Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB OF	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

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L 000	Initial Comments The Annual Licensure Survey was conducted at Brinton Woods of Washington DC from August 11, 2016 through August 18, 2016. Survey activities consisted of a review of 35 sampled residents. The following deficiencies are based on observation, record review and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters C. Diff - Clostridium Difficile CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Infectious Disease ID - Intellectual disability IDT - interdisciplinary team	L 000	Please begin typing your responses here: Brinton Woods of Washington D.C. LLC, "BWDC" is filing this Plan of Correction in accordance with the Compliance requirements for Federal and State regulations. This Plan of Correction constitutes the Facility's written allegation of Compliance for deficiencies cited. However submission of this Plan of Correction does not constitute Admission of facts or conclusions Cited.	

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L 000	Continued From page 1 L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set mcg/act - microgram/actuation 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 NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 026	3207.1 Nursing Facilties The Medical Director shall assume full responsibility for the overall supervision of the medical care provided in the facility. If the Medical Director is absent, he or she shall delegate the continuity and supervision of resident care to a qualified physician. This Statute is not met as evidenced by:	L 026		

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L 026	Continued From page 2 Based on record review and staff interview for one (1) of 35 Stage 2 sampled residents , it was determined that the physician failed to follow through on one (1) resident ' s diagnostic test. Resident #45. The findings include: An interim physician's order dated January 4, 2016 at 12:20 PM directed: " Psychiatry- F/U (Follow-up) for Resident ' s risperidone [secondary to] elevated prolactin level (hormone level made by the pituary gland)- 38.23 (high); (normal range-1.8-20.3) done on 12/21/15. " A review of the clinical record revealed: " Report of Consultation " [not dated], From: [Attending physician named], Report requested regarding: Psychiatry [follow-up] for resident ' s risperidone use secondary to elevated prolactin level 38.23 (1.8-20.3) done on 12/21/15; Report: Findings: Will see today 1/11/16 ... [psychiatry signature] ... " A review of the psychiatry notes revealed the following: December 28, 2016- ... Axis I- Schizophrenia -Trileptal 150mg po bid for mood stabilization, Follow up in 2 weeks January 19, 2016- ...Axis I: Schizophrenia- Continue current treatment, Follow up in [a] month March 28, 2016- ... Axis I: Schizophrenia- Continue current treatment, Follow up in a month June 13, 2016 ... Axis I: Schizophrenia, continue current treatment, Follow up in one month ... " A review of the attending physician ' s notes from January 2016 to August 2016 revealed no documentation regarding the resident ' s elevated	L 026	1. Resident #45 elevated prolactin level has been addressed by the attending physician and psychiatric physician. 2. Pharmacy consultation reports will be audited to ensure recommendations have been addressed by the attending physician and/or other physicians. 3. DON and/or designee to train Nurse Managers to audit pharmacy consultation reports to ensure the recommendations have been addressed. 4. The audits will be done for the next three months then quarterly x2. The results of the audits will be submitted to the QA Committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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L 026	Continued From page 3 prolactin level. There was no evidence in the clinical record that the attending and psychiatric physician followed up to review the status of the elevated prolactin level. A face-to-face interview was conducted with Employees #5 and #19 on August 17, 2016 at approximately 11:20 AM regarding the aforementioned findings. Both acknowledged the findings. Employee #19 stated he/she will follow-up. The clinical record was reviewed on August 17, 2016.	L 026		
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	L 051	1. Residents #39 and #160 Care plans have been updated with goals and approaches to address the impaired vision and behavioral symptoms respectively. 2. Care plans will be audited to ensure goals and approaches address residents' comprehensive assessment. 3. The Nurse Educator and/or designee will educate Nurse Managers and Charge Nurses on developing goals and approaches to address residents' comprehensive assessment. 4. The ADON and/or designee will audit care plans monthly X 3 months then quarterly x2. The MDS Coordinator will randomly audit care plans monthly and notify DON of discrepancies. Results of audits will be submitted to the QA committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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L 051	Continued From page 4 (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 record review and staff interview for three (3) of 35 Stage 2 sampled residents, it was determined that the charge nurse failed to initiate a care plan with goals and approaches to address one (1) resident ' s impaired vision and one (1) resident's behavioral symptoms; to review and revise review one (1) resident's care plan to reflect an integrated approach with the participation of hospice, the facility, and the resident or representative to the extent possible and to ensure that the residents medical record was inclusive of Hospice documents. Residents' #39 and #160, #195. The findings include: 1. The charge nurse failed to initiate a care plan with goals and approaches for Resident #39 who had impaired vision and was diagnosed with Cataract. A review of an Eye Exam Consultation Record dated January 28, 2016 revealed the following diagnosis and treatment: " Age related nuclear cataract, bilateral - Cataracts - OU [each eye or both eye]- moderate/dense --- monitor 6 mos[months]/PRN [as needed]. " A review of the Annual MDS (Minimum Data Set) dated March 9, 2016 revealed that Resident #39 in Section B1000 " Vision " is coded as " Impaired " . Section V Care Area Assessment Summary revealed in care area #4 "Visual Function" that a check mark was placed in the boxes allocated for "Care Area triggered" and "Care planning decision" indicating "care plan	L 051		

