedures on care plan update. Nurse Managers or designee will conduct monthly audits of residents who refuse wearing their dentures to ensure care plans are updated with new approaches. 4. Audits of residents' care plans who refuse to wear their dentures will be conducted by Clinical Nurse Managers or designee. The result of the audit will be reported monthly to the QA committee for the next 3 months to monitor process towards improvement.	4/4/18 5/19/18 5/19/18 5/19/18

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F 656	Continued From page 6 A face-to-face interview conducted with Employee#7 on April 4, 2018, at approximately 1:00 PM regarding the aforementioned finding. The Employee responded, "The staff offers the resident his dentures to wear but he refuses them." The medical record lacked evidence that staff initiated a care plan with goals and approaches to address the resident's refusal to wear his dentures. Employee 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 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	F 657		

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F 657	Continued From page 7 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 43 sampled residents, the facility failed to update the care plan to include goals and approaches to address one (1) resident pulling his gastrostomy tube from the insertion site. Resident #31. Findings included... Resident #31 was admitted to the facility December 29, 2017 with diagnoses to include Adult Failure to Thrive and Dysphagia. The resident was coded as having a feeding tube under Section K0510 (Nutritional Approaches) on the admission MDS completed on January 5, 2018. The Physician's Order dated January 8, 2018 directed Jevity 1.5 65 ml/hr (milliliters per hour) via pump for 18 hours per day or until total nutrient has been delivered. A review of the nursing notes revealed the following: April 2, 2018 at 12:04 AM "Resident came back at 9:18 PM with family member/brother [name] in stable condition. His brother reported that resident pulled out the g-tube (gastrostomy tube)	F 657	1. Resident # 31 was reassessed for pain and trauma to gastrostomy tube site on 4/5/18. Resident #31 suffered no negative outcome. Care plan for behavior of pulling gastrostomy tube (G-Tube) was reviewed and updated with approaches. 2. Audits of residents with new diagnosis of G-Tube and behavior of pulling G-Tube will be reviewed to identify other residents that require updated care plans. Follow up will be completed as indicated. 3. On 4/16/18 the Nurse Managers were re-educated on the policy and procedures on care plan update and education will be on-going for all nurse managers and charge nurses. Nurse Manager or designee will conduct weekly audits/observation of residents requiring enteral feeding via G-Tube for function and placement to ensure care plans are initiated and or updated with new approaches. 4. Audits of residents with G-Tubes will be conducted monthly by Nurse Managers. The result of the audit will be reported monthly to the QA committee for the next 3 months to monitor process towards improvement.	4/5/18 5/19/18 5/19/18 5/19/18

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F 657	Continued From page 8 and brought him back immediately, on assessment there was no bleeding or any drainage noted. Tube replaced per the PRN (as needed) replacement order, g-tube placement confirmed. MD (medical doctor) and RP (responsible party) made aware...will continue to monitor..." April 2, 2018 at 6:01 PM "Resident alert and verbally responsive, observed to be anxious, attempted to pull on hi g-tube. Resident was advised about the injury and complications of pulling on his g-tube, teaching done and resident [acknowledged] understanding. RP [mother] made aware [and] stated she visited with resident on 4/1/18 and saw resident pulling on his g-tube. Ativan 0.5 mg (milligrams) via g-tube given at 9:00 AM for anxiety was effective ..." April 4, 2018 at 6:11 PM ..."several attempts to pull on his g-tube, Ativan 0.5 mg given for anxiety was effective" March 19, 2018 at 9:30 PM "... g-tube was noted dislodged, he verbalized, 'I didn't touch it, and I don't need it..." A review of the resident's care plan for feeding tube lacked evidence that facility revised the plan with new goals and approaches to address the resident pulling his gastrostomy tube from the insertion site (stomach). Employee #16 acknowledged the finding during a face-to-face interview on April 6, 2018 at 1:06 PM.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

