STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495019	A. BUILDING _____ B. WING _____	C 09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBINE REHABILITATION & HEALTHCARE CENTER	2729 KING ST ALEXANDRIA, VA 22302

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/25/18 through 09/27/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 307 certified bed facility was 256 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 8 closed record reviews.	E 000	Woodbine shares the state focus on the health, safety, and wellbeing of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented its plan of correction to demonstrate its continuing efforts to provide quality care to its residents. The deficiencies cited by the surveyor will be put into the Continuing Quality Improvement/Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard survey was conducted 09/25/18 through 09/27/18. Eight complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 307 certified bed facility was 256 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 8 closed record reviews.	F 000	RECEIVED OCT 19 2018 VDH/OLC	
F 550 SS=E	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	F 550	**Corrective Action:** The 3 residents who stated they didn't know the opportunity for voting preferences existed were given an apology. The apology was accepted by all three residents. Another copy of the resident handbook was issued to each of them with the page that highlights access to voting and information was given about the coming 2018 election(s) as noted by the City of Alexandria. 1 of 3 of those residents stated that they were not interested in voting in the upcoming election. This was documented in the resident's medical record.	10.10.18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna J. M. [illegible]
TITLE: Administrator
(X6) DATE: 10/18/2018

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 550	Continued From page 1 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 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 resident and staff interview and facility document review it was determined the facility staff failed to ensure facility residents' voting rights and privileges during the previous two election cycles. Findings:	F 550	**Identification:** To ensure that no other resident was affected, all residents will be re-issued a Resident Handbook and will be asked by the Therapeutic Recreation Department if they would like to vote in the upcoming election and if so; 1) will be offered assistance to register to vote, 2) will be offered assistance to obtain an absentee ballot, or 3) will be offered to help arrange transportation to their assigned polling station. This information will be recorded in the medical record. **Systemic Change:** Therapeutic Recreation Department will speak to each resident on admission and again at their quarterly care plan meeting to review any upcoming elections and to understand if that resident would like to vote. If so, the following will occur; 1) will be offered assistance to register to vote, 2) will be offered assistance to obtain an absentee ballot, or 3) will be offered to help arrange transportation to their assigned polling station. This information will be recorded in the medical record. A notice of any upcoming elections will be put in the resident newsletter that is given to each resident and posted on the electronic boards located on each nursing unit and in the main lobby. **Monitoring:** To ensure that residents are aware of their ability to vote, each quarter, the Therapeutic Recreation Director or designee will audit 20% of resident charts to determine if voting information was discussed and recorded in the medical chart. Any areas of non-compliance will be corrected immediately. A report of non-compliance will be sent quarterly to the CQI/QAPI committee for further discussion and recommendations.	10.15.18 10.14.18 11.8.2018

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F 550	Continued From page 2 The facility staff failed to ensure facility residents' voting rights and privileges during the previous two election cycles. This finding was documented during a group council meeting on 9/27/18 at 2:30 PM with ten alert and oriented members of the Resident Council. The council was asked if the facility staff helped them obtain absentee ballots or took them to the polls so they could vote during elections. The residents in the meeting had varying reports. Some obtained ballots or went out to vote on their own. Some preferred not to vote at all. Three residents (#170-admitted 5/7/17, #73-admitted 6/2/16, and #229-admitted 9/7/16) said they had not approached by any staff members with a choice of voting preferences and said they didn't know the opportunity existed. All three residents stated no one had come to sign them up to vote in any manner. These residents also said they would like to have absentee ballots to vote in the coming election, November 2018. On 9/26/18 the administrator, DON and AA (assistant administrator) were interviewed about the residents that missed the opportunity to exercise their right to vote while living in the facility. The administrator said everyone had been offered the opportunity to vote by either a member of the activities team or the social services team. The surveyor asked to see documentation from the latest election that absentee ballots were offered or made available to each individual resident. On 9/27/18 the administrator and AA brought documentation that absentee ballots had been	F 550		

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F 550	Continued From page 3 obtained for some of the resident during the fall elections of 2014, 2015 and 2016. No documentation was provided for the Gubernatorial election on November the th, 2017 or the Primary Election on June 12th 2018 (U.S. Senate and House of Representatives and Mayor and City Council of Alexandria, Va.) The administrator said the former activities director had resigned and the documentation was not available for those elections but she felt that everyone knew they had the right to vote. She had no explanation why three alert and oriented members of the Resident Council had come forward complaint they had not been notified of same. On 9/27/18 at 10:00 AM the current activities director was interviewed. She said she knew they spoke to some residents about the 2017 election and the June 2018 election but couldn't guarantee all the residents had been contacted and informed to the opportunity to obtain absentee ballots through the facility. She said she was not the activities director at that time and did not have documentation each resident was informed. On 9/27/18 at 10:30 AM the AA brought the surveyor a facility policy on resident rights. She said she couldn't understand how anyone could miss the news they had put on the activity calendar and other bulletins, but acknowledged at least three residents were left out of the process during the last two election cycles. The facility policy on resident's rights contained the following: "....Voting....Resident's rights are encouraged to exercise their right to vote.	F 550		

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F 550	Continued From page 4 Through the Social Work department, residents will be assisted with absentee ballots and voter registration....." The policy did not include a plan by which to implement this system--which was primarily the responsibility of the activities department, according to statements made by the facility administrator and AA. There was no additional information regarding voting privileges prior to the survey team exit.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583	**Corrective Action:** Immediate corrective action was taken by logging off CNA #1 from the kiosk by the unit manager. CNA # 1 received a 1:1 counseling for not logging off and leaving the protected health information visible and the resident was informed and an apology offered. The resident accepted the apology. **Identification** To ensure that no other resident's protected health information is at risk from the wall mounted kiosks, all kiosks on the unit where Resident #201 was residing were checked; no other kiosks were identified to have resident information exposed. The Unit Manger conducted an "on the spot" in-service to remind staff to log off kiosks when walking away in order to safeguard protected health information. The C.N.A.'s on the unit which Resident #201 resides were re-educated on HIPAA/resident information confidentiality; specifically, on using the "log off" button prior to walking away from the kiosk, to ensure privacy of protected health information. **Systemic Change** Nursing supervisors and management staff will be tasked with daily observation of kiosks to ensure that the staff is logging off prior to walking away. Any incidence of non-compliance will result in corrective action for the C.N.A. and offered an apology to the	9.26.2018 9.27.2018 9.30.2018 10.25.2018

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F 583	Continued From page 5 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure confidentiality of medical records for 1 of 38 residents in the survey sample, Resident #201. The findings included: The facility staff failed to ensure that a wall kiosk had been logged off; leaving Resident #201's protected health information visible for unauthorized persons. Resident #201 was a 96-year-old-female who was originally admitted to the facility on 3/30/13, with a readmission date of 9/3/18. Diagnoses included but were not limited to: hypertension, heart disease, type 2 diabetes mellitus, and hypothyroidism. The most recent MDS (minimum data set) assessment for Resident #201 was an annual assessment with an ARD (assessment reference date) of 8/24/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 201 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 201 was cognitively intact.	F 583	resident. Any incident of non-compliance will be reported to the Unit Manager. A written report of non-compliance will be submitted to the DON or his/her designee on a weekly basis which will include the action taken. **Monitoring** The DON or her/his designee will check kiosks on daily rounds for non-compliance. Any incidence of non-compliance will result in corrective action for the C.N.A. and an apology to the resident. Any incident of non-compliance will be reported to the Unit Manager. The DON or her/his designee will issue a report of non-compliance to the quarterly CQI/QAPI team for discussion and further recommendations.	11.9.2018

