Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: _____ B. WING _____	02/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(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) COMPLETE DATE
L 000	Initial Comments The Annual Licensure Survey was conducted at Transitions Center from February 5, 2019 through February 11, 2019. Survey activities consisted of a review of 32 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 60. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date 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	L 000	**L 000**-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	

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L 000	Continued From page 1	L 000		

EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
G-tube- Gastrostomy tube
HR- Hour
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)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
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
Pt - Patient
Q- Every
QIS - Quality Indicator Survey
RD- Registered Dietitian
RN- Registered Nurse

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L 000	Continued From page 2 ROM Range of Motion RP R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observation, record review and staff interview for five (5) of 32 sampled residents, the charge nurse failed to develop and implement a comprehensive care plan for a Bi-level Positive	L 051	**L 051** **1. Corrective action for resident** Residents #19 and #59 no longer reside at the facility. Residents #24, #44, and #60 still reside in the facility. The residents that still reside in the facility have had their care plans reviewed and revised as appropriate to reflect their current needs. **2. Identify other residents** An audit of other residents in the facility was conducted to determine if other residents were affected by this practice. No other residents were identified. **3. Systemic changes** The interdisciplinary team has been educated by the Director of Nursing and/or the Director of Reimbursement on the policy of comprehensive care plan completion and revisions. New hires will be educated on the care plan policy at time of orientation. Care plans will be reviewed (revised as needed) by the IDT team on admission, changes in medications or treatments, significant changes (improvements or declines), quarterly, and prior to discharge.	

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L 051	Continued From page 3 Airway Pressure (BIPAP) machine for one (1) resident, dental care for one (1) resident, for nine (9)or more medications for one (1) resident, the use of a neck collar for one (1) resident and for respiratory therapy care for one (1) resident. Residents' #19, #24, #44, #59 and #60. Findings included . . . 1) Resident #19 was admitted to the facility on September 14, 2018, with diagnoses that included Dysphagia, Gastroesophageal Reflux Disease, Acute and Chronic Respiratory Failure, Hypoxemia, Heart Failure, Essential Hypertension, and Muscle Weakness. A review of the Quarterly Minimum Data Set (MDS) completed November 23, 2018, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Review of the Physician's orders directed, "Place BIPAP on at night until [Doctor's name] review ABG (arterial blood gases) at bedtime". A review of the care plans lacked person-centered goals and approaches to address the use of the BIPAP machine for Resident #19. During a face-to-face interview with Employee #3 at approximately 9:30 AM on February 11, 2019 she stated the resident uses the BIPAP but	L 051	**4. Monitor corrective actions** The Unit Managers will complete audits of 10 resident records weekly for care plan accuracy. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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L 051	Continued From page 4 sometime he refuses to wear it. Employee #3 further acknowledged that the care plans with goals and approaches to address the use of the BIPAP machine was not developed. 2.The charge nurse failed to develop and implement a comprehensive care plan for Resident #24's dental care needs. Resident #24 was admitted to the facility on December 3, 2016, with diagnoses which included Hypertension, Hyperlipidemia, Diabetes Mellitus, Dysphagia, Oropharyngeal Phase, Prostate Cancer, Gastroesophageal Reflux Disease and Major Depressive Disorder. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of December 15, 2018, showed Section C0500 a Brief Interview for Mental Status (BIMS) score of "14" which is an indication that the resident is cognitively intact and able to make decisions. Under Section L Oral/Dental Status L0200 Broken or loosely fitting or partial denture (chipped, cracked, uncleanable, or loose) and Mouth or facial, discomfort or difficulty with chewing was left blank, indicating there were no dental issues at the time of assessment for Resident #24. A review of the Physicians' order sheet from December 2018 to February 8, 2019 showed the following orders: "Dental follow up for crowning with [Dentist's Name] on 12/05/2018 at 12 PM" "Dental consult one time only until 01/02/2019" "Follow up a dental appointment with [Dentist's	L 051		

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L 051	Continued From page 5 Name] on 01/24/19 at 9:15 AM one time only for one day". A review of the Progress notes on February 8, 2019, at approximately 10:00 AM showed the following: "1/11/2019 at 15:15 Psychosocial note: Resident Broke his dental plate ..." "1/17/19 at 21:27 Psychosocial note: Resident has an appointment next week with the dentist to repair his dental plate." "1/25/19 at 12:34 Psychosocial note: Resident visited the dentist today and show off his bridge to the therapist." A review of the care plans on the clinical record showed evidence that the charge nurse failed to develop a care plan with person-centered goals and interventions to address the dental care for Resident #24." A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019, the employee acknowledged the findings. 3. The charge nurse failed to develop and implement a comprehensive care plan for Resident #44's use of nine (9) or more medications. Resident #44 was admitted to the facility on June 23, 2018, with diagnoses which include Chronic Respiratory Failure, Hypertension, Diabetes	L 051		

