Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0007	A. BUILDING: ______ B. WING ______	R-C 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

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{L 000}	Initial Comments An unannounced Revisit Survey was conducted at this facility, from March 13, 2023 - March 14, 2023. Survey activities consisted of observations, record reviews, and staff interviews. The facility's census on the first day of the survey was 170 and the survey sample included seven (7) residents. After analysis of the findings, it was determined that the facility was not in compliance with 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram	{L 000}	Washington Center for Aging Services makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State laws.	

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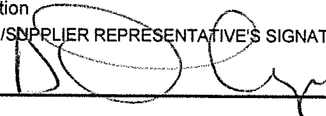
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE LNHA

(X6) DATE 3/17/23

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{L 000}	Continued From page 1 EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse 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) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed	{L 000}		

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{L 000}	Continued From page 2 Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record TV - Television Ug - Microgram	{L 000}		
{L 052}	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities;	{L 052}		

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{L 052}	Continued From page 3	{L 052}		

(f)Encouragement and assistance to:

(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:
Based on two (2) of two observations, record reviews, staff interviews, and for one (1) of seven (7) sampled residents, facility staff failed to ensure that sufficient nursing time was given to protect residents from accident hazards; and ensure that one resident, who is unable to carry out activities of daily living, received the necessary care to maintain good grooming and personal hygiene. Resident #1.

The findings included:

According to the "Occupational Safety and Health Administration (OSHA)", " ... [The] policy is that recapping of needles, in general, is not

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{L 052}	Continued From page 4 appropriate. Used needles are to be placed in sharps disposal containers without recapping ..." https://www.osha.gov/laws-regs/standardinterpretations/1990-09-13#:~:text=OSHA%20policy%20is%20that%20recapping%20of%20needles%2C%20in,such%20as%20self-sheathing%20needles%20are%20the%20preferred%20method. Review of the "Point of Care Testing" policy (not dated) documented, " ...All disposable needles, syringes and sharps shall be placed in sharps containers ..." Review of the policy, "AM (morning) and PM (evening) Care (not dated) showed, "... All residents in the facility will be provided assistance with care as needed ... assist/have resident bathe hands ..." 1. Facility staff failed to ensure that sufficient nursing time was given to protect residents from accident hazards as evidenced by leaving a needle syringe unattended, on top of a medication cart in the hallway. During a tour of unit 2 Green on 03/13/23 at 12:10 PM, a needle syringe was observed unattended on top of a medication cart in the hallway, as residents were walking by. Also observed, was a resident sitting in his wheelchair, within arm's reach of the medication cart and unattended needle syringe. The closest employee was observed down the hall, to the left of the cart. The surveyor got the employee's attention, who then came and acknowledged the unattended needle syringe on top of the medication cart. Employee #5 (Registered Nurse assigned to the medication cart) quickly took the	{L 052}	1. The needle/syringe was discarded into the sharp's container immediately. Employee #5 was re-educated immediately on the Point of Care Testing Policy. No resident was affected by this practice. 2. All medication carts were checked, and no other cart was noted to have syringes on them. All carts had a sharps' container attached, which was being used. 3. Licensed Nursing Staff were re-educated on the Point of Care Testing Policy, which included safety as it pertains to syringes/needles being left on the cart as well as proper disposal of sharps into sharps' container. 4. Nurse managers will utilize monitoring tool to ensure syringes and needles are being properly disposed of and nursing staff not recapping syringes/needles. The results will be reported to the QA committee quarterly. 5. Completion Date: March 17, 2023 6. DON/ADON	**03.17.2023**