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F 583	Continued From page 6 On 9/26/18 at 12:10 pm, the surveyor observed a wall kiosk on 2 South that was unattended with Resident #201's photograph, room number, and medical diagnoses visible. On 9/26/18 at 12:12 pm, CNA # 1 (certified nursing assistant) returned to the wall kiosk. The surveyor asked CNA # 1 if she had been working on the kiosk. CNA # 1 replied, "Yes." The surveyor asked CNA # 1 if she would normally leave the wall kiosk unattended with resident health information exposed for everyone to see. CNA # 1 replied "No." On 9/26/18 at 6:00 pm, the administrator, assistant administrator, and director of nursing were made aware of the findings as stated above. On 9/27/18 at 12:23 pm, the director of nursing presented the surveyor with documentation that CNA # 1 had been in serviced on HIPAA (health insurance portability and accountability act) on 3/24/18. The facility "HIPAA/Confidentiality of Resident information form," contains documentation that included but is not limited to: ... "I agree to take special precautions to protect confidential and sensitive and protected health information by: 4. Storing confidential and/or sensitive information in a place physically secure from access by unauthorized persons." ... No further information regarding this issue was provided to the survey team prior to the exit conference on 9/27/18.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(l)(1)-(7)	F 584	Corrective Action: Immediate Corrective Action was taken as follows: The gloves that were found in the bed of resident #42 were	9.28.2018

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F 584	Continued From page 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; §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	F 584	immediately discarded by the C.N.A. The floor of room 219 was stripped and re-waxed. The privacy curtains in Room 219 were removed and fresh privacy curtains were installed. The bathroom of room 219 was cleaned and sanitized. The vent and wall surrounding of room 219 was cleaned and sanitized. The Sprinkler head in room 218 bathroom was dusted. The wall of bathroom in room 218 was scraped, re-plastered and re-painted where discoloration and peeling paint was found. **Identification:** In order to ensure that no other residents were affected, the following occurred in the rooms on the unit where room 219 is located: • The beds were assessed for soiled gloves; no other soiled gloves were found. • The floors and bathrooms were checked for cleanliness; no other floors or bathrooms were identified as being soiled. • The vents and the wall surrounding the Vent were inspected; no other stains were located. • All sprinkler heads on unit were inspected to ensure sprinkler head was free of dust or spider webs; no other dust or spider web were located. The walls were inspected for peeling paint and discoloration; no other area was found peeling or discolored. Privacy curtains were inspected. Any privacy curtain that appeared to be stained was taken down and replaced by a clean privacy curtain.	9.27.2018 9.26.2018 9.27.2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 584	Continued From page 8 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure a safe, clean and homelike environment for 1 Resident and in 2 Resident rooms on 2 South, Resident # 42 and room 219 and room 218. 1. The findings included: A pair of used gloves were observed in the bed with Resident #42. Resident #42 was a 60-year-old male who was originally admitted to the facility on 8/2/16 with a readmission date of 6/18/18. Diagnoses included but were not limited to: benign prostatic hyperplasia, diabetes mellitus, chronic kidney disease, and dysphagia. The clinical record for Resident # 42 was reviewed on 9/26/18 at 1:42 pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 8/25/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 42 had a BIMS (brief interview for mental status) score of 08 out of 15, which indicated that Resident # 42's cognitive status was moderately impaired. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 42 required extensive assistance of one person providing physical assistance for bed mobility, toilet use, and personal hygiene, and total assistance of 2 or	F 584	**Systemic Change** Nursing staff on the unit in which room 218 and 219 are located will receive an in-service on ensuring that all gloves are removed from the residents bed linens after care, timely removal of refuse/trash from resident rooms, removal of dirty linens, towels and washcloths from the room and notification regarding sanitation and maintenance concerns including but not limited to; Soiled privacy curtains, sticky floors, ceiling tiles discoloration, peeling paint, sprinkler heads free of dust/debris, and mildew. Housekeeping staff on the unit where rooms 219 and 218 are located will complete an in-service on how to properly clean and inspect a room which includes, but not limited to; privacy curtain inspection, floor cleaning, high dusting, and removal of debris. They will also receive an in-service on inspection / proper notification of maintenance areas included but not limited to; vent areas, sprinkler head free of dust/debris, ceiling tile discoloration, peeling paint and mildew. The maintenance staff will receive in-service on increased frequency of vent inspections when humidity levels are high for more than 3 days. The Unit Manager, The Director of Environmental Services and The Director of Engineering together will inspect 6 rooms on the unit on a weekly basis. If any area of non-compliance is noted, the issue will be corrected, and the staff will be subject to corrective action. A report of non-compliance will be submitted by the Director of Environmental Services to the Assistant Administrator weekly.	10.31.2018

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F 584	Continued From page 9 more persons providing physical assistance for bathing. On 9/26/18 at 9:36 am, the surveyor observed Resident # 42 in bed in room 219. The surveyor observed a pair of used disposable gloves lying on the sheet on the right side of the bed, near Resident # 42's legs. On 9/26/18 at 10:01 am, the surveyor entered room 219 to see CNA (certified nursing assistant) #1 repositioning Resident # 42. The surveyor asked CNA # 1 if she had seen the pair of used gloves that had been in bed with Resident # 42. CNA # 1 stated that the gloves had already been discarded. On 9/26/18 at 6:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 9/27/18. 2. The facility staff failed to ensure that room 219 was free of mildew and that the floor, privacy curtains, and Resident bathroom in room 219 were clean. On 9/26/18 at 9:43 am, the surveyor walked across the floor in room 219 and noted the floor to be sticky, the surveyor also observed a dark black and brown substance in between the floor tiles in the room. The surveyor also observed a vent in room 219 that had a moderate amount of a black substance on the vent and wall surrounding the vent. On 9/26/18 at 12:52 pm, 2 surveyors observed Room 219 along with the director of	F 584	**Monitoring** The Assistant Administrator or designee will inspect 20% of the rooms located on the unit where 218 and 219 are located each quarter. Any area of non-compliance will be immediately corrected and the staff responsible will be subject to corrective action. A report of non-compliance will be submitted to the CQI/QAPI Team for discussion and recommendations. RECEIVED OCT 19 2018 VDH/OLC	11.8.2018

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F 584	Continued From page 10 environmental services. The surveyors made the director of environmental services aware that the floor was sticky and made him aware of the observation of the black and brown substance in between the floor tiles in room 219. The director of environmental services in the presence of 2 surveyors scraped the areas in between the floor tiles with his pen. The director of environmental services confirmed that the floor had not been cleaned and stated that the floor would be stripped. The 2 surveyors along with the director of environmental services observed brown debris on 2 privacy curtains in room 219. The director of environmental services stated to the surveyors that he would have the privacy curtains taken down and cleaned. In the resident's bathroom in room 219, the surveyors along with the director of environmental services observed a brown substance on the wall and ceiling above the commode, a trash can overflowing with paper and used adult briefs, and a soiled washcloth with a brown substance was observed in the bathtub. On 9/26/18 at 1:27 pm, the surveyor observed the black substance on the vent and wall surrounding the vent with the maintenance manager. The surveyor observed water dripping from the vent at that time. The surveyor asked the maintenance manager what the black areas on the vent and wall surrounding the vent was. The maintenance manager stated, "Mildew." According to the facility "Environmental Services" policy, documentation included but was not limited to ... "7. Cleaning. All areas of the facility shall be cleaned daily and the director of environmental services shall develop and maintain daily cleaning schedules to assure that each area of the facility is maintained in a clean	F 584		