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L 051	Continued From page 5 needed." A review of the clinical record lacked evidence of a careplan initiated with goals and approaches to address Resident #39's impaired vision. A face-to-face interview was conducted on August 17, 2016 at approximately 11:05 AM with Employee #4 who acknowledged the aforementioned findings. The record was reviewed on August 17, 2016. 2. The charge nurse failed to initiate a care plan with goals and approaches to address Resident #160's behavioral symptoms. A history and physical dated February 20, 2016 revealed Resident #160's diagnoses included: " Hypertension, Seizure Disorder, Status Post Brain Abscess ... Neurological: Poor, uncooperative [with] exam ... " An admission MDS (Minimum Data Set) dated February 26, 2016 revealed Section E0800 Behavioral Symptoms (rejection of care) was one of the triggered care areas to be addressed in the care plan. A review of Resident #160 ' s comprehensive care plan lacked evidence of a care plan with goals and approaches to address the resident ' s behavioral symptoms. A face-to-face interview was conducted with Employee #3 on August 17, 2016 at approximately 11:20 AM. After review of the aforementioned he/she acknowledged the findings. The clinical record was reviewed on August 17, 2016.	L 051		

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L 051	Continued From page 6 3a. The charge nurse failed to review and revise Resident #195's care plan to reflect an integrated approach with the participation of hospice, the facility, and the resident or representative to the extent possible. A review of the Physician's Order Sheet dated November 8, 2015 directed: Admit to [Hospice Agency Name]. Hospice start date [November 13, 2015]. A review of the resident's care plan revealed a care plan for " Resident has a terminal prognosis r/t [related/to] [Diagnosis named] " with goals and approaches initiated November 9, 2015. However, the care plan lacked specific identification of the disciplines responsible for the approaches/interventions with hospice, the facility, resident or the responsible party. A face-to-face interview was conducted on August 16, 2016 with Employee #4. After review of the aforementioned he/she acknowledged the findings. 3b. The charge nurse failed to ensure that the residents medical record was inclusive of Hospice documents for one (1) resident. Resident #195. A review of the Physician's Order Sheet dated November 8, 2015 directed: Admit to [Hospice Agency Name]. Hospice start date [November	L 051	1. Resident #195 care plan has been updated. 2. All residents receiving Hospice services care plans will be audited to ensure disciplines and/or teams responsible for implementing interventions of the hospice care plan are identified. 3. Hospice will attend care plans and care plans will be reviewed with the interdisciplinary team during the resident's first scheduled care plan meeting. 4. ADON and/or designee will audit care plans monthly x 3 months then quarterly x2. The results of the audits will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/02/16