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{L 052}	Continued From page 5 needle syringe and threw it into the trash receptacle that did not have a trash bag. It should be noted that there was a sharps container attached to the medication cart, located directly above the trash receptacle. During a face-to-face interview conducted at the time of the observation, Employee #5 stated, "I went to use the needle to draw up Insulin (medication to lower blood sugar), but I noticed it was bent when I opened it (uncapped it) so I couldn't use it. The needle was never used." The employee was asked is it standard of practice to recap a needle. The employee responded, "I did not use the needle. It was bent." When asked why she recapped the needle and why she did not discard of the needle instead of leaving it unattended, on top of the medication cart, the employee did not provide a response. The employee was asked why she discarded the needle syringe in the trash and not the sharp's container. Employee #5 stated, "Yes, I know. It's [needle syringe] supposed to go in the sharps container." The evidence showed that facility staff facility staff failed to ensure that the resident environment remained free of accident hazards as evidenced by a needle syringe being left unattended, on top of a medication cart in the hallway. During a face-to-face interview conducted at on 03/13/23 at 12:15 PM, Employee #9 (unit 2 Green Unit Manager) was made aware of the findings. Employee #9 acknowledged the findings and stated that she would talk to Employee #5. During a face-to-face interview conducted on 03/13/23 at approximately 12:40 PM, Employees #1 (Administrator) and Employee #2 (Director of	{L 052}		

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{L 052}	Continued From page 6 Nursing) were also made aware of the findings. 2. Facility staff failed to ensure that sufficient nursing time was given to ensure that Resident #1, who is unable to carry out activities of daily living, received the necessary care to maintain good grooming and personal hygiene. Resident #1 was admitted to the facility on 06/08/20 with multiple diagnoses that included: Age-related Physical Debility, Muscle Weakness and Altered Mental Status. During an observation on 03/13/23 at 11:06 AM, Resident #1 was observed laying in bed, with his arms folded on his chest. All ten (10) of his fingernails were noted to be very long with thick, caked up, dark colored substance underneath each fingernail. Review of Resident #1's medical record revealed the following: 09/12/20 [physician's order] " ... Head to toe skin observation for any abnormalities ... twice a week on shower days ...Mondays and Thursday s night shift ..." 08/30/21 [physician's order] "Target Behavior ... (A) kicking/hitting staff (B) scratching staff (C) refusing care ...Every Shift ..." A Quarterly Minimum Data Set (MDS) dated 12/15/22 showed facility staff coded the following: moderately impaired cognitive skills for daily decision making; no rejection of care behaviors; required extensive assistant of two person assist for personal hygiene; and had no functional limitation in range of motion.	{L 052}	1. Resident #1 was provided nail care immediately. 2. Resident rounds were made on all units and all residents nails were checked. No other resident was found to be affected by this practice. 3. In-service training on Activities of Daily Living, including nail hygiene was conducted for CNAs and Licensed Nursing Staff by the Unit Managers. 4. Nursing management will monitor ADL's and hygiene of residents daily, including nail care. The results will be reported to the QA committee quarterly. 5. Completion Date: March 17, 2023 6. DON/ADON	03.17.2023

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{L 052}	Continued From page 7 Care plan focus area: "Self-Care Deficit related to muscle weakness, age- related physical debility ..." last reviewed on 12/28/22 had the interventions of " ...Nursing staff will groom and dress resident daily ...Nursing staff will bath resident daily and give shower twice a week on shower day ..." Care plan focus area: "Resident exercising his rights to refuse care (...ADL [activities of daily living] assistance)" last reviewed on 12/28/22 had the interventions of " ...When resident begins to resist care, STOP and try the task later. Do not force the resident to do the task ... Notify MD/NP (medical doctor/Nurse Practitioner) and RP (representative) of lab refusal and care ..." Care plan focus area: "Resident has physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, abusing others ..." last reviewed on 01/26/23 had the interventions of: " ...When resident becomes physically abusive, STOP and try task later. Do not force to do task. When resident becomes physically abusive, keep distance between resident and others (e.g., staff, other residents, visitors). Call for assistance if resident is agitating and is not safe to leave him alone ..." Review of the progress notes, Medication Administration Record (MAR), Treatment Administration Record (TAR) and the Certified Nurse Aide (CNA) documentation from 03/10/23 to 03/13/23 (three days), showed no documented evidence that the resident refused medications, ADL care or had any physical behavioral symptoms towards the staff; the CNA documentation also showed that the resident was provided staff assistance to "maintain personal	{L 052}		