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F 584	Continued From page 11 safe, and comfortable manner. a. Housekeeping services shall be provided to residents on a daily basis to include routine cleaning of resident rooms. The charge nurse shall alert environmental services personnel of potential hazards and instruct them regarding proper precautions and protective clothing to be used, if any, in isolation rooms. Bathrooms including showers, commodes, etc. will also be cleaned daily. b. Daily cleaning shall include but not be limited to, emptying waste receptacles, servicing toilet paper holders, servicing and cleaning soap dispensers, servicing and cleaning towel dispensers, dusting window sills, ledges, etc., inspecting privacy curtains and laundering if needed, wash basins, commodes, etc., polishing fixtures, sweeping, mopping, and scrubbing floors. c. All floors shall be mopped/cleaned and polished/buffed daily in accordance with established procedures." ... On 9/26/18 at 6:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 9/27/18. 3. The facility staff failed to ensure that the Resident bathroom in room 218 was free from water damage and spider webs. On 9/26/18 at 1:00 pm, two surveyors observed discoloration and peeling paint on the wall above the commode, and spider webs on the sprinkler system in the ceiling in the bathroom that was for Resident use in room 218.	F 584		

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F 584	Continued From page 12 On 9/26/18 at 1:26 pm, the surveyor met with the maintenance manager and together they observed the discoloration and peeling paint on the wall above the commode and spider webs on the sprinkler system in the ceiling in the bathroom that was for Resident use in room 218. The maintenance manager told the surveyor that the areas above the commode were due to water damage and that the water damage above the commode and the spider webs in the ceiling would be corrected as soon as possible. According to the facility "Environmental Services" policy, documentation included but was not limited to ... "7. Cleaning. All areas of the facility shall be cleaned daily and the director of environmental services shall develop and maintain daily cleaning schedules to assure that each area of the facility is maintained in a clean safe, and comfortable manner. d. Housekeeping services shall be provided to residents on a daily basis to include routine cleaning of resident rooms. The charge nurse shall alert environmental services personnel of potential hazards and instruct them regarding proper precautions and protective clothing to be used, if any, in isolation rooms. Bathrooms including showers, commodes, etc. will also be cleaned daily. On 9/26/18 at 6:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 9/27/18.	F 584		
F 684	Quality of Care	F 684	Corrective Action: Resident #159's heels were floated immediately per	9.27.2018

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F 684 SS=D	Continued From page 13 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, clinical record review, and staff interview, the facility staff failed to follow physician's orders for 1 of 58 residents in the survey sample, Resident # 159. The findings included: 1. The facility staff failed to ensure that Resident # 159's heels were floated per physician's orders. Resident # 159 was a 44-year-year-old-female who was originally admitted to the facility on 6/30/17, with a readmission date of 8/18/17. Diagnoses included but were not limited to: anxiety disorder, traumatic hemorrhage of cerebrum, dysphagia, and hypertension. The clinical record for Resident #159 was reviewed on 9/26/18 at 2:52 pm. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 8/15/18. Section C of the MDS assesses cognitive patterns. In Section C1000, the facility staff documented that Resident # 159's cognitive status was severely impaired.	F 684	physician's order. The resident's heels were assessed by the Unit Manager and no new redness or skin issues were identified. The attending physician was notified and no new orders were received. The resident's representative was also notified. The nurse and the C.N.A. who were caring for Resident #159 at the time received counseling. The Unit Manager reviewed the care plan and treatment orders for resident #159 with the care team. **Identification** To ensure that no other resident was affected, residents that had orders to float heels, on the unit where resident # 159 resides, were checked for compliance by the Unit Manager. No areas of non-compliance were identified. **Systemic Change** Nursing Staff will be in-serviced on the importance of floating heels per the physician's order. Any resident with a physician order for floating heels will have the order added to resident profile in the Electronic Medical Record to ensure compliance. Unit manager where resident # 159 resides or designee will check for floating heels every shift. Any area of non-compliance will be corrected, the MD and the Resident Representative will be notified, and the staff will be subject to corrective action. The Unit Manager will submit a written report of non-compliance to the DON weekly. **Monitoring** The ADON or designee will inspect 20% of residents with orders for floating heels daily on the unit where resident #159 resides. A report of any non-compliance will be submitted Quarterly CQI/QAPI team for discussion and further recommendations.	9.27.2018 10.30.18 11.9.2018

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F 684	Continued From page 14 The current plan of care for Resident #159 was reviewed and revised on 9/16/18. The facility staff documented a problem area for Resident #159 as "Resident is at risk for pressure ulcer due to: Bedfast/impaired mobility, impaired cognition that limits her ability to verbalize needs, bladder and bowel incontinence." Interventions included but were not limited to: "Float heels at intervals while in bed q (every) shift." Resident # 159 has current orders that were initiated on 5/9/18 to "Float heels at intervals while in bed." On 9/26/18 at 8:03 am, the surveyor observed Resident # 159 lying in bed. The surveyor did not observe a pressure-relieving device in place to float Resident # 159's heels at that time. On 9/26/18 at 9:00 am, the surveyor observed Resident # 159 lying in bed. The surveyor did not observe a pressure-relieving device in place to float Resident # 159's heels at that time. On 9/26/18 at 2:52 pm, the surveyor observed Resident # 159 lying in bed. The surveyor did not observe a pressure-relieving device in place to float Resident # 159's heels at that time. On 9/26/18 at 4:15 pm, the surveyor reviewed the treatment administration history for Resident # 159. The facility staff documented that Resident # 159's heels were floated at intervals while in bed as ordered by the physician. On 9/27/18 at 9:33 am, the surveyor observed Resident # 159 lying in bed. The surveyor did not observe a pressure-relieving device in place to float Resident # 159's heels at that time.	F 684		

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F 684	Continued From page 15 On 9/27/18 at 10:15 am, the surveyor along with RN (registered nurse) # 2 unit manager observed Resident # 159 lying in bed without a pressure-relieving device in place to float Resident # 159's heels. The surveyor informed RN # 2 unit manager that Resident # 159 has current orders to float heels at intervals while in bed. RN # 2 stated to the surveyor that Resident # 159 would not keep the pressure-relieving device in place to float her heels. The surveyor informed RN # 2 that the facility staff had documented that Resident # 159's heels were floated at intervals while in bed, and on each observation that surveyor made on 9/26/18, Resident # 159's heels were not floating. RN # 2 unit manager voiced understanding. On 7/27/18 at 12:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 9/27/18.	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 by: Based on observation the facility staff failed to ensure an environment that remained free of	F 689	**Corrective Action:** The water on the floor was wiped up by Registered Nurse #1 on 9/26/18. LPN # 1 received 1:1 counseling regarding leaving a water spill on the floor without placing the proper identification. **Identification** To ensure that no other residents were at risk, the rooms and corridors that are on the same unit where resident #96 resides were inspected for water spills. There were no other areas identified. **Systemic Change** All staff on the unit where resident # 96 resides will be in-serviced on safety and ensuring that all water spills are either immediately cleaned up by the staff member, or proper identification is placed at the water spill to	9.26.2018 9.26.2018 10.30.2018