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L 051	Continued From page 7 13, 2015.] After further review of the medical record there was no evidence that the hospice " Initial Nursing Assessment, and the Physician ' s Plan of Care " was readily accessible on the active clinical record. A face-to-face interview was conducted on August 16, 2016 with Employee #4. After review of the aforementioned he/she acknowledged the findings and had the documents faxed to the facility. The record was reviewed on August 16, 2016.	L 051		
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	L 052	1. Nurse administering the Flovent HFA Inhaler has been in-serviced on how to properly administer Flovent HFA Inhaler. Resident #109 physician order has been clarified. The resident will rinse with thickened water after receiving the inhaler. 2. All residents receiving Flovent HFA Inhaler be identified and times of administration. Residents receiving Flovent Inhaler will be reviewed to ensure they are receiving instructions to rinse their mouths after the medication is administered.	10/02/16

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L 052	Continued From page 8 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; (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 observation, record review and staff interview for two (2) of 35 Stage 2 sampled residents, it was determined that sufficient nursing time was not given to clarify physician's orders to rinse the resident's mouth following an oral aerosol inhalation and failed to administer an oral aerosol inhalation treatment per the manufacturer ' s specifications for one (1) resident; and failed to follow through on an Infectious Disease [ID] appointment for one (1) resident. Residents' #109 and #160. The findings include:	L 052	3. The Nurse Educator and/or Designee will educate/train licensed nursing staff on proper administration of Flovent to include resident rinsing his/her mouth after the inhalation is administered. Nurse Managers will randomly observe licensed nurses administering Flovent HFA Inhaler and report findings to DON. 4. ADON and/or designee will audit residents receiving Flovent Inhaler for next 3 months to ensure they are rinsing after the medication is administered. Pharmacy Services will send a list of residents receiving Flovent monthly to DON for the next 3 months then quarterly x2. The Nurse Educator and/or Nurse Managers will observe mediation pass on licensed nurses administering Flovent Inhaler monthly x3 months then quarterly X2. The results of the medication administration observation will be submitted to the QA Committee. The QA committee will determine the need for further actions.	10/02/16

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L 052	Continued From page 9 According to " GlaxoSmithKline Company-www.flovent.com " ; Revised July 2016-pp 33-35; stipulates: " How to use your Flovent HFA inhaler ... Step 2. Hold the inhaler with the mouthpiece down [canister should be pointed upward] ... Step 7. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it..." 1a. Sufficient nursing time was not given to clarify physician's orders to rinse Resident #109's mouth following an oral aerosol inhalation treatment. On August 11, 2016 at approximately 10:10 AM, Employee #18 was observed administering an oral inhalation aerosol to Resident #109. Resident #109 had a physician ' order for Flovent HFA (Hydrofluoroalkane- propellant in the inhaler) 110 mcg/act (micrograms)/(actuation) - 1 puff inhale orally two times a day for SOB (shortness of breath) (After administration of flovent, monitor resident to rinse mouth with water and spit completely.) The employee administered Resident #109 one (1) puff from the Flovent inhaler. After administering the inhaler, the employee did not instruct resident to rinse his/her mouth with water. A face-to-face interview was conducted with Employee #18 at approximately 10:00 AM. He/she was queried regarding not having the resident rinse with water and spit after administering the flovent. He/she replied, that since the resident is on aspiration precautions, [she/he] is not instructed to rinse with water because of the possibility of the resident	L 052	1. Resident #160 has been discharged from the facility therefore we are unable to reschedule the appointment. 2. Current residents' medical records will be reviewed for scheduled and unscheduled medical appointments. 3. Nurse Educator and/or designee will in-service Unit Clerks, Charge Nurses and Team Leaders on importance of setting up medical appointments for residents. The in-service will also include how to reschedule missed appointments and required documentation. 4. ADON and Nurse Managers will audit residents' appointments for the next three months then quarterly x2. The results of the audits will be submitted to the QA Committee. The QA Committee will determine the need for the further audits or actions.	10/02/16