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F 658	Continued From page 9 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, during Medication Pass Observation, the facility staff failed to inform one (1) of 43 sampled resident about the purpose of his medications before administering them, and failed to document orthostatic blood pressures for one (1) of 43 sampled residents in accordance with accepted professional standards of clinical practice for a resident who fell. Residents' #4, and 7. Findings included... 1. Facility staff failed to inform Resident #4 about the purpose of his medications before administering them. Resident #4 was admitted to the facility on January 17, 2018, with diagnoses, which included Neuropathy, Potassium, Depression, Seizure, Muscle Spasm, Dementia, Hypothyroidism, Benign Prostatic Hyperplasia, Chronic Obstructive Disease, Osteoporosis, Hypertension, and Dry Eyes. During medication administration observation on April 4, 2018, at 9:40 AM, Employee #8 visited Resident #4 to perform morning medication	F 658	1. Resident # 4 was reassessed on 4/4/18, and resident #4 did not suffered no negative outcome. 2. Charge nurse was educated on 4/4/18 on the policy and procedure of medication administration and communicating purpose of medications prior to administering. No other residents were affected. 3. Licensed nurses were re-educated on 4/9/18 on policy and procedures regarding communicating purpose of medication prior to administering. Clinical Nurse Manager or designee will conduct weekly observations of Medication Pass and education will be on-going. 4. Audits of Medication Pass will be conducted monthly by Nurse Manager or designee. The result of the audit will be reported monthly to the QA committee for the next 3 months to monitor process towards improvement.	4/4/18 4/4/18 5/19/18 5/19/18

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F 658	Continued From page 10 administration. The resident was in his room sitting in his wheelchair. Employee #8 identified the resident and stated, "I brought your medication (Resident Name)." The employee administered the following medications: Gabapentin capsule 300 milligram (mg) for Neuropathy Intelence tablet for Antiviral Isentress tablet for Antiviral Klor -con powder packet 20meq mix in water for a Potassium supplement Levetiracetam solution 7.5ml for seizures Aspirin chew tab 81 mg for Cardiovascular Prophylaxis Baclofen tablet 10 mg for Muscle Spasm Furosemide tablet 20 mg for Hypertension Losartan tablet 100 mg for Hypertension Norvir tablet 100 mg for Antiviral Oyster CAL+D tablet 500 mg for Osteoporosis Prezista tablet 60 mg for Antiviral Rivastigmine capsule 4.5 mg for Dementia Sertraline tablet 50 mg for Depression Bactrim DS tablet 800/160mg for Antiviral Prophylaxis Tamsulosin capsule 0.4mg for Benign Prostatic Hyperplasia Spiriva Hand Inhaler 1puff for Chronic Obstructive Pulmonary Disease. Artificial Tears Solution 1drop in each eye for dry eyes The above-cited medications were given to the resident without being properly informed of the medications being administered. A face-to-face interview conducted with Employee	F 658		

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F 658	Continued From page 11 #8 on April 4, 2018, at approximately 10:00 AM to discuss properly notifying the resident of the medications being administered before administration. Employee #8 acknowledged the findings. 2. Facility staff failed to record orthostatic blood pressure in accordance with standards of clinical practice for a resident who fell. On April 4, 2018, at approximately 11:00 AM, a medical record review showed a Resident Face Sheet with diagnoses that include: Unspecified Dementia with Behavioral Disturbance (Admission), Unspecified Osteoarthritis, Hyperlipidemia, and Vitamin D Deficiency. A nurse's note dated March 20, 2018 showed Resident #7 experienced a sudden loss of balance while walking in the hallway with staff and sat on buttocks on the floor. There was no visible injury and the physician was notified. An Interim Order form dated March 20, 2018 showed a doctor's verbal telephone order to perform "Orthostatic BP (blood pressure)". Orthostatic blood pressure: includes measuring the blood pressure and pulse in the lying, standing, and sitting (if the patient is unable to stand) position. Further review of the medical record showed a Treatment Administration Record (TAR) with dated March 20, 2018, which reads "Orthostatic BP S/P (status-post) sitting on floor." In the allotted space on the form under the date of March 20, 2018, a blood pressure was recorded	F 658	1. Resident #7 was reassessed on 4/4/18 and resident #7 did not suffer any negative outcome. 2. Nurse Manager/Designee conducted audits to identify other residents who have a physician order for orthostatic blood pressure to be performed to ensure no other residents were affected. 3. Clinical Nurse Manager/ designee will conduct weekly physician orders and ensure the treatment administration record (TAR) for orthostatic blood pressure is reflected appropriately. Licensed nurses have been re-educated on policy and procedure following physician orders and completing orthostatic BP. 4. Director of Nursing / Designee will conduct monthly audit to validate physician orders for orthostatic blood pressure are conducted and documented on the TAR. The result of the audit will be reported monthly to the QA committee for the next 3 months to monitor process towards improvement.	4/4/18 5/19/18 5/19/18 5/19/18