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F 689	Continued From page 16 accident hazards in 1 Resident room on 2 South. The findings included: The facility staff failed to clean up water that had been spilled creating an accident hazard. On 9/26/18 at 08:27 am, the surveyor was conducting an interview with Resident # 96 in his room. The surveyor observed LPN # 1 (licensed practical nurse) administering medications to Resident # 96. Resident # 96 spilled a cup of water on the floor. LPN # 1 and stated that she would wait for housekeeping to come to clean up the spilled water. LPN # 1 finished administering the medications to Resident # 96. LPN # 1 then observed the catheter bag for Resident # 96 was on the floor. LPN # 1 picked up the cup that the water was in and discarded it into the trash and picked the catheter bag up off the floor and secured it on the right side of Resident # 96's bed near the foot of the bed. LPN # 1 removed her gloves, discarded them, sanitized her hands, and exited the room without cleaning the spilled water. On 9/26/18 at 08:45 am, the surveyor observed that the spilled water had flowed over to the left side of Resident # 96's bed. At this time RN # 1 (registered nurse) who is the treatment nurse, entered Resident # 96's room and realized that water was on the floor. RN # 1 went into the hallway, retrieved a bath blanket, and cleaned up the water. On 9/26/18 at 6:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit	F 689	prevent accidents, until the proper cleaning can take place. Staff will be in-serviced on where items are located for cleaning up water spills and proper methods for identification/signage placed where there is a water spill until it can be cleaned to prevent accidents. **Monitoring** The unit manager or designee will check for water spills during daily rounds. Any water spill that is noted not cleaned up, or without proper identification will be rectified immediately. The staff members on the unit at the time the water spill is identified will be subject to corrective action. Any areas of non-compliance will be reported to the Director of Nursing in a weekly report. The DON or designee will submit a report of non-compliance quarterly to facility QAPI meeting for discussion and recommendations.	11.8.2018

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F 689	Continued From page 17 conference on 9/27/18.	F 689		
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 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.	F 690	**Corrective Action:** Immediate corrective action was taken by removing both catheter bags off the floor for residents #42 and # 96 and the assigned nurse for both residents #42 and # 96 received 1:1 counselling. The catheter for Resident #42 was changed to the correct size. The physician was notified and no new orders were given. The resident representative was notified. **Identification** In order to ensure that no other residents were affected, any resident that had an order for a Foley catheter on the Unit where resident's #42 and #96 reside were inspected for ensuring the correct size catheter per physician order and that the catheter bag was not on the floor; No areas of non-compliance were identified. The nurse that inserted the incorrect size catheter received corrective action. Licensed staff on the unit where resident #42 and #96 reside will be in-serviced about the importance of keeping catheter bags off the floor and the potential risk of infection. Nurses will be in-serviced on following physician order and utilizing the correct size catheter. **Systemic change** The Unit manager of the unit or designee will be tasked to observe all catheter bags on this unit every shift and submit a report of non-compliance to the DON daily. Nursing supervisors will visually observe all catheter bags on this unit daily and submit a report of non-compliance at end of the shift daily. Any areas of non-compliance will be corrected and the staff will be subject to corrective action. The Unit Manager or designee will inspect resident with indwelling catheters daily to ensure that correct size catheter, per physician order is in place. Any areas of non-compliance will be corrected, the nurse will be subject to corrective action, and a report of non-compliance will be submitted to the DON weekly.	9.26.2018 9.26.2018 10.25.2018 10.30.2018

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F 690	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide services to prevent urinary tract infections for 2 of 58 Residents in the survey sample, Resident #42 and Resident #96. The findings included: The facility staff failed to ensure that the urinary catheter bags for Resident #42 and Resident #96 were kept off the floor, and failed to ensure that Resident #42 had in the correct size catheter per physician's orders. 1. Resident #42 was a 60-year-old male who was originally admitted to the facility on 8/2/16 with a readmission date of 6/18/18. Diagnoses included but were not limited to: benign prostatic hyperplasia, diabetes mellitus, chronic kidney disease, and dysphagia. The clinical record for Resident # 42 was reviewed on 9/26/18 at 1:42 pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 6/25/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 42 had a BIMS (brief interview for mental status) score of 08 out of 15, which indicated that Resident # 42's cognitive status was moderately impaired. Section H assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 42 had an indwelling catheter. The current plan of care for Resident #42 was reviewed and revised on 9/10/18. The facility staff	F 690	**Monitoring** The ADON or his/her designee will visually observe Foley catheters 20% of the catheters on the unit where resident #42 and resident #96 resident, on daily rounds to ensure that no catheter bag is on the floor and that the correct size catheter is inserted per physician orders. A report of non-compliance will be submitted to the DON. Any areas of non-compliance will be corrected, the attending physician notified and the responsible representative notified. The nurse responsible will be subject to corrective action. The ADON or his/her designee will submit a Quarterly report of non-compliance to the CQI/QAPI team for discussion and recommendations.	11.8.2018

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F 690	Continued From page 19 documented a problem area for Resident # 42 as "Resident requires an indwelling urinary catheter due to : Neurogenic bladder." Interventions included but were not limited to. "Do not allow tubing or any part of the drainage system to touch the floor," and "Use urinary catheter as ordered." Resident # 42 had current orders that were initiated by the physician on 6/18/18 for "#20 FR (French) 30 cc (cubic centimeter) to straight drainage every shift. On 9/26/18 at 9:34 am, the surveyor observed a full urinary catheter bag for Resident #42 on the floor on the right side of the resident's bed. On 9/26/18 at 12:24 pm, RN # 1 (registered nurse) showed the surveyor Resident #42's Foley catheter after receiving Resident # 42's permission. The surveyor observed that Resident # 42 had a 22 Fr (French) catheter with 10 cc (cubic centimeter) bulb inserted into the bladder. On 9/27/18 at 10:05 am, the surveyor along with RN # 2 unit manager observed the Foley catheter for Resident # 42 after obtaining Resident # 42's permission. The surveyor along with the surveyor observed that Resident # 42 had a 22 Fr with 10 cc bulb inserted into the bladder. On 9/27/18 at 10:10 am, the surveyor along with RN # 2 unit manager reviewed the current orders for Resident # 42. The surveyor along with RN # 2 observed in the clinical record that Resident # 42 has current orders for a # 20 Fr Foley catheter with a 30 cc to straight drainage. RN # 2 unit manager agreed that Resident # 42 did not have the correct size physician ordered catheter inserted into the bladder.	F 690		

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F 690	Continued From page 20 On 9/27/18 at 12:05 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 9/27/18. 2. Resident #96 was a 73-year-old male who was admitted to the facility on 11/16/17. Diagnoses included but were not limited to: type 2 diabetes mellitus, benign prostatic hyperplasia, atrial fibrillation, and Parkinson's disease. The clinical record for Resident # 96 was reviewed on 9/25/18 at 3:37pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 7/27/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 96 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 96 was cognitively intact. Section H assesses bladder and bowel. In Section H0100, the facility staff documented that Resident # 96 had an indwelling catheter. The current plan of care for Resident #96 was reviewed and revised on 9/8/18. The facility staff documented a problem area for Resident # 96 as "Resident requires an indwelling urinary catheter due to: obstructive uropathy secondary to BPH (benign prostatic hyperplasia)." Interventions included but were not limited to "Do not allow tubing or any part of the drainage system to touch the floor." Resident # 96 has current orders that were initiated on 11/16/17 for "Indwelling urinary	F 690		