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L 052	Continued From page 10 swallowing it. Sufficient nursing time was not given to clarify physician's orders to rinse Resident #109's mouth following an oral aerosol inhalation treatment. The observation and record review were conducted on August 11, 2016. 1b. sufficient nursing time was not given to administer an oral aerosol inhalation treatment per the manufacturer ' s specification. Resident #109 On August 11, 2016 at approximately 10:10 AM, Employee #18 was observed administering an oral inhalation aerosol treatment to Resident #109. Resident #109 had a physician's order for Flovent HFA (Hydrofluoroalkane- propellant in the inhaler) 110 mcg/act - 1 puff inhale orally two times a day for SOB (shortness of breath) (After administration of flovent, monitor resident to rinse mouth with water and spit completely). Employee #18 instructed the resident to take a deep breath in and out. Proceeded to position the mouthpiece of the inhaler in the resident's mouth in an upward position [with the canister pointed downward]. A face-to-face interview was conducted with Resident #109 after the medication was administered. A query was made, if he/se felt the effect of the medication? He/she responded, "Yes, I felt it going down." A face-to-face interview was conducted with Employee #18. He/she was queried regarding the	L 052		

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L 052	Continued From page 11 correct positioning of the mouthpiece of the inhaler in the resident's mouth. He/she stated, "It should be positioned with the mouthpiece in the down position[with the canister in the upward position]. That's the way I usually administer it." The observation and record review were conducted on August 11, 2016. 2. Sufficient nursing time was not given to follow through on an infectious disease appointment for Resident #160. A history and physical dated February 20, 2016 revealed Resident #160 ' s diagnoses included: " Hypertension, Seizure Disorder, Status Post Brain Abscess, HIV (Human Immunodeficiency Virus), and AIDS (Autoimmune Deficiency Syndrome) ... " The physician's order sheet and plan of care dated February 20, 2016 directed: " Abacavir (antiretrovirals) 300mg on (1) tab po (by mouth) daily for HIV, Lamivudine (antiretrovirals) 150mg (milligram)- 15ml (milliliters) po daily for HIV and Lopinavir-ritonavir (antiretrovirals)- two (2) tablets po BID (twice a day) for HIV ... " A review of the March 8, 2016 pharmacy consultation report read: " [Resident ' s name] .... receives antiretroviral therapy, Abacavir, Epivir, Kaletra.. The following monitoring plan for antiretroviral therapy is recommended .... (1) continuous therapy: CD4 count and viral load ... . Physician ' s response: I accept the recommendations(s) with the following modifications: [Patient with ID [Infectious Disease] [follow-up]. Will [check] ID notes. Follow up ID on March 22, 2016. "	L 052		

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L 052	Continued From page 12 An infectious disease consult dated: March 8, 2016 revealed: " Plan: RTC (Return to clinic)- 2 weeks ... " According to a nurse ' s note dated March 28, 2016 -1446 (2:46 PM)- " F/U with infectious disease on March 28, 2016 with [MD named] ... Appointment rescheduled..." A review of the medical record lacked evidence that the facility followed through on the infectious disease recommendation to return in two (2) weeks. A face-to-face interview was conducted with Employee #3 regarding the resident ' s follow-up ID appointment. He/she acknowledged the findings. The clinical record was reviewed on August 17, 2016.	L 052		
L 056	3211.5 Nursing Facilities 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 tenths (0.6) hours 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. This Statute is not met as evidenced by: Based on record review and staff interview during a staffing review [direct care per resident day hours], it was determined that the facility failed to meet 0.6 [six tenth] hour for Registered	L 056		

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L 056	Continued From page 13 Nurses/APRN [Advanced Practice Registered Nurse] hours on twenty five of the twenty five days and four and one tenth (4.1) hours of direct nursing care per resident per day for twenty one of twenty five days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings include: A review of Nurse Staffing was conducted on August 18, 2016 at approximately 10:50AM. Twenty-five days were reviewed; July 24, 2016 through August 17, 2016. According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 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. The facility failed to meet the 0.6 [six tenth] hour of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] for twenty-five days reviewed as outlined below. On Sunday, July 24, 2016 it was determined that the facility provided RN coverage at a rate of 0.36 hours of direct nursing care per resident day.	L 056	1. We constantly recruit for nursing staff in all categories-RNs, LPNs and CNAs. We scheduled job fairs on a frequent basis. Nursing care is provided 24 hours a day. All nursing staff participates in the care of the residents to meet their needs up to and including ADON/DON. 2. Staffing is reviewed weekly by facility management on a regular basis regarding recruitment and retention efforts. Human Resources conduct exit interviews to ascertain reason for leaving employment at BWDC. 3. Recruitment efforts, such as job fairs and incentives, and results are being audited for effectiveness by the Human Resources Director. Results of the efforts are reported to the team during the weekly meetings and during QA. 4. Vacancies, Recruitment efforts, retention rates are discussed in QA Committee monthly. The vacancy rate and retention rates are submitted to the QA Committee. The QA committee evaluates how to recruit and retain nursing staff; QA Committee will determine the need for further audits and actions.	10/02/16