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L 051	Continued From page 6 Mellitus, Dysphagia, Oropharyngeal Phase, Gastroesophageal Reflux Disease, Acute Kidney Failure, Tracheostomy, Gastrostomy, and Colostomy. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of January 10, 2019, showed a Brief Interview for Mental Status (BIMS) score of "12" which is an indication that the resident is moderately cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident is totally dependent on two or more persons for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. He receives all enteral feeding and medication via gastrostomy tube. A review of Resident #44's Medication Administration Record on February 8, 2019, showed the following medications: Routine Medications 1. Lantus inject 12 unit subcutaneously at bedtime for Diabetes Mellitus 2. Humalog 100U [unit]/ml [millimeters] inject as per sliding scale subcutaneously with meals for Diabetes Mellitus 3. Multivitamin with minerals 5mg [milligrams] po [by mouth] one time a day for a supplement 4. Quetiapine Fumarate tablet 25mg give 2 tablets by mouth at bedtime for mood disorder 5. Divalproex 500mg give one tablet by mouth twice a day for mood disorder 6. Sertraline HCL [hydrochloride] tablet 25mg give 1 tablet by mouth one time a day for Depression	L 051		

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L 051	Continued From page 7 7. Zinc Sulfate give 1 capsule by mouth one time a day for wound healing 8. Ascorbic acid 500mg give 1 tablet by mouth two times a day for a wound healing 9. Ranitidine HCL 150mg give 1 tablet by mouth two times a day for GERD [Gastroesophageal Reflux Disease] 10. Tylenol 325mg give 2 tablets by mouth every day and every evening shift for pain 11. Aspirin 81 mg by mouth one time a day for DVT [Deep Vein Thrombosis] prophylaxis 12. Ergocalciferol Cap [capsule] 50000 unit give 1 capsule by mouth one time a day every Friday for a supplement 13. Ferrous Sulfate tablet give 325mg by mouth one time a day for a supplement 14. Thiamine tablet 100mg give 1 tablet by mouth one time a day for a supplement 15. Docusate sodium give 10 ml by mouth two times a day for bowel regiment 16. Lactobacillus tab 1 tablet by mouth three times a day for prophylaxis 17. Midodrine HCL 5 mg by mouth four times a day for Hypotension A review of the care plans on the clinical record showed evidence that the charge nurse failed to develop a care plan with person-centered goals and interventions to address the use of nine (9) or more medications for Resident #44. A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019. The employee acknowledged the findings. 4) Resident #59 was admitted to the facility on January 9, 2019, with diagnoses that included Quadriplegia, Anxiety Disorder, Acute and	L 051		

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L 051	Continued From page 8 Chronic Respiratory Failure, Dependence on Respirator [Ventilator] Status, Peripheral Vascular Disease, Hypothyroidism, Dysphagia and the resident has a gastrostomy tube. On February 6, 2019 at approximately 9:45 AM Resident #59 was observed wearing a neck collar while in bed. Review of the Physician's orders directed, "RN staff to remove c-collar q (every) shift and inspect skin for redness and pressure injuries. Support neck while turning and repositioning at all times ..." A review of the care plans lacked person-centered goals and approaches to address the use of the neck collar for Resident #59. During a face-to-face interview with Employee #3 at approximately 9:30 AM on February 11, 2019, she acknowledged that the care plans with goals and approaches to address the use of the neck collar was not developed. 5. The charge nurse failed to develop and implement a comprehensive care plan for Respiratory Therapy care for Resident #60. Resident #60 was admitted to the facility on September 7, 2018, with diagnoses, which include Acute and Chronic Respiratory Failure, Hypertension, Paraplegia, Epilepsy, Encephalopathy, Dysphagia, Oropharyngeal Phase, Gastrostomy, and Tracheostomy Status.	L 051		