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F 690	Continued From page 21 catheter #16 FR (French) 10 cc (cubic centimeter) to straight drainage every shift." On 9/26/18 at 8:08 am, the surveyor observed Resident # 96's urinary catheter bag lying on the floor on the right side near the foot of the bed. On 9/26/18 at 6:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 9/27/18.	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**Corrective Action:** The attending physician for resident # 396 was notified for not administering Spiriva on 9.23.18 at 9 a.m.; no new orders were received. On 9.26.2018 the licensed nursing staff on the unit which resident #396 resides were reeducated on the contents in the Omni cell. The Licensed Nurse, who did not access the Omnicell for the Medication, received 1:1 correction action. The attending physician for resident # 398 was notified on 9/23/18 at 11a.m that the Vancomycin was not available as ordered; no new orders were received. The attending physician for resident # 398 was notified on 9.23.18 at 1 p.m. that the Vancomycin was not available as ordered; no new orders were received. On 9.24.2018 the attending physician extended the vancomycin duration by two days. The RR and the pharmacy were notified. The licensed nurse who notified the attending physician that the Vancomycin was not available received 1:1 corrective action for not documenting physician notification in progress notes. **Identification** All medications were reviewed for new residents admitted on 9/22/18 with antibiotics orders and no other areas of non-compliance were identified.	9.27.2018 9.27.2018

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F 755	Continued From page 22 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure that physician ordered medications were available for administration for 2 of 35 Residents in the sample survey, Resident #396 and Resident #398. The Findings included: 1. For Resident #396 the facility staff failed to ensure that physician ordered Spiriva was available for administration. Resident #396 was a 69 year old female who was admitted on 9/22/18. Admitting diagnoses included, but were not limited to: malignant neoplasm of the left bronchus, secondary malignant neoplasm of the brain, pleural effusion, dysphagia and shortness of the breath. No Minimum Data Set (MDS) assessment was available due to Resident #96's recent admission. On September 26, 2018 at 8:43 a.m., the surveyor reviewed Resident #396's clinical record. Review of the clinical record produced Physician Orders. Physician Orders included, but were not limited to: "Spiriva Respimart (tiotropium bromide) mist; 1.25mcg/actuation; amt (amount):	F 755	**Systemic Change** Licensed nursing staff will be re-in serviced on the use of Omni cell for first dose medication for new admissions and the list of all medications in the Omni cell will be placed on all med carts for easy access. The staff will be re-educated on notifying the pharmacy when medications are not available in the Omni cell. The pharmacy will then use the backup pharmacy to deliver medications to the facility. The staff will be in-serviced on proper documentation when notifying the physician and resident representative. **Monitoring** Nursing supervisors will be tasked to audit all MARs for new residents for administration of first dose of medications. A report will be submitted to the unit manager who will follow up the next business day. DON or designee will audit 20% of new admission eMAR records for compliance. A report will be submitted to quarterly QAPI meeting for discussion.	10.30.2018 11.8.2018

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F 755	Continued From page 23 2 puffs into lungs; inhalation [DX (diagnosis): Shortness of breath] Once a Day; 09:00 AM." (sic) Continued review of the clinical record produced the September 2018 Medication Administration Records (MAR's). Review of the September 2018 MAR's documented that Resident #396's Spiriva was not available for administration on 9/23/18 at 9 a.m. On September 26, 2018 at 9 a.m., the surveyor notified the Unit Manager (UM), who was a Registered Nurse), that Resident #396's Spiriva was not available for administration on 9/23/18 at 9 a.m.. The surveyor reviewed Resident #396's clinical record with the UM. The surveyor specifically pointed out the physician order for the Spiriva. The surveyor then reviewed the September 2018 MAR's with the UM. The surveyor pointed out that the facility staff documented that the Spiriva was not available for administration on 9/23/18 at 9 a.m. The surveyor asked if the facility had a backup pharmacy and the UM named a local pharmacy. The surveyor requested the facility policy and procedure for obtaining medications when not available. On September 26, 2018 at 9:40 a.m., the Director of Nursing (DON) approached the surveyor and hand delivered the facility policy and procedure for obtaining medications when they were unavailable from the pharmacy. On September 26, 2018 at 12:20 p.m., the DON approached the surveyor and informed the surveyor that the Spiriva was in the Omni Cell at the facility. The DON stated that the facility staff was supposed to pull the Spiriva from the Omni	F 755		

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F 755	Continued From page 24 Cell. The surveyor requested a list of medications available from the Omni Cell. On September 26, 2018 at 2 p.m., the DON hand delivered a list of medications available in the Omni Cell. The surveyor identified that Spiriva was available in the Omni Cell. On September 26, 2018 at 5 p.m., the survey team met with the Administrator (ADM), DON and Assistant Administrator (AAdm). The surveyor notified the Administrative Team (AT) that Resident #396's Spiriva was not available for administration on September 23, 2018 at 9 a.m. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure that Resident #396's physician ordered Spiriva was available for administration. 2. For Resident #398 the facility staff failed to ensure that physician ordered Vancomycin was available for administration. Resident #398 was a 57 year old female who admitted on 9/22/18. Admitting diagnoses included, but were not limited to: acute kidney failure, chronic viral Hepatitis B, hypertension, alcohol abuse, acute cholecystitis and Enterocolitis due to Clostridium difficile (C-diff), recurrent. No Minimum Data Set (MDS) assessment was available due to Resident #398's recent admission. On September 26, 2018 at 10 a.m., the surveyor reviewed Resident #398's clinical record. Review	F 755		

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F 755	Continued From page 25 of the clinical record produced Physician Orders. Physician Orders included, but were not limited to: "vancomycin capsule; 125mg; amt (amount); 1 capsule; oral [DX (diagnosis): Enterocolitis due to Clostridium difficile, recurrent] Four Times a Day; 09:00 AM, 01:00 PM, 05:00 PM, 09:00 PM." (sic) This order was ordered on 9/22 and discontinued on 9/22/18. "VANCOMYCIN LIQUID liquid; 125MG; oral [DX: Enterocolitis due to Clostridium difficile, recurrent] Four Times a Day: 09:00 AM, 01:00 PM, 05:00 PM, 09:00 PM." (sic) This order was ordered on 9/22/18 and discontinued on 9/24/18. "VANCOMYCIN LIQUID liquid: 125 MG; amt: 1 tablet; oral [DX: Enterocolitis due to Clostridium difficile, recurrent] Every 6 hours; 12:00PM, 06:00 PM, 12:00 AM, 06:00AM." (sic) This order was ordered on 9/24/18. Continued review of the clinical record produced the September 2018 Medication Administration Record (MAR's). The September 2018 MAR's documented that the Vancomycin was not available for administration on 9/22/18 at 9 p.m., on 9/23/18 at 9 a.m. and on 9/23/18 at 1 p.m.. On September 26, 2018 at 10:40 a.m., the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #398 was on Vancomycin for C-diff. The surveyor notified the UM that the facility staff documented that the Vancomycin was not available for administration on several occurrences. The surveyor reviewed the clinical record with the UM. The surveyor specifically pointed out the physician orders for the Vancomycin. The surveyor then reviewed the September 2018 MAR's with the UM. The	F 755		