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L 056	Continued From page 14 On Monday, July 25, 2016 it was determined that the facility provided RN coverage at a rate of 0.45 hours of direct nursing care per resident day. On Tuesday, July 26, 2016 it was determined that the facility provided RN coverage at a rate of 0.46 hours of direct nursing care per resident day. On Wednesday, July 27, 2016 it was determined that the facility provided RN coverage at a rate of 0.50 hours of direct nursing care per resident day. On Thursday, July 28, 2016 it was determined that the facility provided RN coverage at a rate of 0.50 hours of direct nursing care per resident day. On Friday, July 29, 2016 it was determined that the facility provided RN coverage at a rate of 0.51 hours of direct nursing care per resident day. On Saturday, July 30, 2016 it was determined that the facility provided RN coverage at a rate of 0.28 hours of direct nursing care per resident day. On Sunday, July 31, 2016 it was determined that the facility provided RN coverage at a rate of 0.28 hours of direct nursing care per resident day. On Monday, August 1, 2016 it was determined that the facility provided RN coverage at a rate of 0.48 hours of direct nursing care per resident day.	L 056		

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L 056	Continued From page 15 On Tuesday, August 2, 2016 it was determined that the facility provided RN coverage at a rate of 0.47 hours of direct nursing care per resident day. On Wednesday, August 3, 2016 it was determined that the facility provided RN coverage at a rate of 0.42 hours of direct nursing care per resident day. On Thursday, August 4, 2016 it was determined that the facility provided RN coverage at a rate of 0.53 hours of direct nursing care per resident day. On Friday, August 5, 2016 it was determined that the facility provided RN coverage at a rate of 0.58 hours of direct nursing care per resident day. On Saturday, August 6, 2016 it was determined that the facility provided RN coverage at a rate of 0.43 hours of direct nursing care per resident day. On Sunday, August 7, 2016 it was determined that the facility provided RN coverage at a rate of 0.43 hours of direct nursing care per resident day. On Monday, August 8, 2016 it was determined that the facility provided RN coverage at a rate of 0.47 hours of direct nursing care per resident day. On Tuesday, August 9, 2016 it was determined that the facility provided RN coverage at a rate of 0.48 hours of direct nursing care per resident day.	L 056		

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L 056	Continued From page 16 On Wednesday, August 10, 2016 it was determined that the facility provided RN coverage at a rate of 0.58 hours of direct nursing care per resident day. On Thursday, August 11, 2016 it was determined that the facility provided RN coverage at a rate of 0.48 hours of direct nursing care per resident day. On Friday, August 12, 2016 it was determined that the facility provided RN coverage at a rate of 0.57 hours of direct nursing care per resident day. On Saturday, August 13, 2016 it was determined that the facility provided RN coverage at a rate of 0.43 hours of direct nursing care per resident day. On Sunday, August 14, 2016 it was determined that the facility provided RN coverage at a rate of 0.38 hours of direct nursing care per resident day. On Monday, August 15, 2016 it was determined that the facility provided RN coverage at a rate of 0.57 hours of direct nursing care per resident day. On Tuesday, August 16, 2016 it was determined that the facility provided RN coverage at a rate of 0.52 hours of direct nursing care per resident day. On Wednesday, August 17, 2016 it was determined that the facility provided RN coverage at a rate of 0.52 hours of direct nursing care per	L 056		