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F 658	Continued From page 12 as 112/66 (position unknown). There was no evidence to support the blood pressure was taken in all required positions for orthostatic blood pressure assessment. Also, there was no evidence the pulse was assessed. At the time of the medical record review, Employee#15 acknowledged the finding.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		

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F 660	Continued From page 13 (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge	F 660		

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F 660	Continued From page 14 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview for one (1) of 43 sampled residents, facility staff failed to update the care plan to address the needs and goals of one (1) resident whose plan is to be discharged from the facility. Resident #30. Findings included... Resident #30 was admitted to the facility December 29, 2017 with diagnoses to Multiple Sclerosis (MS). During a face-to-face interview with Resident #30 on April 3, 2018 at 10:41 she stated, "I wish to go home. I can live on my own with help. I have to get out of here. I spoke with a member of the Multiple Sclerosis Society to see if they can help me with housing." A review of the progress notes revealed the following: March 2, 2018 at 1:07 PM, " Social worker telephoned [Name], Community Transition Specialist to get information on available housing. Wait list for housing has closed. She will contact [the] Social Worker when the next housing list is	F 660	1. Review of resident #30 care plan was reassesed, and resident #30 suffered no negative outcome. Resident discharge care plan was updated on 4/30/2018. 2. Social Services Director conducted an audit of resident care plans who have goals of discharging from the facility to ensure care plans have been initiated and updated. 3. Social Services was in-serviced on policy and procedure on discharge planning to include of initiating and updating care plans of residents whose plans to discharge from the facility. 4. The Social Service Director/designee will monitor and conduct monthly audits on discharge planning care plans. The findings will be reported at the QA meetings monthly for the next 3 months to monitor process towards improvement.	4/30/18 5/19/18 5/19/18 5/19/18

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F 660	Continued From page 15 available. " March 21, 2018 at 8:58 AM, "Social Worker was contacted by [Name], [MS organization]...Resident reached out to [Name] for assistance with housing. She will contact the Case Manager, [MS organization] to see if someone can help out and get back with Social Worker. Based on resident's income, she can only afford low income housing". A review of the Resident's record revealed a care plan dated January 11, 2018, and titled, "Resident is not a candidate for discharge at this time." There was no evidence that facility staff updated the care plan to reflect the resident's current discharge needs and goals. Employee #14 acknowledged the finding during a face-to-face interview on April 6, 2018, at 11:50 AM.	F 660		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 685		

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F 685	Continued From page 16 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 43 sampled residents facility staff failed to ensure received a hearing aid evaluation. Resident# 81. Findings included... Facility staff failed to show evidence Resident# 81 received a hearing aid evaluation for a diagnosis of Asymmetric Sensorineural Hearing Loss. A review of Resident# 81 Admission Record showed diagnoses Hypertension, essential, Post Traumatic Seizures, Hemorrhage, subdural, Anemia Iron Deficiency. On April, 5, 2018 at approximately 10:00 AM a medical record review showed an Ear Nose and Throat (ENT) Report of Consultation dated June 20, 2017, for ENT follow-up appointment. In the section marked Findings "clear ears bilaterally asymmetric hearing loss, Diagnosis: Asymmetric Sensorineural Hearing Loss and under section Recommendations: 1. CT (computerized tomography) of the IAC (Internal Auditory Canal) with contrast 2. Hearing Aid Evaluation 3. Clearance Pending CT scan On April 5, 2018 at approximately 10:30 AM a review of the Quarterly Minimum Data Set (MDS) dated January 20, 2018, Section B- Hearing, Speech and Vision B0200 [Hearing] ability to hear (with hearing aid or hearing devices if normally used) the allocated space coded "2" which indicate moderate difficulty-speaker has to	F 685	1. Resident #81 was reassessed on 4/6/18 and the primary physician was made aware. Resident #81 suffered no negative outcome. A new order for Ear, Nose, Throat (ENT) consultation was obtained on 4/6/2018. 2. Nurse Manager/designee conducted an audit of residents diagnosed with hearing deficit and or change in communication was reviewed to identify other residents needing hearing aid evaluation. No other residents found to be affected. 3. Licensed nurses were in-serviced on policy and procedure of physician notification of consult recommendations. Clinical Nurse Manager/designee will conduct monthly audits on resident consultations and recommendations. 4. The Clinical Nurse Manager/designee will conduct monthly audit of residents returning from ENT consultation. The findings will be reported at the QA meetings monthly for the next 3 months to monitor process towards improvement.	4/6/18 5/19/18 5/19/18 5/19/18