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F 755	Continued From page 26 surveyor pointed out that the facility staff documented that the Vancomycin was not available for administration. The surveyor requested copies of Resident #398's clinical record, The surveyor also asked if the facility had a backup pharmacy and the UM named a local pharmacy. The surveyor requested the facility policy and procedure for obtaining medications when not available. On September 26, 2018 at 3:30 p.m. the Director of Nursing (DON) hand delivered the facility policy and procedure titled, "Medication Ordering and Receipt." The Policy and Procedure read in part ... "(Name of pharmacy vendor withheld) provides pharmacy services 7 days a week, 24 hours a day, and 365 days a year in order to assure timely availability of medications for its customers. ... A (name of pharmacy vendor withheld) pharmacist is available 24 hours a day and is able to dispense needed medications from the pharmacy, or to arrange dispensing from a back-up pharmacy to meet the needs of the facility." On September 26, 2018 at 5 p.m., the survey team met with the Administrator (ADM), DON and Assistant Administrator (AAdm). The surveyor notified the Administrative Team (AT) that Resident #398's Vancomycin was not available for administration on multiple occurrences. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure that Resident #398's physician ordered Vancomycin was available for administration.	F 755		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812	Corrective Action The prunes and corn syrup were immediately discarded by staff.	9.25.2018

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F 812 SS=D	Continued From page 27 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 observation, staff interview and facility document review, the facility staff failed to remove expired food items from the refrigerator. The findings included: The facility staff failed to remove food items that were expired from the refrigerators. The surveyor toured the facility kitchen on 9/25/18 beginning at 1:01: p.m. The dietary services manager, the day supervisor and the registered dietician accompanied the surveyor. In one of the reach-in refrigerators, the surveyor observed a container of prunes and dated 9/13/18. The surveyor asked what the dot with the date written	F 812	**Identification** In order to ensure that no residents were affected, all refrigerators and storage area in the dietary department were inspected by the dietary manager for food with expired dates. No areas of non-compliance were identified. **Systemic Change** The dietary supervisors or their designee, will be required to inspect all refrigerators and storage areas in the dietary department on a daily basis to ensure that all products have not expired and report findings in their daily supervisor report. Any areas of non-compliance will be immediately corrected. On the last day of each month, the Supervisor or his/her designee will inspect the refrigerators for "use by" and "expire" dates for long shelf life products. Any item that has a "use by" or "expiration" date in the coming month will be discarded. In-service for dietary staff was conducted for food-safety and sanitation, including labeling and dates. **Monitoring** To ensure compliance, the Dietary Manager will conduct a weekly inspection of dietary for products that may have expired. Any areas of non-compliance will be immediately corrected and 1:1 education will be conducted with the staff. Any areas of non-compliance will be reported to Assistant Administrator. A quarterly report of areas of non-compliance will be submitted to the QA/QAPI committee by the Dietary Manager for discussion and further recommendations.	9.25.2018 10.25.2018 11.9.2018

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F 812	Continued From page 28 on it indicated. The registered dietician stated the staff date the leftovers and then remove them in 7 days. She was asked if the prunes were past their use by date and she stated yes. The dietary services manager promptly removed and discarded them. Also, in the reach-in refrigerator was a 128 fluid ounce (fl oz) bottle of light corn syrup with a handwritten date of 4/16. The registered dietician and the dietary services manager checked the bottle for any further dates but none were found. Both stated that the bottle of corn syrup should be removed. The surveyor informed the administrator, the director of nursing (DON) and the assistant administrator of the above concern during the end of the day meeting on 9/26/18 at 5:00 p.m. and requested the facility policy on food labeling and dating. The surveyor reviewed the facility policy titled "Food Storage" and read in part "13. Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code. (Also, see policy on Use of Leftovers later in this chapter). Check state regulations as state regulations may allow shorter time frames for use of leftovers." No further information was provided prior to the exit conference on 9/27/18.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814	**Corrective Action** The manhole cover area outside the kitchen exit door was cleaned of debris and food particles the same day it was discovered.	9.25.2018

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F 814	Continued From page 29 properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure the area outside the kitchen was free of food and other debris. The findings included: The facility staff failed to ensure the area outside of the kitchen was free of food and other debris. The surveyor and the dietary services manager toured the kitchen on 9/25/18 and completed the tour around 1:45 p.m. The surveyor and the dietary services manager exited the kitchen and headed toward the dumpster. Near the kitchen exit door, the surveyor observed a manhole cover that was covered with a metal grill approximately 20-30 feet from the exit door. In the top of the manhole cover, the surveyor observed food particles (carrots and carrot peelings and three soiled gloves) and empty package wrappers (sugar packets). The dietary services manager asked a dietary staff member to get a pair of gloves and clean up the debris. The surveyor informed the administrator, the assistant administrator, and the director of nursing (DON) of the above concern on 9/26/18 at 5:00 p.m. The surveyor asked what staff member would be responsible for cleaning the area outside the kitchen. The administrator stated both housekeeping and the dietary staff. No further information was provided prior to the exit conference on 9/27/18.	F 814	**Identification** In order to ensure that no other residents were affected, all refuse areas on the premise were inspected for debris and no other areas of non-compliance were identified. **Systemic Change** The dietary supervisors will be required to inspect this area during opening and closing rounds of the department and report findings in their daily supervisor report. Any non-compliance will be immediately corrected. The Environmental Services Lead or designee will inspect this area daily and report any findings to Director of Environmental Services and any non-compliance will be immediately corrected. In-Service for dietary/housekeeping staff on properly disposing of garbage and refuse will be conducted. **Monitoring** To ensure compliance, the Dietary Manager and Director of Environmental Services or their designee, will conduct inspection of area during their daily rounds for any debris or food particles at manhole cover. Any non-compliance will be immediately corrected and 1:1 education will be conducted with the staff member responsible for leaving the debris. Any area of non-compliance will be reported to Assistant Administrator in a weekly report. A quarterly report of areas of non-compliance will be submitted to the QA/QAPI committee by Assistant Administrator for discussion and further recommendations.	9.25.2018 10.25.2018 11.8.2018

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F 880 SS=D	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 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:	F 880	**Corrective Action:** Resident # 398 was transferred into a private room for isolation on 9/27/18 and an apology was rendered to the roommate. The roommate's family and MD were notified of the potential of C.Diff exposure. The roommate was monitored for signs or symptoms of C.Diff. No signs or symptoms were noted as of 10.13.2018. **Identification** In order to ensure that no other residents were affected, the hospital discharge orders, hospital medical records/discharge summaries and facility Admission Orders were reviewed for antibiotics and C. Diff treatment for the previous 7 days. No other areas of non-compliance for isolation were identified. **Systemic change** Admission staff, licensed staff and the infection control nurse will receive in-services on when to isolate residents. The Admission staff will ensure that Hospitals send the discharge summary that includes reason for antibiotics prior to transfer. If a hospital sends a resident to Woodbine without sending the discharge summary, the Director of Admissions will notify the Director of Case Management and Chief Medical Office of the non-compliant hospital. The Director of Admissions will submit a report to the Director of Nursing, Infection Preventionist, Medical Director and Administrator monthly. Unit Manager or designee will review the admissions to the facility by reviewing the hospital discharge orders, hospital discharge summary and facility admission orders for new antibiotics and proper C.Diff diagnosis. If any discrepancy is found, the resident will be placed in isolation immediately and the attending physician will be contacted for clarification on isolation status until and the attending physician will be contacted immediately for clarification.	9.27.2018 9.27.2018 10.30.2018