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L 056	Continued From page 17 resident day. The facility failed to meet four and one tenth (4.1) hours of direct nursing care per resident per day for twelve of nineteen days reviewed as outlined below. On Sunday, July 24, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.29 hours. On Monday July 25, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.79 hours. On Tuesday, July 26, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.02 hours. On Wednesday, July 27, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.79 hours. On Friday, July 29, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.90 hours. On Saturday, July 30, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.34 hours. On Sunday, July 31, 2016 it was determined that the facility provided direct nursing care coverage	L 056		

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L 056	Continued From page 18 at a rate of 3.71 hours. On Monday, August 1, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.09 hours. On Tuesday, August July 2, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.09 hours. On Friday, August 5, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.92 hours. On Saturday, August 6, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.40 hours. On Sunday, August 7, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.03 hours. On Monday, August 8, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.92 hours. On Tuesday, August 9, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.02 hours. On Wednesday, August 10, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.07 hours.	L 056		

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L 056	Continued From page 19 On Thursday, August 11, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.04 hours. On Friday, August 12, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.04 hours. On Saturday, August 13, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.64 hours. On Sunday, August 14, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 3.73 hours. On Tuesday, August 16, 2016 it was determined that the facility provided direct nursing care coverage at a rate of 4.04 hours. The review was done in the presence of Employee #17. He/she acknowledged the findings	L 056		
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.	L 099	1. This deficient practice did not 8/30/16 directly affect any resident. 2. On August 16, 2016 a walk through was conducted on all nursing units and main kitchen to make sure all steam tables and other equipment were clean and free of food residue.	10/02/16

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L 099	Continued From page 20 This Statute is not met as evidenced by: Based on observations made on August 16, 2016 at approximately 9:30 AM, it was determined that the facility failed to serve foods under sanitary conditions as evidenced by four (4) of 16 soiled steam table wells in the facility. The findings include: Steam table wells located on the second floor dining room were soiled with leftover food residue, four (4) of 16 steam table wells surveyed. These observations were made in the presence of Employee #14 who acknowledged the findings.	L 099	3. The steam tables were removed 8/30/16 from all nursing units. Tray assembly transitioned to the main kitchen. 4. The Food Service Director and/or designee will conduct random observation audits on the steamtables and other equipment in the kitchen. This will be quantified and reported to the QAPI committee monthly for 3 consecutive months 5 The QAPI committee will determine based on the results of the monthly audits the need for further monitoring.	10/06/16
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined that the facility staff failed to remove one resident ' s expired medications from the 2nd floor medication cart. The findings include: On August 18, 2016 at approximately 1:40 PM the medication storage observations revealed the following: Resident #176 had one (1) blister packet with a total of twenty-one Zolpidem 5mg tablets medication. The expiration date on the blister packet was July 31, 2016. He/she last received	L 161	1. Resident #176 blister pack was removed from medication storage. 2. All medication storage areas have been checked for expired medications. 3. The Nurse Educator and/or designee will provide in-services to licensed staff on discarding expired medications. Licensed nurses will be re-trained to review expiration dates when counting controlled medications and/or administering medications. 4. ADON and/or designee will audit medication storage areas for expired medications monthly x3 months then quarterly x2. The results of the audits will be presented to the QA committee. The QA Committee will determine the need for further audits or actions.	10/02/16

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L 161	Continued From page 21 the medication on July 9, 2016 at 11:35PM. The observation was made in the presence of Employee #16. He/she acknowledged the findings.	L 161		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name, age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in	L 201	1. Resident #76, #133 and #158 inventory or personal belongings have been completed. 2. Current residents' inventory assessment will be completed by 30 September 2016. 3. Residents' inventory assessment will be completed quarterly during the months of March, June, September and December. 4. Nurse Managers and/or designee will audit the completion of the inventory assessment monthly x6 months then quarterly x2. The results of the audit will be submitted to the QA committee. The QA committee will determine the need for further audits or actions.	10/02/16

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L 201	Continued From page 22 relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by:	L 201		