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L 051	Continued From page 9 A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of December 15, 2018, under Section C Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of "3" indicating the resident's cognition was severely impaired (never /rarely made decisions). Under Section O, Special Treatments, Procedures and Programs Respiratory treatments were coded for "oxygen therapy, suctioning, and tracheostomy". A review of the Physicians' order sheet on February 8, 2019, showed the following: "FIO2 (Fraction of inspired oxygen): 28...Trach Size: 6 every shift for Respiratory Failure related to Acute and Chronic respiratory failure Unspecified whether with Hypoxia or Hypercapnia Wean FIO2 as tolerated and to keep sats [saturations] greater than 92%" "Trach care every shift and PRN every shift". A review of the care plans on the clinical record showed that the charge nurse failed to develop a care plan with person-centered goals and interventions to address Resident #60's Respiratory therapy care. A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019. The employee acknowledged the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each	L 052		

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L 052	Continued From page 10 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; (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;	L 052	**L 052** **1. Corrective action for resident** Resident #58 still resides in the facility. The resident has been shaven. **2. Identify other residents** A review of other residents in the facility did not reveal any additional residents with unmet grooming needs. **3. Systemic changes** The CNAs Have been in-serviced on the importance of routine ADL care. Licensed staff have been in-serviced on monitoring residents for unmet ADL grooming needs. Residents will be assessed during rounds and any concerns brought to the attention of the CNA for correction. **4. Monitor corrective actions** The Unit Managers will complete audits of 10 resident records weekly for ADL care. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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L 052	Continued From page 11 (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 an observation, record review and staff interview for one (1) of 32 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain good grooming for Resident #58 who was observed unshaven for several days. Findings included ... A review of Resident #58's Admission Minimum Data Set (MDS) dated January 23, 2019, revealed that the resident was coded as severely cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene]. On February 5, 2019, at 3:06 PM Resident #58 was observed lying in bed unshaven. On February 6, 2019, at approximately 10:00 AM, Resident #58 was again observed lying in bed unshaven. After a face-to-face interview with Employee #2 on February 6, 2019 at 10:15 AM, she acknowledged the findings after observing the residents unshaven status.	L 052		

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L 052	Continued From page 12 Facility staff failed to carry out activities of daily living necessary to maintain grooming for Resident #58.	L 052		
L 055	3211.4 Nursing Facilities Beginning January 1, 2011, each facility shall have either a physician, physician assistant, or an advanced practice registered nurse, excluding hours per week attributed to medical director duties, available on-site for a minimum of two tenths (0.2) hours per week for each resident at the facility. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per resident day hours], it was determined that the Nursing Facility failed to meet the 4.1 hours of direct nursing care per resident per on three (3) of the fourteen (14) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels." Findings included... "Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenth (0.6) hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.	L 055	**L 055** **1. Corrective action for resident** The staffing coordinator and Director of Nursing have been in-serviced on how to calculate the direct nursing care hours to ensure at least 4.1 hours of direct nursing care per resident per day and at least 0.6 hours of those hours in RN hours per patient per day. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** The Director of Nursing will review the nursing schedule prior to each weekend and holiday to ensure enough nursing coverage is available to meet the 4.1 hours of direct nursing care required. In addition, the nursing leadership will be on-call to come in and work in the event staff call outs cause the direct care staffing to fall below 4.1 hours per resident per resident per day. The Administrator will be contacted by the Director of Nursing for additional resources as needed to ensure appropriate staffing ratios.	

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L 055	Continued From page 13 The following days did not meet the required hours of direct nursing care per resident: January 27, 2019 - 3.8 hours of direct nursing care per resident February 3, 2019 - 4.0 hours of direct nursing care per resident February 4, 2019 - 3.7 hours of direct nursing care per resident The findings were acknowledged during a face-to-face interview Employee #1 on February 11, 2019, at approximately 3:00 PM.	L 055	**4. Monitor corrective actions** The Director of Nursing will complete audits of schedules as worked weekly for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
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 record review and staff interview the facility failed to develop a system of surveillance to identify track and monitor infections or communicable diseases within the facility; failed to maintain one (1) of one (1) ice machine on the 3 West resident care unit in clean condition, and failed to conduct a facility risk assessment to identify where Legionella and other waterborne pathogens could grow and multiply. The facility census on the first day of survey 60. Findings included... 1. The facility staff failed to develop a system of surveillance to identify track and monitor	L 091		

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	HFD02-0023	A. BUILDING: _____ B. WING _____	02/11/2019