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F 880	Continued From page 31 (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 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 observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement an effective infection control program for 1 of 35 Residents in the sample survey, Resident #398. The Findings included: The facility staff failed to place Resident #398, who had Clostridium Difficile (C-Diff), in contact	F 880	The Infection Preventionist Nurse or designee will review residents that are admitted on antibiotics for C.diff and ensure that the proper isolation precautions are in place. Any areas of non-compliance will be corrected immediately and the physician, resident representative and DON will be notified immediately for further recommendation. **Monitoring** The DON or designee will audit 20% of all new admissions for appropriate isolation and diagnosis of C.Diff. Any area of non-compliance will be corrected and staff responsible will be subject to corrective action. A report of non-compliance will be submitted to the CQI/QAPI team for discussion and further recommendations.	11.8.2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 precautions. Resident #398 was a 57 year old female who admitted on 9/22/18. Admitting diagnoses included, but were not limited to: acute kidney failure, chronic viral Hepatitis B, hypertension, alcohol abuse, acute cholecystitis and Enterocolitis due to Clostridium difficile (C-diff), recurrent. No Minimum Data Set (MDS) assessment was available due to Resident #398's recent admission. On September 25, 2018 at 2:18 p.m., the surveyor observed Resident #398 sitting up in wheelchair at the side of her bed. Resident #398 was dressed in a hospital gown and talking on her telephone. The surveyor did not observe any isolation signage or isolation equipment/supplies. On September 25, 2018 at 3:45 p.m., the surveyor observed Resident #398 sitting up in her wheelchair at the side of her bed. The surveyor observed a staff person in room and providing care. The surveyor did not observe the facility staff using any infection control precautions while caring for Resident #398. The surveyor did not observe any isolation signage or isolation equipment/supplies. On September 25, 2018 at 5:42 p.m., the surveyor observed Resident #398 sitting up in her wheel chair and feeding herself her supper. The surveyor stepped into Resident ##98's room and interviewed Resident #398. Resident #398 stated she was able to set up own tray. The surveyor did not observe any isolation signage or isolation equipment/supplies.	F 880		

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F 880	Continued From page 33 On September 26, 2018 at 8:39 a.m., the surveyor observed Resident #398 lying in bed. The head of the bed was raised. Resident #398was feeding herself her breakfast and talking on the telephone. The surveyor did not observe any isolation signage or isolation equipment/supplies. On September 26, 2018 at 9:45 a.m., the surveyor observed Resident #398 lying in bed. The surveyor interviewed Resident #398. Resident #398 stated that the facility staff were taking very good care of her. The surveyor did not observe any isolation signage or isolation equipment/supplies. On September 26, 2018 at 10 a.m., the surveyor reviewed Resident #398's clinical record. Review of the clinical record produced Physician Orders. The surveyor observed that when Resident #398 was admitted into the facility of 9/22/18 the physician ordered for Resident #398 to receive Cipro 500 mg, an antibiotic, by mouth every 12 hours for C-diff. Resident #398 was still receiving the Cipro. Physician orders also included an order for Metronidazole (Flagyl) 500mg, an antibiotic, by mouth every 8 hours for C-Diff. Resident #398 was still receiving the Metronidazole. Physician orders also included an order for Vancomycin 125mg, an antibiotic. Further review of the clinical record did not produce a repeat stool specimen to verify that Resident #398's C-Diff had been resolved. On September 26, 2018 at 10:40 a.m., the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #398 was	F 880		

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F 880	Continued From page 34 on Vancomycin, Cipro and Metronidazole for C-Diff. The surveyor alerted the UM that Resident #398 had an active contagious infection, C-Diff, and was not on isolation/contact precautions. The surveyor reviewed Resident #398's clinical record with the UM. The surveyor reviewed the physician orders and treatment for the active diagnoses of C-Diff. The UM requested for the surveyor to walk down to Resident #398's room. The surveyor and UM walked down to Resident #398's room. The UM entered Resident #398's room without using any infection control/contact precautions. The surveyor observed that a staff person was in the room providing care to Resident #398 and that the staff was not using any isolation precautions. The surveyor pointed out that Resident #398 was not in isolation. The surveyor requested the facility policy and procedure for isolation/infection control. On September 26, 2018 at 2:20 p.m., the surveyor observed a Policy and Procedure on the table in the conference room. The surveyor reviewed the Policy and Procedure titled, "INFECTION CONTROL- Use of Isolation." The policy and procedure read in part... "Contact Precautions (Isolation)"- a series of procedures designed to minimize the transmission of infectious organisms by direct or indirect contact with an infected patient or his environment. Contact precautions require the use of protective equipment such as disposable gowns, gloves, and masks when exposure to a resident's body fluids and/or the resident's environment is anticipated. .... Type and Duration of Precautions Recommended for Selected Infections and Conditions ... Clostridium: C.	F 880		

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F 880	Continued From page 35 difficile- C (Contact Precautions). See below under Gastroenteritis. Gastroenteritis ... C. difficile-Discontinue antibiotics if appropriate. Do not share electronic thermometers. Ensure consistent environmental cleaning and disinfection. Hypochloride solutions may be required for cleaning if transmission continues. Handwashing with soap and water are preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs." On September 26, 2018 at 5 p.m., the survey team met with the Administrator (ADM), DON and Assistant Administrator (AAdm). The surveyor notified the Administrative Team (AT) that Resident #398 was currently being treated for C-Diff with Vancomycin, Cipro and Metronidazole. The surveyor notified the AT that Resident #398 had not been in contact isolation on initial tour of the facility on 9/25/18 and on 9/26/18. On September 27, 2018 at 8:55 a.m., the Director of Nursing (DON) approached the surveyor and informed the surveyor that on 9/26/18 the facility staff put Resident #398 in isolation for her diagnoses and treatment of C-Diff. The DON stated that they had moved Resident #398's roommate to another room. The DON also stated that the family of Resident #398 and her roommate's family had been notified. Lastly, the DON stated that the physician had been contacted and orders were obtained to obtain a stool specimen to check for C-Diff on Resident #398 and on Resident #398's roommate. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to place Resident #398 in contact precautions/isolation for her diagnoses of	F 880		

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F 880	Continued From page 36 C-Diff. The facility staff failed to implement an effective infection control program for Resident #398.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain an effective pest control program. The findings included: Roaches, ants, and flying insects were observed in the facility during the onsite survey. On 9/26/18 at 8:50 am, the surveyor observed a roach crawl underneath of a Resident's closet. On 9/26/18 at 9:50 am, the surveyor was standing in the hallway on 2 south. The surveyor observed something brown crawling in her hair. The surveyor shook her hair and a brown roach fell from the surveyor's hair onto her right arm. The surveyor brushed the roach from her arm onto the floor and stepped on the roach. CNA # 2 (certified nursing assistant) was in the hallway and the surveyor asked CNA #2 if there was a problem with roaches in the facility. CNA # 2 stated, "I know they have had issues with them but they are working on it." CNA # 2 provided the surveyor with a piece of tissue upon the surveyors request and the surveyor retrieved the	F 925	**Corrective Action** Immediate action by facility policy was taken by the staff when notified by the surveyor: 1) placing the alleged sighting by the Surveyor in the pest control book, 2) notifying the Director of Environmental services and 3) Inspecting all of the rooms on the unit where the surveyor reported the sighting for other pests. No additional pests were noted. 4) The pest control company was notified of the surveyor's sighting and scheduled to return to the facility. The pest control company was on site 9.27.2018 and 9.28.2018 to inspect and treat all areas. A detailed inspection was completed on the unit in which the surveyor reported pests. An apology was issued to the surveyor from the Administrator. A review of the log of pest sightings was completed with the pest control company. All areas were re-inspected for any additional activity. If any additional activity was noted, the area was treated and recommendations provided by the Pest Control were followed. The company that is contracted to maintain the plants in the building was notified of the gnat/fly sighting by the surveyor and came on-site for treatment on 9.28.2018 on 10.1.2018 and again on 10.14.2018 **Identification** In order to ensure that no other residents were affected, an inspection of all rooms in the facility was completed on 9.27.18 by the facility staff. The pest control company did a detailed inspection of the unit in which the surveyor reported her sighting. The residents on the unit in which pests were identified by the surveyor were interviewed for any pest concerns. If there was a concern verbalized, the pest issue was addressed and an apology was given to the resident.	9.28.2018 9.27.2018 10.30.2018 10.14.2018 9.27.2018

