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L 000	Initial Comments		L 000		
·	Brinton Woods of W 2016 through Augus consisted of a revie	ire Survey was conducted at //ashington DC from August 11, st 18, 2016. Survey activities w of 35 sampled residents. The es are based on observation, staff interviews.			
	The following is a directory of abbreviations and/or acronyms that may be utilized in the report:			Please begin typing your responses	here:
				Brinton Woods of Washington D.	c.
				LLC, "BWDC" is filing this Plan o	
	Abbreviations AMS - Altered M	lental Status		Correction in accordance with the	•
	ARD - assessme BID - Twice- a-	ent reference date dav		Compliance requirements for	
	B/P - Blood Pr cm - Centime	essure		Federal and State regulations. T	nis
	C. Diff - Clostridi	um Difficile for Medicare and Medicaid		Plan of Correction constitutes the	•
	Services	d Nurse Aide	10	Facility's written allegation of	
	CRF - Commu	nity Residential Facility of Columbia		Compliance for deficiencies cited	l.
<u>.</u>	DCMR- District of Regulations	of Columbia Municipal		However submission of this Plan not constitute	of Correction does
	D/C Discontinue DI - deciliter			Admission of facts or conclusion	s
	EKG - 12 lead EMS - Emerge	ent of Mental Health Electrocardiogram ency Medical Services (911) stomy tube		Cited.	
	HSC Health S HVAC - Heating ID - Infection	Service Center ventilation/Air conditioning is Disease			
		ual disability iplinary team			
Hoolth Boss	lation & Densing Adminis	stration			
neam Kegu	ijadori & Erçensing Adminis	ou auvii			(VA) DATE

Health Regulation & Lipensing Administration

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

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continuation sheet 1 of

FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____ HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 000 L 000 Continued From page 1 I -Liter Lbs -Pounds (unit of mass) MAR -Medication Administration Record MD-Medical Doctor MDS -Minimum Data Set mcg/act - microgram/actuation milligrams (metric system unit of mass) Mg milliliters (metric system measure of mL volume) mg/dl milligrams per deciliter mm/Hg millimeters of mercury MN midnight Neuro - Neurological Nurse Practitioner NP -PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy POby mouth physician 's order sheet POS -Prn -As needed Pt-Patient Q-Every QIS -Quality Indicator Survey Rp, R/P -Responsible party Special Care Center SCC Sol-Solution TAR -Treatment Administration Record L 026 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:

<u>Health R</u>	<u>equiation & Licensing</u>	Administration				
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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L 026	Continued From page Based on record reversity (1) of 35 Stage 2 sand determined that the through on one (1) of Resident #45. The findings included An interim physician at 12:20 PM directer for Resident 's risperprolactin level (horrogland)- 38.23 (high) on 12/21/15. " A review of the clinic Consultation " [not physician named], Psychiatry [follow-up secondary to elevate (1.8-20.3) done on see today 1/11/16 A review of the psychological policy of the psychological poli	ge 2 riew and staff interview for one mpled residents, it was physician failed to follow esident 's diagnostic test. I's order dated January 4, 2016 d: "Psychiatry- F/U (Follow-up) eridone [secondary to] elevated none level made by the pituary; (normal range-1.8-20.3) done cal record revealed: "Report of dated], From: [Attending Report requested regarding: p] for resident 's risperidone use ed prolactin level 38.23 12/21/15; Report: Findings: Will [psychiatry signature] " Chiatry notes revealed the i Axis i- Schizophrenia bid for mood stabilization,	L 026		n level ng will be s have hysician Nurse ultation tions next e results e QA	02/16
	March 28, 2016 current treatment, F June 13, 2016 As current treatment, F A review of the atte January 2016 to Au	Axis I: Schizophrenia- Continue follow up in a month kis I: Schizophrenia, continue follow up in one month " Inding physician 's notes from gust 2016 revealed no arding the resident 's elevated				