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L 091	Continued From page 14 infections or communicable diseases within the facility. On February 7, 2019, at approximately 1:45 PM a review of the facilities infection prevention and control program was conducted. At this time, it was noted that the surveillance documentation presented was not a systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. Infectious surveillance data for April and May 2018, showed that the data was not used for staff education to help minimize the spread of the infection (e.g., staff education and competency assessment). Employees' # 1 and # 11 acknowledged the findings during a face-to-face interview on February 7, 2019, at approximately 1:45 PM. 2. One (1) of one (1) ice machine on West was soiled with mineral deposits at the tip of the water dispenser. Employee #8 acknowledged the finding during a face-to-face interview on February 6, 2019, at approximately 4:15 PM 3. A review of the facility's water management program on February 11, 2019, at approximately 1:55 PM showed that a facility risk assessment that identifies areas where water borne pathogens such as legionella could grow and spread in the facility's water system was not available.	L 091	**L 091** **1. Corrective action for resident** No residents were affected. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** The Infection Preventionist has been educated by the Director of Quality on the requirements of the role with regard to surveillance to identify, track, and monitor infections or communicable diseases within the facility. New tools have been created to facilitate facility surveillance activities. The findings will be reported monthly to the QAPI committee. **4. Monitor corrective actions** The Director of Quality will complete monthly audits of the Infection Control reports. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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L 091	Continued From page 15 Employee #9 acknowledged the finding during a face-to-face interview on February 11, 2019, at approximately 2:00 PM.	L 091	**L 099** **1. Corrective action for resident** The ham, scalloped potatoes, and puree pork were discarded and the residents were served foods at the appropriate temperatures. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** Dietary staff have been re-educated on the proper techniques to ensure that foods are served at the appropriate temperatures. The dietary manager/shift supervisor will monitor food temperatures during each meal service. **4. Monitor corrective actions** The Dietary Manager will complete weekly audits of 3 random tray temperatures for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 140 degrees Fahrenheit (F) on six (6) of 12 observations. Findings included ... During a food test tray assessment on February 8, 2019, at approximately12:45 PM, hot foods such as Ham (117 F), scalloped potatoes (121 F), puree pork (131 F), green beans (135 F), puree potatoes (137 F) and puree green beans (138 F) tested below 140 degrees Fahrenheit (F). These observations were acknowledged by Employee #7 during a face-to-face interview on February 8, 2019, at approximately 1:00 PM.	L 099		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the	L 128		

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L 128	Continued From page 16 Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on staff interview and a review of records, it was determined that the facility failed to ensure that in-service training for nursing personnel was conducted by a pharmacist. The findings include: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3224 Supervision of Pharmaceutical Services (3c). "The supervising pharmacist shall provide a minimum of two (2) in services sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications..."	L 128	**L 128** **1. Corrective action for resident** The pharmacy has been contacted to schedule the required in-services for staff. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** Administrative staff have been educated on the requirement for the pharmacy to provide a minimum of two in-service sessions per year to all nursing staff. The training must include one session on indications, contraindications, and possible side effects of commonly used medications. The training requirements have been added to the education calendar. **4. Monitor corrective actions** The Administrator will complete quarterly audits of the educational calendar for compliance. The results will be reported to the QAPI Committee monthly x 6 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 128	Continued From page 17 A review of the in-service training files revealed no pharmacy in-services were provided during the survey look back period, in accordance with state law that included indications, contraindications, and possible side effects of commonly used medications." During a face-to-face interview conducted on May 30, 2017, Employee # 11 acknowledged the findings.	L 128		
L 157	3227.8 Nursing Facilities Each refrigerator that is used for storage of medication shall operate at a temperature between thirty-six degrees (36°F) and forty-six (46°F) Fahrenheit; each refrigerator shall be equipped with a thermometer that is easily readable, accurate and in proper working condition. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, facility staff failed to ensure that medication refrigerator temperature logs that were not within the facility's acceptable range were reported according to the facility's plan of correction to safely store refrigerated medicine in one (1) of two (2) medication refrigerators observed. Findings included... A review of the 3West Medication Refrigerator log on February 11, 2019, at 11:00 AM showed the	L 157	**L 157** **1. Corrective action for resident** The medication refrigerator has been checked by Plant Operations and is within required range. **2. Identify other residents** Every resident on 3 West has the potential to be affected by this alleged practice. **3. Systemic changes** Licensed nurses have been re-educated on the protocol for ensuring refrigerator temperatures are within range. The refrigerators will be checked every shift by a charge nurse. If a temperature is noted out of range, it must be addressed immediately. The charge nurse should contact the Unit Manager or Supervisor to follow up with Plant Operations. Actions taken are to be documented on the log sheet for reference. **4. Monitor corrective actions** The Unit Managers will complete daily audits of refrigerator logs for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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L 157	Continued From page 18 refrigerator temperature ranges for January 2019 and February 2019 as follows: January 13, 14, 15, 16, 18, 23, 24, 25, 28, and 30, 2019, refrigerator was out of range (below 34 degrees Fahrenheit). No comment made as to the action taken. January 1, 3, 4, 6, 9, 16, 19, 20, 21, 22, 23, and 26, 2019, freezer temperature was out of range (above 10 degrees Fahrenheit). No comment made as to the action taken. February 8 and 11, 2019, refrigerator temperatures were out of range (below 34 degrees Fahrenheit). No comment made as to the action taken. According to the facility plan of action written at the bottom of the Medicine Refrigerator log form, the instructions directed: "Freezer temperature: 0-10 Degrees" "Refrigerator Temperature: 34 - 44 Degrees" "Report to Maintenance and RCC (resident care coordinator) if temperature is out of range" Facility staff on 3West unit failed to ensure the medication refrigerator temperature logs that were out of range were reported according to the facility's plan of correction as evidenced by the comment section left "blank" indicating, nothing was done to report the temperatures that were out of range.	L 157		