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L 201	Continued From page 23 Based on record review and staff interview for three (3) of 35 sampled residents the facility failed to maintain quarterly inventory of personal clothing, belongings and valuables in the medical record. Resident #76, #133 and #158. The findings include: 1. A review of the clinical record revealed Resident #76 was admitted to Facility on March 24, 2011. The personal property inventory form dated September 24, 2014 indicated the last date the resident ' s inventory was recorded in the medical record. There was no evidence the medical record included a quarterly inventory of the president ' s personal clothing, belongings, and valuables. A face-to-face interview was conducted with Employee #4 at approximately 3:00PM on August 18, 2016. During the interview the employee was queried regarding the process for monitoring the residents clothing, belongings, and valuables. The employee responded, " On admission all of resident ' s personal property is documented by CNA and that the facility does not routinely monitor the resident ' s belongings on an ongoing basis. " Another face-to-face interview was conducted with Employees #2 at approximately 3:45 PM on August 18, 2016. The employee acknowledged that aforementioned findings. The record was reviewed on August 18, 2016	L 201		

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L 201	Continued From page 24 2. A review of the clinical record revealed Resident #133 was admitted to Facility on November 17, 2012. The personal property inventory form dated July 15,2015 indicated the last date the resident ' s inventory was recorded in the medical record. There was no evidence the medical record included a quarterly inventory of the resident ' s personal clothing, belongings, and valuables. A face-to-face interview was conducted with Employee #5 at approximately 2:00PM on August 18, 2016. During the interview the employee was queried regarding the process for monitoring the residents clothing, belongings, and valuables. The employee responded, " On admission all of resident ' s personal property is documented by CNA and that the facility does not routinely monitor the resident ' s belongings on an ongoing basis. " Another face-to-face interview was conducted with Employees #2 at approximately 3:45 PM on August 18, 2016. The employee acknowledged that aforementioned findings. The record was reviewed on August 18, 2016. 3. A review of the clinical record revealed Resident #158 was admitted to Facility on March 28, 2014. The personal property inventory form dated September 24, 2014 indicated the last date the resident ' s inventory was recorded in the medical record.	L 201		

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L 201	Continued From page 25 There was no evidence the medical record included a quarterly inventory of the resident ' s personal clothing, belongings, and valuables. A face-to-face interview was conducted with Employee #4 at approximately 3:00PM on August 18, 2016. During the interview the employee was queried regarding the process for monitoring the residents clothing, belongings, and valuables. The employee responded, " On admission all of resident ' s personal property is documented by CNA and that the facility does not routinely monitor the resident ' s belongings on an ongoing basis " . Another face-to-face interview was conducted with Employees #2 at approximately 3:45 PM on August 18, 2016. The employee acknowledged that aforementioned findings. The record was reviewed on August 18, 2016.	L 201		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to ensure that resident's environment remain free of accident hazards as evidenced by a missing light cover in the bathroom of one (1) of 37 resident's rooms surveyed.	L 214	1. No residents were harmed or effected by the findings 2. Light cover in room #307 was replaced immediately on 8/16/16 3. Audit was conducted on all residents' bathroom light covers on 8/17/16. Housekeeping staff instructed to notify maintenance of any light covers noticed missing immediately	10/02/16