PRINTED: 09/01/2016 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ... B. WING HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 026 | Continued From page 3 L 026 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. 1. Residents #39 and #160 Care plans 10/02/16 L 051 L 051 3210.4 Nursing Facilities have been updated with goals and approaches to address the impaired vision A charge nurse shall be responsible for the and behavioral symptoms respectively. following: 2. Care plans will be audited to ensure (a) Making daily resident visits to assess physical goals and approaches address residents' and emotional status and implementing any comprehensive assessment. required nursing intervention; 3. The Nurse Educator and/or designee (b)Reviewing medication records for completeness, will educate Nurse Managers and Charge accuracy in the transcription of physician orders, Nurses on developing goals and and adherences to stop-order policies; approaches to address residents' comprehensive assessment.

Health Regulation & Licensing Administration

them as needed;

employee on the unit; and

(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising

(d)Delegating responsibility to the nursing staff for

direct resident nursing care of specific residents;

(e)Supervising and evaluating each nursing

4. The ADON and/or designee will audit

randomly audit care plans monthly and

notify DON of discrepancies. Results of audits will be submitted to the QA

determine the need for further audits or

care plans monthly X 3 months then quarterly x2. The MDS Coordinator will

committee. The QA Committee will

actions.

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L 051	Continued From pag	ge 4	L 051			
; 	her designee inform	ctor of Nursing Services or his or ed about the status of residents. met as evidenced by:				
	(3) of 35 Stage 2 sadetermined that the care plan with goals one (1) resident's resident's behaviorarevise review one (1 an integrated approhospice, the facility, representative to the that the residents madetermined and the stage of the s	view and staff interview for three mpled residents, it was charge nurse failed to initiate a and approaches to address impaired vision and one (1) al symptoms; to review and 1) resident's care plan to reflect ach with the participation of and the resident or e extent possible and to ensure ledical record was inclusive of s. Residents' #39 and #160,				
	The findings include	e:				
	with goals and appr	e failed to initiate a care plan roaches for Resident #39 who and was diagnosed with		·		
	dated January 28, 2 diagnosis and treat cataract, bilateral -	Exam Consultation Record 2016 revealed the following ment: " Age related nuclear Cataracts - OU [each eye or e/dense monitor 6 [as needed]."				
	dated March 9, 201 Section B1000 " Vi Section V Care Are revealed in care are check mark was pla	nual MDS (Minimum Data Set) 6 revealed that Resident #39 in ision " is coded as " Impaired " . a Assessment Summary ea #4 "Visual Function" that a aced in the boxes allocated for d" and "Care planning decision" n				

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L 051	careplan initiated wi address Resident # A face-to-face interval, 2016 at approxii #4 who acknowledg The record was review ith goals and approxii #160's behavioral size A history and physic revealed Resident # Hypertension, Seizu Abscess Neurolo exam " An admission MDS February 26, 2016 Behavioral Symptom the triggered care a plan. A review of Resident plan lacked evidence.	cal record lacked evidence of a th goals and approaches to 39's impaired vision. riew was conducted on August mately 11:05 AM with Employee ed the aforementioned findings. ewed on August 17, 2016.		DEFICIENCY		
	A face-to-face inter Employee #3 on Au 11:20 AM. After re he/she acknowledg	view was conducted with agust 17, 2016 at approximately view of the aforementioned led the findings. The clinical ad on August 17, 2016.				

PRINTED: 09/01/2016 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WING HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ΙD (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX DATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1. Resident #195 care plan has been L 051 L 051 10/02/16 Continued From page 6 updated. 3a. The charge nurse failed to review and revise 2. All residents receiving Hospice services Resident #195's care plan to reflect an integrated care plans will be audited to ensure approach with the participation of hospice, the disciplines and/or teams responsible for facility, and the resident or representative to the implementing interventions of the hospice extent possible. care plan are identified. 3. Hospice will attend care plans and care A review of the Physician's Order Sheet dated plans will be reviewed with the November 8, 2015 directed: Admit to [Hospice interdisciplinary team during the resident's Agency Name]. Hospice start date [November 13, first scheduled care plan meeting. 2015]. 4. ADON and/or designee will audit care plans monthly x 3 months then quarterly A review of the resident's care plan revealed a care x2. The results of the audits will be plan for "Resident has a terminal prognosis r/t submitted to the QA committee. The QA [related/to] [Diagnosis named] " with goals and committee will determine the need for approaches initiated November 9, 2015. However, further audits or actions. 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