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F 685	Continued From page 17 increase volume and speak distinctly. Section B0300 [Hearing Aid], Hearing aid or other hearing appliances used the allocated space has a "0" (zero) which indicate no hearing aid or hearing appliances used. During an interview with Employee# 12, Clinical Nurse Manager stated "if we receive a recommendation on the consultation form the nurse informs the doctor so that it gets carried out. In this case I only see the resident was scheduled for an appointment. I am not sure if she went because the hearing aid evaluation was not done, I will need to follow up on this." A review of the medical record failed to show documented evidence Resident# 81 received a recommended hearing aid evaluation for Asymmetrical Sensorineural Hearing Loss or that the physician was notified hearing aid evaluation was not done as recommended. Employee# 12 acknowledged the finding.	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		

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F 688	Continued From page 18 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview of one (1) of 43 sampled residents, the facility staff failed to apply a splint to a resident with limited range of motion (Resident #119). Findings included... Resident #119 was admitted with diagnoses to include Cerebrovascular Accident, Hypertension, Contractures, and Muscle weakness. Resident # 119 was observed lying in bed without splint applied to right hand and elbow on the following dates and times; April 2, 2018, at 10:30 AM, April 3, 2018, at 2:00 PM, and April 5, 2018, at 12:30 PM. Review of the Minimum Data Set dated February 7, 2018, showed functional limitations in range of motion on one (1) side for both upper and lower extremities. Review of the medical record on April 5, 2018, at 3:30 PM showed a physician order dated March 19, 2018, for Occupational Therapy- "patient to wear splints on right hand and elbow on 7AM-3PM and 3 PM- 11 PM shifts".	F 688	1. Resident #119 was reassessed, and splint was applied on 4/5/2018. Resident #119 suffered no negative outcome. 2. Nurse Managers/ Designee conducted an audit of all residents with an order for splint. No other residents were effects. 3. Licensed nursing were in-serviced on policy and procedure on physician orders and splint usage for limited range of motion. 4. Clinical Nurse Manager/ designee will monitor and conduct weekly audits on physician orders for splint usage. The findings will be reported at the QA Meetings monthly for the next 3 months to monitor process towards improvement.	4/5/18 5/19/18 5/19/18 5/19/18

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F 688	Continued From page 19 According to the "Physician order dated March 23, 2018, D/C (discontinue) skilled OT (Occupational Therapy) services patient to be seen by restorative nursing for strengthening and orthotic management." There was no evidence the splint was being applied as ordered. During a face-to-face interview with Unit Manager Employee #4 on April 5, 2018, at 12:30 PM the findings were acknowledged and confirmed.	F 688	1. Immediate action was taken by conducting an in-service on 4/3/2018 with the dietary cook supervisors and cooks on maintaining the food temperature when meals are being delivered during service time. 2. Food service temperatures were increased from 165 degrees to 180 degrees to ensure proper food tempature is maintained for serving all the meals to the residents. 3. In addition, dietary supervisors were in-serviced on 4/4/2018 to monitor food service lines to ensure temperature guidelines are maintained during meal periods. Also, nursing staff were in-serviced on 4/4/2018 to monitor the dining areas to ensure meal trays are passed efficiently. 4. The food service director/ designee will conduct weekly audits by testing the food temperatures and conduct test tray audits to ensure the regulatory tempatures are maintained and all findings will be reported during monthly Quality Assurance meetings.	4/3/18 5/19/18 5/19/18 5/19/18
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff confirmation, the dietary services staff failed to maintain required hot foods temperatures as evidenced by food items such as steam broccoli and white rice that tested below135 degrees Fahrenheit (F) at the point of service. Findings included ... Observations on April 3, 2018, at approximately 1:35 PM showed hot foods items such as steam broccoli (128.4 degrees F) and white rice (132.8	F 800		

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F 800	Continued From page 20 degrees F) tested below the required hot holding temperature of 135 degrees F. The observations made, in the presence of Employee #9, were acknowledged.	F 800		