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L 214	Continued From page 26 The findings include: The cover to the ceiling light in the bathroom of resident room #307 was missing and its electrical wires were exposed and accessible to residents, staff and/or the public, in one (1) of 37 resident's rooms surveyed. These observations were made in the presence of Employee #15 who acknowledged the findings.	L 214	4. Environmental service director and/or designee will audit weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made on August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to maintain call bells in good working condition as evidenced by a call bell that failed to alarm when tested in one (1) of 37 resident ' s rooms and a one (1) of three (3) call	L 306	1. No residents were harmed by the findings 2. Call cord in resident room #126 was immediately replaced in room #126 on 8/16/16. Pull cord was immediately replaced in third floor shower room on 8/16/16 3. Audit was conducted in all rooms and shower rooms on all floors for call bells and pull cords 4. An audit of all call bells will be conducted on a quarterly basis. 5. Maintenance director and/or designee will audit weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: _____ B. WING _____	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 306	Continued From page 27 bells in the shower room on the third floor that lacked a pull cord. The findings include: 1. The call bell in resident room #126, one (1) of 37 resident ' s rooms did not initiate an alarm when tested. 2. One (1) of three call bells in the shower room on the third floor was missing a pull cord. These observations were made in the presence of Employee #15 who acknowledged the findings.	L 306		
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 made on August 16, 2016 at approximately 3:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary environment as evidenced by loose privacy curtains in five (5) of 37 residents' rooms, dusty exhaust vents in three (3) of 37 residents' rooms, soiled shower floors in one (1) of three shower rooms and one (1) of three clinical sink hopper in the facility that failed to flush when tested. The findings include: 1. Privacy curtains were detached and hanging off the hooks in five (5) of 37 residents' rooms	L 410	1. No residents were harmed or affected by the findings. 2. The privacy curtains in rooms #143, 227, 242, 319 and #341 were either replaced or re-attached on 8/16/16. The bathroom exhaust in rooms #108, 307 and 319, were cleaned on 8/16/16. As well as the floors of each shower rooms on all three unit, were cleaned on 8/17/16. The hopper on the third floor soiled utility room was repaired on 8/16/16 3. An audit was conducted of the bathrooms exhaust vents, the shower rooms floors and privacy curtains on 8/17/16 Housekeeping has been re-instructed to check exhaust vents, shower rooms for cleanliness and curtains daily 4. Maintenance will also check exhaust vent monthly when cleaning a/c filters on resident room units EVS director will inspect curtains, exhaust vents, hoppers, and shower room floors on a weekly basis.	10/02/16

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L 410	Continued From page 28 including rooms #143, 227, 242, 319 and #341. 2. Bathroom exhaust vents were soiled with dust in three (3) of 37 residents' rooms (#108, 307 and 319). 3. The floor to one (1) of three (3) shower rooms in the facility was soiled. 4. A clinical sink hopper located in the soiled utility room on the third floor failed to flush and was not functioning as intended, one (1) of three (3) clinical sink hoppers in the facility. These observations were made in the presence of Employee #15 who acknowledged the findings.	L 410	5. Maintenance director and/or designee will audit weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16
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 made on August 11, 2016 at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of four (4) broken burner grates from the gas stove, two (2) of eight (8) steam wells covers with a missing handle, a malfunctioning temperature gauge and power light from one (1) of one (1) reach-in refrigerator, and a torn air curtain in the walk-in freezer. The findings include: 1. One (1) of four (4) burner grates from the gas stove in the main kitchen was broken and part of it was missing.	L 442	1. No residents or staff were harmed or effected by the findings 2. On 8/11/16 the torn air curtain in a walk-in freezer and the steam table covers with missing handles were replaced. On 08/12/16 the broken burner grate was replaced. The malfunctioning temperature gauge and power light on reach-in refrigerator is being assessed for repair or replacement. Hanging analog thermometer located on the inside of the reach - in refrigerator.	10/02/16

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L 442	Continued From page 29 2. One (1) of four (4) steam table well lid from the steam table in the main dining room and one (1) of four (4) steam table well lid from the steam table on the third floor were missing a handle. 3. The built-in thermometer and the power light from one (1) of one (1) reach-in/prep refrigerator in the main kitchen were out of service. 4. One (1) of seven (7) air curtains from one (1) of one (1) walk-in freezer was torn. These observations were made in the presence of Employee #14 who confirmed the findings.	L 442	3. On August 11, 2016 a walk through of the kitchen was conducted by the assistant Food Service Director to check all Kitchen equipment were in safe Operating condition. 4. The Food Service Director and/or designee will conduct random observation audits on all kitchen equipment to ensure they are in safe operating condition. Broken equipment will be reported to maintenance for repair. 5. The Food Service Director and/or designee will audit weekly. All finding and corrective action, will be reported to QA Committee monthly x3. QA committee will determine the need for further audit or action.	10/02/16