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1001	Continued From pag	yo <i>i</i>		L 00)			
	13, 2015.]						
	After further regions	of the medical record the	ara waa				
		e hospice " Initial Nursing		ļ			
		e Physician 's Plan of C		İ		•	
		ble on the active clinical					
	•						
		view was conducted on A		1	· ·		
		byee #4. After review of she acknowledged the fi					
		ents faxed to the facility.					
		d on August 16, 2016.	1110				
		9					
			Ì		•		
1 052	0044 4 Noveley Cas	11141		L 052	1. Nurse administering the Flovent	н Б	40/00/46
L U52	3211.1 Nursing Fac	cilities		L 052	Inhaler has been in-serviced on he		10/02/16
	Sufficient nursing fir	me shall be given to eac	h l		properly administer Flovent HFA li	1	
	resident to ensure t				Resident #109 physician order has		•
	receives the following	ng:			clarified. The resident will rinse with		
		-			thickened water after receiving the		
		cations, diet and nutrition	nal				
		uids as prescribed, and			2. All residents receiving Flovent I	-IFA	
	rehabilitative nursin	ig care as needed;			Inhaler be identified and times of		
	(b)Proper care to m	ninimize pressure ulcers	and		administration. Residents receivin		
		promote the healing of			Flovent Inhaler will be reviewed to		
		, .	-		they are receiving instructions to r		
1		ly personal grooming so	that the		their mouths after the medication administered.	io	
		able, clean, and neat as			aummatereu.		
		om from body odor, clea					
	1	clean, neat and well-gro	omed				
	hair;						
	(d) Protection from	accident, injury, and infe	ection:		,		
	(=) 1 1010000011110111	account injury; and init					
	(e)Encouragement,	, assistance, and training	g in				
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L 052	self-care and group (f)Encouragement at (1)Get out of the be or her own clothing; shall be clean and it (2)Use the dining rows (3)Participate in me activities; with eating (g)Prompt, unhurried requires or request (h)Prescribed adapt him or her in eating independently; (i)Assistance, if need including oral acre; j)Prompt response help. This Statute is not Based on observation interview for two (2) residents, it was detime was not given rinse the resident's inhalation and faile inhalation freatments specifications for of follow through on a signal in the signal in the signal in the signal in the signal inhalation for of follow through on a signal in the signal inhalation inhalat	activities; and assistance to: d and dress or be dressed in his and shoes or slippers, which n good repair; om if he or she is able; and aningful social and recreational g; d assistance if he or she help with eating; tive self-help devices to assist		3. The Nurse Educator and/or Desi will educate/train licensed nursing sproper administration of Flovent to resident rinsing his/her mouth after inhalation is administered. Nurse Managers will randomly observe lic nurses administering Flovent HFA and report findings to DON. 4. ADON and/or designee will audi residents receiving Flovent Inhaler 3 months to ensure they are rinsing the medication is administered. Ph Services will send a list of resident receiving Flovent monthly to DON next 3 months then quarterly x2. Thurse Educator and/or Nurse Man will observe mediation pass on lice nurses administering Flovent Inhal monthly x3 months then quarterly results of the medication administrobservation will be submitted to the Committee. The QA committee will determine the need for further activities.	staff on include the censed Inhaler t for next g after armacy s for the he agers ensed er X2. The ration e QA I	10/02/16

The findings include:

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE \$URVEY COMPLETED		
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pp 33-35; stipulates: "IHFA inhaler Step 2. Imouthpiece down [canis upward] Step 7. Rins after breathing in the month of the mo	mithKline .com "; Revised July 2016- How to use your Flovent Hold the inhaler with the ster should be pointed se your mouth with water ledicine. Spit out the water. me was not given to clarify use Resident #109's mouth of inhalation treatment. t approximately 10:10 AM, served administering an oral lesident #109. hysician ' order for Flovent le- propellant in the inhaler) ms)/(actuation) - 1 puff a day for SOB (shortness of ration of flovent, monitor a with water and spit tered Resident #109 one (1) haler. After administering the did not instruct resident to h water. w was conducted with eximately 10:00 AM. He/she not having the resident rinse er administering the flovent.	L 052	1. Resident #160 has been dischar from the facility therefore we are unreschedule the appointment. 2. Current residents' medical recorbe reviewed for scheduled and unscheduled medical appointment. 3. Nurse Educator and/or designed service Unit Clerks, Charge Nurse: Team Leaders on importance of semedical appointments for residents in-service will also include how to reschedule missed appointments a required documentation. 4. ADON and Nurse Managers will residents' appointments for the nemonths then quarterly x2. The residents will be submitted to the Committee. The QA Committee will determine the need for the further or actions.	nable to ds will s. e will in- s and etting up s. The and I audit ext three ults of QA II		

Health Regulation & Licensing Administration			FORIVI	APPROVED
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L 052 Continued From page 10 swallowing it. Sufficient nursing time was not given to clarif physician's orders to rinse Resident #109's in following an oral aerosol inhalation treatment. The observation and record review were condon August 11, 2016. 1b. sufficient nursing time was not given to administer an oral aerosol inhalation treatment the manufacturer 's specification. Resident in manufacturer 's specification. Resident in the manufacturer 's specification. Resident inhalation aerosol treatment to Resident #100 Resident #109 had a physician's order for FHFA (Hydrofluoroalkane- propellant in the in 110 mcg/act - 1 puff inhale orally two times for SOB (shortness of breath) (After administ of flovent, monitor resident to rinse mouth wwater and spit completely). Employee #18 instructed the resident to take breath in and out. Proceeded to position the mouthpiece of the inhaler in the resident's man 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 feeffect of the medication? He/she responded felt it going down." A face-to-face interview was conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18. He/she was queried regarding the second conducted with Employee #18.	mouth t. inducted ent per #109 AM, an oral 09. Flovent inaler) a day stration with e a deep enouth in d n elt the d, "Yes, I			

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L 052	correct positioning of in the resident's more positioned with the reposition with the resident's the way I usu observation and reconsultation and reconsultation report in receives antiretroviral therap continuous therapy: Physician's response for the position of the pos	of the mouthpiece of the inhaler ath. He/she stated, "It should be mouthpiece in the down hister in the upward position]. Ally administer it." The ord review were conducted on time was not given to follow ious disease appointment for all dated February 20, 2016 and Immunodeficiency Virus), une Deficiency Syndrome) " The sheet and plan of care dated directed: "Abacavir and on (1) tab po (by mouth) udine (antiretrovirals) 150mg hilliliters) po daily for HIV and antiretrovirals)-two (2) tablets of the HIV " The sheet and plan for yead: "[Resident's name] all therapy, Abacavir, Epivir, ing monitoring plan for y is recommended (1) CD4 count and viral load	L 052			