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L 157	Continued From page 19 A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 11, 2019. The employee acknowledged the findings that there was no documented evidence on the reported action taken.	L 157		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by marred doors and door jambs in twelve (12) of 40 resident's rooms, a clogged bathroom sink in one (1) of 40 resident's rooms, one (1) of one (1) soiled ice machine on one (1) of two (2) resident care units and a loose water faucet from the hand sink in one (1) of 40 resident's rooms. During an environmental tour of the facility on February 6, 2019 between 12:55 PM and 4:15 PM the following observations were made: 1. Entrance doors and door jambs to twelve (12) of 40 resident's rooms were marred, specifically rooms #301, 317, 318, 320, 330, 331, 332, 334, 335, 341, 342, 343, the entrance door to the dayroom on 3 West and one (1) of two (2) entrance doors to the dayroom on 3 East.	L 410	**L 410** **1. Corrective action for resident** Resident Rooms #301, 317, 318, 320, 330, 331, 332, 334, 335, 341, 342, 343 and entrance door to the dayroom on 3 West and the entrance door to the dayroom on 3 East have been re-painted. The bathroom sink in room 335 has been unclogged. The ice machine on 3 West has been cleaned. The faucet in room 314 has been tightened. **2. Identify other residents** An audit of resident room doors, dayroom doors, sinks, and faucets was conducted by the Director of Plant Operations to determine if other residents were affected by this alleged practice. There were no additional findings related to this citation. **3. Systemic changes** Plant operations staff have been educated on the importance of environmental rounds/inspections and subsequent follow up. The Director of Plant Operations will be responsible for validating environmental rounds/inspections and subsequent follow up on findings.	

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L 410	Continued From page 20 2. The bathroom sink was clogged in resident room #335, one (1) of 40 resident's rooms. 3. One (1) of one (1) ice machine on West was soiled with mineral deposits at the tip of the water dispenser. 4. The water faucet from the hand sink was loose in resident room #314, one (1) of 40 resident's rooms. Employee #8 acknowledged the findings during a face-to-face interview on February 6, 2019, at approximately 4:15 PM.	L 410	**4. Monitor corrective actions** The Director of Plant Operations will complete audits of all environmental rounds/inspections to assess compliance with follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain essential equipment in safe condition as evidenced by nine (9) of 18 resident's wheelchairs that were observed with various mechanical concerns. Findings included ... During an evaluation of resident's wheelchairs on February 7, 2019, at approximately 11:00 AM, nine (9) of 18 wheelchairs were observed with torn armrests, loose armrests, loose brakes and worn out wheels. During a face-to-face, interview on February 7, 2019, at approximately 11:00 AM, Employee #8 revealed that the facility does not stock wheelchair spare parts and does not maintain the	L 442	**L 442** **1. Corrective action for resident** The 18 residents that use wheelchairs were assessed for appropriate seating and positioning by the rehabilitation department. Their wheelchairs have been either repaired or replaced. **2. Identify other residents** No others residents were affected. **3. Systemic changes** The Rehabilitation, Plant Operations, Therapeutic Recreation, and Nursing staff have been educated on identifying wheelchairs in need of repairs, the process for reporting, repairing, and replacing wheelchairs.	