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{L 052}	Continued From page 8 hygiene" on 03/13/23 at 6:44 AM. During a face-to-face interview conducted on 03/13/23 at 11:08 AM at Resident #1's bedside, Employee #8 (assigned nurse) and Employee #7 (Unit Manager) both acknowledged the finding. When asked why Resident #1's fingernails had not been cut or cleaned, Employee #7 stated, "We try as much as he allows. He hits the staff." Employee #8 then proceeded to cut and clean the resident's nail. It should be noted that the resident did not display any physically aggressive behavior towards Employee #8 as she performed this task.	{L 052}		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on one (1) of one observation, record review and staff interviews, facility staff failed to maintain infection control practice and procedures as evidenced by recapping a needle syringe and disposing of the needle in the trash receptacle instead of the sharp's container. The findings included: According to the "Occupational Safety and Health Administration (OSHA)", " ... [The] policy is that recapping of needles, in general, is not appropriate. Used needles are to be placed in sharps disposal containers without recapping ..." https://www.osha.gov/laws-regs/standardinterpret	L 091	1. Employee #5 was re-educated immediately, and demonstrated competency and skills necessary as it pertains to recapping a needle, placement of needle syringe and disposal of needle syringe. 2. All medication carts were checked, and no other cart was noted to have syringes on them. All carts had a sharps container attached, which was being used.	03.17.2023

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L 091	Continued From page 9 ations/1990-09-13#:~:text=OSHA%20policy%20is%20that%20recapping%20of%20needles%2C%20in,such%20as%20self-sheathing%20needles%20are%20the%20preferred%20method. Review of the "Point of Care Testing" policy (not dated) documented, " ...All disposable needles, syringes and sharps shall be placed in sharps containers ..." During a tour of unit 2 Green on 03/13/23 at 12:10 PM, a needle syringe was observed unattended on top of a medication cart in the hallway, as residents were walking by. Also observed, was a resident sitting in his wheelchair, within arm's reach of the medication cart and unattended needle syringe. The closest employee was observed down the hall, to the left of the cart. The surveyor got the employee's attention, who then came and acknowledged the unattended needle syringe on top of the medication cart. Employee #5 (Registered Nurse assigned to the medication cart) quickly took the needle syringe and threw it into the trash receptacle that did not have a trash bag. It should be noted that there was a sharps container attached to the medication cart, located directly above the trash receptacle. During a face-to-face interview conducted at the time of the observation, Employee #5 stated, "I went to use the needle to draw up Insulin (medication to lower blood sugar), but I noticed it was bent when I opened it (uncapped it) so I couldn't use it. The needle was never used." The employee was asked is it standard of practice to recap a needle. The employee responded, "I did not use the needle. It was bent." When asked why she recapped the needle and why she did not discard of the needle instead of leaving it	L 091	3. Licensed Nursing Staff were re-educated on the Point of Care Testing Policy, which included safety as it pertains to syringes/needles being left on the cart as well as proper disposal of sharps into sharp's container. Medication Pass Administration was conducted on licensed nursing staff which included infection control practices. 4. Nurse Managers will utilize med pass audit tool to test infection control practiced as it pertains to disposal of syringes. The results of the tool will report to the QA Committee Quarterly. 5. Completion Date: March 17, 2023 6. DON/ADON	**03.17.2023**

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L 091	Continued From page 10	L 091		

unattended, on top of the medication cart, the employee did not provide a response. The employee was asked why she discarded the needle syringe in the trash and not the sharp's container. Employee #5 stated, "Yes, I know. It's [needle syringe] supposed to go in the sharps container."

The evidence showed that facility staff failed to maintain infection control practice and procedures as evidenced by recapping a needle syringe and disposing of the needle in the trash receptacle instead of the sharp's container.

During a face-to-face interview conducted at on 03/13/23 at 12:15 PM, Employee #9 (unit 2 Green Unit Manager) was made aware of the findings. Employee #9 acknowledged the findings and stated that she would talk to Employee #5.

During a face-to-face interview conducted on 03/13/23 at approximately 12:40 PM, Employees #1 (Administrator) and Employee #2 (Director of Nursing) were also made aware of the findings.