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Health Regulation & Licensing Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 052 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 056 3211.5 Nursing Facilities L 056 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A BUILDING: HFD02-0011 STREET ADDRESS, CITY, STATE, ZIP CODE	<u>Health R</u>	<u>legulation & Licensing</u>	Administration	Health Regulation & Licensing Administration					
RRINTON WOODS HEALTH & REHAB OF RRINTON WOODS HEALTH & REHAB OF WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES RECORDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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				1 ' '					
Description Summary statement of Deficiencies Washington, DC 20032 Summary statement of Deficiencies Washington, DC 20032 Summary Statement of Deficiencies Cach Deficiency Must be preceded by Full Regulatory Deficiency Must be preceded by Full Regulatory Cach Deficiency Must be preceded by Full Regulatory Tag Cach Deficiency Must be preceded by Full Regulatory Tag Cach Deficiency Must be preceded by Full Regulatory Deficiency Cach Deficiency Ca	-		HFD02-0011	B. WING		08/1	7/2016		
Description Summary statement of Deficiencies Washington, DC 20032 Summary statement of Deficiencies Washington, DC 20032 Summary Statement of Deficiencies Cach Deficiency Must be preceded by Full Regulatory Deficiency Must be preceded by Full Regulatory Cach Deficiency Must be preceded by Full Regulatory Tag Cach Deficiency Must be preceded by Full Regulatory Tag Cach Deficiency Must be preceded by Full Regulatory Deficiency Cach Deficiency Ca	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE				
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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. Each DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 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,	BRINTO	WOODS HEALIH & F	WASHIN	GTON, DC 20	032				
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	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE		
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	Nurses/APRN [Adva Nurse] hours on twe and four and one tercare per resident per five days reviewed, DCMR Section 3217 Required Staffing Lease The findings included A review of Nurse Staugust 18, 2016 at Twenty-five days we through August 17, According to the Dis Regulations for Nurse Staugust 18, 2016 at Twenty-five days we through August 17, According to the Dis Regulations for Nurse Beginning January provide a minimum tenth (4.1) hours of per day, of which at be provided by an anurse or registered to any coverage recommendation. The facility failed to direct nursing care Nurse/APRN [Adva for twenty-five days on Sunday, July 24 the facility provided	anced Practice Registered enty five of the twenty five days onth (4.1) hours of direct nursing or day for twenty one of twenty in accordance with Title 22 1, Nursing Personnel and evels. Etaffing was conducted on approximately 10:50AM. ere reviewed; July 24, 2016 2016. Strict of Columbia Municipal sing Facilities: 3211.5 1, 2012, each facility shall daily average of four and one direct nursing care per resident least six tenth (0.6) hour shall advanced practice registered nurse, which shall be in additional quired by subsection 3211.4. The meet the 0.6 [six tenth] hour of per resident day for Registered nurse reviewed as outlined below. 1, 2016 it was determined that RN coverage at a rate of 0.36	i n	all categories-RNs, LPNs and CN scheduled job fairs on a frequent Nursing care is provided 24 hours. All nursing staff participates in the the residents to meet their needs and including ADON/DON. 2. Staffing is reviewed weekly by management on a regular basis recruitment and retention efforts. Resources conduct exit interview ascertain reason for leaving emp at BWDC. 3. Recruitment efforts, such as journal and incentives, and results are be audited for effectiveness by the Resources Director. Results of the are reported to the team during the meetings and during QA. 4. Vacancies, Recruitment efforts retention rates are discussed in Committee monthly. The vacance retention rates are submitted to form to recruit and retain nursing Committee will determine the new committee will determine the new committee will determine the new committee.	As. We basis. See a day. See care of up to facility regarding Human see to doyment see the efforts one weekly see QA servaluates staff, QA	10/02/16		

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 056 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.

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		t 2, 2016 it was determ					
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		st 4, 2016 it was detern					
		RN coverage at a rate ing care per resident da					
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	hours of direct nurs	ing care per resident da	ay.	:			
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		t 7, 2016 it was determi l RN coverage at a rate					
		sing care per resident da					
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	On Monday, Augus	st 8, 2016 it was determ	ined that				
	the facility provided	l RN coverage at a rate	of 0.47				
	nours of direct nurs	sing care per resident d	ay.				
		st 9, 2016 it was detern					
		l RN coverage at a rate sing care per resident d					
	nouls of unectifuls	ang oute per resident d	~y.				