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F 925	Continued From page 37 dead roach off the floor. On 9/26/18 at 10:28 am, the surveyor spoke with the director of environmental services. The surveyor asked the director of environmental services if he was aware of any issues with roaches within the facility. The director of environmental services stated that he was aware that the facility had issues with roaches and that the facility had a contract with (company's name withheld), and the company was in the facility providing pest control services last Thursday. The director of environmental services stated that the company services certain areas based on complaints from service logs that are kept on the units. The surveyor informed the director of environmental services that a roach had been observed in a Resident's room and a roach had crawled in the surveyor's hair. The surveyor gave the director of environmental services the roach that had been retrieved from the floor as stated above to the director of environmental services in the presence of the survey team. The surveyor requested to see the service logs that are kept on the units. On 9/26/18 at 1:27 pm, the surveyor observed flying insects and ants crawling on the floor in a wardroom on 2 south. On 9/26/18 at 2:00 pm, the surveyor reviewed the "Special Service Record" that had been provided by the director of environmental services. The service records contained entries dated 8/21/18 through 9/26/18. The "Special Service Record" contained documentation that included but were not limited to: TCU (transitional care unit)	F 925	**Systemic Change** The Director of Housekeeping, the Director of Engineering, the contracted pest control company and Administrator will assess all areas that are prone to standing water when experiencing prolonged rain activity (as the weeks prior to the surveyor inspection) which can lead to increased pest activity. All recommendations made will be implemented. An evaluation with the team will be completed seasonally/quarterly for other environmental factors that could contribute to increased pest activity and implement recommendations. The Director of Housekeeping and the Assistant Administrator will meet with the Pest Control Company any time that an area has a repeat pest sighting to ensure that all recommendations are identified and implemented to remediate the pest. The facility will send a letter to all residents and their representatives regarding the right to store items, including food in resident rooms and the proper way of storing items in rooms to prevent pests. (For example food should be in closed plastic containers and additional storage should be in plastic storage containers, not cardboard which attracts pests). For residents who's preference it is to store larger amounts of items in their room, a discussion will take place regarding proper storing of items (included but not limited to how to properly store food in resident room, discarding of old food, keeping the floor free of storage and not using cardboard to store items) and allowing the staff to thoroughly detail clean their room (including drawers and wardrobes) on a more frequent basis. A thorough or "terminal cleaning" will be conducted for all rooms located on the unit which was identified during the survey. Families and residents were notified in advance to remove any unwanted items and the need to store items in plastic containers.	10.31.2018

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F 925	Continued From page 38 8/30/18- Roaches- room 50 bathroom 9/13/18-Roaches-Nourishment, Nurse Station, Rooms 9/14/18-Mouse-in med room under sink 9/17/18-Flies-room 49 9/20/18- House Flies-room 40 and TCU DR (dining room) 9/26/18-Flies-room 40 1 North 8/10/18 -ants crawling in room-130 9/18/18-cockroach- nurse's station and hallway 1South 9/9/18-ants in the left corner 119 (B bed) 9/17/18-roaches room 107 bathroom 2 North 8/21/18-roaches-245,251,247,249 8/21/18-roaches-242 roaches running around 8/28/18-ants-Nutrition room (by microwave) 8/29/18-roaches-249 nightstand by air conditioner 9/6/18- roaches-249 9/11/18-bugs/roaches-251 9/11/18-roaches-Nursing station 9/18/18-Max Roaches-Big picture on hallway by room 249 2 South 8/28/18-roaches- room 224 bathroom 8/28/18 roaches- housekeeping cart 8/29/18-roaches-nurse station drawers and floor 8/30/18-roaches 2 south utility room 9/11/18-bugs-room 204 9/17/18-roaches room 215A inside drawers 9/18/18-roaches-room 205 9/18/18-roaches- room 206 9/20/18-roaches-room 214 9/23/18-roaches room 209B	F 925	A notice will be placed in all facility owned potted plants to say "please do not water" to ensure that only the plant service waters facility potted plants. This will protect the soil from being overwater that may be an opportunistic environment for flies and gnats. Housekeeping staff will be in-serviced how to identify personal plants in resident rooms that may be dying or overwatered that may be attractive to pests. Any identification of personal plant that is not in good condition will be reported to the Environmental Services Director daily so that the resident or their family can be notified of the plant and the need to discard or remove it. Managers will report any pest activity during daily management meeting. **Monitoring** The pest control logs will be reviewed every two weeks by the Assistant Administrator. Any area that has not been addressed or has a repeat in activity will immediately be treated. An inspection after treatment will be conducted to ensure remediation of the pest. A quarterly report of non-compliance will be submitted to the CQI/QAPI team for discussion and further recommendations. The Environmental Services Director or designee will complete an inspection of 20% rooms in the facility monthly for signs of pest activity. Any area noted will be treated immediately and a follow-up after treatment will be conducted to ensure remediation of the pest activity. Any areas of non-compliance will be reported quarterly at the QA/QAPI meeting for discussion and for further recommendation.	10.1.2018 11.8.2018

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F 925	Continued From page 39 3 South 9/6/18-roaches-shower room small 9/10/18-roaches 313A cabin The facility "Environmental Services" policy contained documentation that included but was not limited to: ..."9. Pest Control. The director of environmental services shall be responsible for ensuring that the facility is kept free of insects and rodents." On 9/26/18 at 6:00 pm, the administrator, assistant administrator, and the director of nursing was made aware of the sightings of roaches, ants, and flying insects. During this meeting, a flying insect was observed in the room and killed by a surveyor in the presence of the survey team and the administrative team. On 9/27/18 at 12:10 pm, the surveyor spoke with the administrator, assistant administrator, director of environmental services, and pest control technician. The surveyor asked the pest control technician how often the facility is serviced for pest control. The pest control technician informed the surveyor that someone from the company services the facility on a weekly basis and can be called in for emergencies. The surveyor asked the pest control technician if the entire facility is serviced each week. The pest control technician stated that a different area is serviced each week, as well as areas where there have been complaints of pests. The administrator informed the surveyor that because of the weather conditions there had been a large amount of freestanding water, which is a contributing factor to the flying insects. The administrator stated that they have removed plants from certain areas, and	F 925		

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F 925	Continued From page 40 changed pest control contractors in efforts to effectively manage pests. The surveyor informed the administrative team that based on the observations made while in the facility and review of the facility documentation that the interventions were not effectively managing pests. No further information was provided to the survey team prior to the exit conference on 9/27/18.	F 925		