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	HFD02-0023	A. BUILDING: _____ B. WING _____	02/11/2019

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L 442	Continued From page 21 wheelchairs. Employee #8 acknowledged the findings during a face-to-face interview on February 7, 2019, at approximately 11:00 AM.	L 442	**4. Monitor corrective actions** The Director of Rehabilitation will complete monthly audits of the condition of resident wheelchairs. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
L 519	3269.1b Nursing Facilities (b) To be fully informed by the nursing facility of all resident rights and all facility rules governing resident conduct and responsibilities upon admission and annually thereafter; This Statute is not met as evidenced by: Based on record review and staff interview for four (4) of 32 sampled residents, the facility staff failed to ensure residents and or their representatives received and signed an admissions contract/packet upon the residents admission to the facility. Residents' #8, #19, #61 and #112. Findings included ... The facility's Admission Agreement Policy Statement dated 12/17/2018, stipulates, "All residents have a signed and dated Admission Agreement on file...Policy Interpretation and Implementation: 1) At the time of admission, the resident (or his/her representative) must sign an Admission Agreement (contract). 2) The Admission Agreement (contract) will reflect all charges for covered and non-covered items, as well as identify the parties that are responsible for the payment of such services. 4) A copy of the Admission Agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident's permanent file."	L 519	**L 519** **1. Corrective action for resident** Residents #8, # 19, #61, and #112 no longer reside in the facility. All of the responsible parties for the residents were contacted in attempts to complete the Admissions Agreement. **2. Identify other residents** All resident records were audited for completed admissions agreements. Resident representatives were contacted for any resident that did not have a completed Admissions Agreement on file. All residents and/or their representatives in the facility at the time of the identification of this issue was given a copy of the resident's rights.	

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	HFD02-0023	A. BUILDING: _____ B. WING _____	02/11/2019

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L 519	Continued From page 22 Review of resident files showed the following: 1)Resident #61 was admitted to the facility on December 31, 2018, with diagnoses that included Anemia, Gastroesophageal Reflux Disease, Benign Prostatic Hyperplasia, Diabetes Mellitus, Respiratory Failure, and Dependence on Respirator [Ventilator] Status. At the time of this review, February 7, 2019 (38 days post admission to the facility) the resident did not have a signed Admission's contract on his electronic health record or paper chart. 2) Resident #8 was admitted to the facility on September 14, 2018, with diagnoses that included Fracture of Right Lower Leg, Major Depressive Disorder, Dysphagia, Essential Hypertension, Sleep Apnea, Unspecified Atrial Fibrillation, and Chronic Respiratory Failure. At the time of this review, February 7, 2019 (146 days post admission to the facility) the resident did not have a signed Admission's contract on her electronic health record or paper chart. 3) Resident #19 was admitted to the facility on September 14, 2018, with diagnoses that included Dysphagia, Gastroesophageal Reflux Disease, Acute and Chronic Respiratory Failure, Hypoxemia, Heart Failure, Essential Hypertension, and Muscle Weakness. At the time of this review, February 7, 2019 (146 days post admission to the facility) the resident did not have a signed Admission's contract on his electronic health record or paper chart. 4) Resident #112 was admitted to the facility on	L 519	**3. Systemic changes** Admissions and Business Office staff have been educated by the Administrator on the Admission Agreement policy and expectations for completion and documentation of attempts to review Admissions Agreement. The Administrator will be notified of any barriers to completing the Admissions Agreements timely for guidance and assistance. The Admissions/Business Office will reach out to perspective resident and/or their representative to schedule a meeting prior to admission whenever possible. If they are unable to meet prior to the admission, the appointment will be scheduled for the earliest available date during the first 24-48 hours of admission. In cases of extreme hardship, the Admissions agreement will be mailed, faxed, or emailed per the representative's direction. A staff member will be available for telephone consultation to address any questions that might come up regarding the Admissions Agreement. **4. Monitor corrective actions** The Business Office Manager will complete audits of all new admissions to assess compliance with completion of Admissions Agreements weekly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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L 519	Continued From page 23 January 30, 2019, with diagnoses that included Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia and Dependence on Respirator [Ventilator] Status, Atrial Fibrillation, Hypothyroidism, Anemia, and Pulmonary Hypertension. At the time of this review, February 7, 2019, (8 days post admission to the facility) the resident did not have a signed Admission's contract on her electronic health record or paper chart. There was no evidence the facility staff had provided the resident and or their responsible party with the Admission's contract/packet disclosing to them notice of special characteristics or service limitations of the facility upon admission. During a face-to-face interview with Employee #10 Admissions Supervisor on February 7, 2019, at 11:10 AM , she acknowledged the findings.	L 519		