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		WASHING	TON, DC 200			
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L 056	Continued From pag	ge 16	L 056			
	that the facility provi	gust 10, 2016 it was determined ded RN coverage at a rate of nursing care per resident day.				
	that the facility provi	st 11, 2016 it was determined ded RN coverage at a rate of nursing care per resident day.				
	the facility provided	2, 2016 it was determined that RN coverage at a rate of 0.57 ng care per resident day.				
	that the facility provi	st 13, 2016 it was determined ided RN coverage at a rate of nursing care per resident day.				
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ł	the facility provided	t 15, 2016 it was determined tha RN coverage at a rate of 0.57 ing care per resident day.	t			
	that the facility prov	et 16, 2016 it was determined rided RN coverage at a rate of a nursing care per resident day.				
		igust 17, 2016 it was determined rided RN coverage at a rate of rursing care per				

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
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L 056	Continued From pag	ge 17	L 056	·					
	resident day.								
	hours of direct nursi	meet four and one tenth (4.1) ing care per resident per day for days reviewed as outlined below.							
		l, 2016 it was determined that direct nursing care coverage at s.							
		i, 2016 it was determined that the ect nursing care coverage at a							
		26, 2016 it was determined that I direct nursing care coverage at s.							
	On Wednesday, Ju that the facility prov coverage at a rate of	aly 27, 2016 it was determined vided direct nursing care of 3.79 hours.			·				
		2016 it was determined that the ect nursing care coverage at a							
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Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 08/17/2016 HFD02-0011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 056 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.

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L 056	Continued From pag	ge 19	L 056		
(st 11, 2016 it was determined ided direct nursing care of 4.04 hours.			
		2, 2016 it was determined that direct nursing care coverage at			
		st 13, 2016 it was determined ided direct nursing care of 3.64 hours.			
		t 14, 2016 it was determined tha direct nursing care coverage at s.			
:		st 16, 2016 it was determined rided direct nursing care of 4.04 hours.			
	The review was do	ne in the presence of Employee owledged the findings			
L 099	9 3219.1 Nursing Fac	cilities	L 099	This deficient practice did not 8/30/16 directly affect any resident. On August 16, 2016 a walk through	10/02/16 was
	from spoilage, safe served in accordan forth in Title 23, Su	all be clean, wholesome, free for human consumption, and ace with the requirements set abtitle B, D. C. Municipal B). Chapter 24 through 40		conducted on all nursing units and ma kitchen to make sure all steam tables other equipment were clean and free food residue.	iin and

PRINTED: 09/01/2016 FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 08/17/2016 HFD02-0011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 10/06/16 3. The steam tables were removed L 099 L 099 Continued From page 20 8/30/16 from all nursing units. Tray This Statute is not met as evidenced by: assembly transitioned to the main kitchen. Based on observations made on August 16, 2016 at approximately 9:30 AM, it was determined that the 4. The Food Service Director and/or facility failed to serve foods under sanitary designee will conduct random observation conditions as evidenced by four (4) of 16 soiled audits on the steamtables and other steam table wells in the facility. equipment in the kitchen. This will be quantified and reported to the QAPI The findings include: committee monthly for 3 consecutive months Steam table wells located on the second floor dining room were soiled with leftover food residue, four (4) 5 The QAPI committee will determine of 16 steam table wells surveyed. based on the results of the monthly audits the need for further monitoring. These observations were made in the presence of Employee #14 who acknowledged the findings. L 161 L 161 3227.12 Nursing Facilities 1. Resident #176 blister pack was 10/02/16 removed from medication storage. Each expired medication shall be removed from usage. 2. All medication storage areas have been This Statute is not met as evidenced by: checked for expired medications. Based on observation, record review, and staff interviews, it was determined that the facility staff 3. The Nurse Educator and/or designee failed to remove one resident 's expired will provide in-services to licensed staff on medications from the 2nd floor medication cart. discarding expired medications. Licensed nurses will be re-trained to review expiration dates when counting controlled The findings include: medications and/or administering medications.

following:

On August 18, 2016 at approximately 1:40 PM the

Resident #176 had one (1) blister packet with a total

of twenty-one Zolpidem 5mg tablets medication.

31, 2016. He/she last received

The expiration date on the blister packet was July

medication storage observations revealed the

GZ9J11

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

further audits or actions.

be presented to the QA committee. The

QA Committee will determine the need for

Health Re	<u>egulation & Licensinc</u>	Administration			(X3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION			
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L 161	Continued From page	ge 21	L 161				
	the medication on J	uly 9, 2016 at 11:35PM.					
		s made in the presence of she acknowledged the findings					
	Linployee #10. Her	she additioned god the infallige	*				
L 201	3231.12 Nursing Fa	acilities	L 201	1. Resident #76, #133 and #158 i	nventory 10/02/16		
	Each medical recor information:	d shall include the following		or personal belongings have beer completed.			
	race, martial status	ame, age, sex, date of birth, home address, telephone		Current residents' inventory as will be completed by 30 Septemb			
	number, and religio (b)Full name, addre the personal physic member or sponsor	esses and telephone numbers cian, dentist and interested fam	of ily	Residents' inventory assessments completed quarterly during the march, June, September and Dec. Nurse Managers and/or design	onths of cember.		
ļ	(c)Medicaid, Medicanumbers;	are and health insurance		audit the completion of the invent assessment monthly x6 months t quarterly x2. The results of the au	hen		
	(d)Social security a	and other entitlement numbers;		be submitted to the QA committee QA committee will determine the	e. The		
		on, results of pre-admission g diagnoses, and final		further audits or actions.			
	(f)Date of discharge	e, and condition on discharge;					
	(g)Hospital dischar from the attending	ge summaries or a transfer for physician;	rm				
		allergies, physical examinationsis and rehabilitation;	n,				
	(i)Vaccine history, information about i	if applicable, and other pertine immune status in	nt .				
1							

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L 201	Continued From pag	ne 22	L 201			
	•	preventable disease;				
	(j)Current status of t	resident's condition;			1	
	at the time of obser- changes in the resid medication or treath renewed or when the	ss notes which shall be written vation to describe significant dent's condition, when nent orders are changed or e resident's condition remains status quo condition;		•		
	discharge, which sh attending physician diagnoses, course of essential informatio	dical experience upon all be summarized by the and shall include final of treatment in the facility, n of illness, medications on ion to which the resident was				
	(m)Nurse's notes w with the resident's r policies of the nursi	hich shall be kept in accordance nedical assessment and the ng service;	9	·		
	ongoing reports of putherapy, speech the	esident's assessment and ohysical therapy, occupational erapy, podiatry, dental, on, dietary, and social services;	,			
	(o)The plan of care	;				
	(p)Consent forms a	nd advance directives; and				
	(q)A current invento clothing, belongings	ory of the resident's personal s and valuables.				
	This Statute is not	met as evidenced by:		. ,		

Health Regulation & Licensing Administration							
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HFD02-0011	B. WING		08/17/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE			
BRINTO	N WOODS HEALTH & F	PEHAR OF	THERN AVE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE		
L 201	Continued From page	ne 23	L 201				
	Based on record rev (3) of 35 sampled re maintain quarterly in	iew and staff interview for three sidents the facility failed to ventory of personal clothing, ables in the medical record.					
	The findings include	;					
	#76 was admitted to The personal proper September 24, 2014	nical record revealed Resident Facility on March 24, 2011. ty inventory form dated indicated the last date the was recorded in the medical					
	1	nce the medical record included of the president's personal and valuables.					
	Employee #4 at appl 18, 2016. During the queried regarding the residents clothing, be employee responded resident 's personal CNA and that the face	view was conducted with roximately 3:00PM on August enterview the employee was enterview the employee was enterview the elongings, and valuables. The digital of the property is documented by cility does not routinely monitoringings on an ongoing basis."					
	Employees #2 at app 18, 2016. The emplo	interview was conducted with proximately 3:45 PM on August yee acknowledged that ngs. The record was reviewed					

Health Regulation & Licensing Administration STATE FORM

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMP	COMPLETED			
AND PLAN (OF CORRECTION	IDENTIFICATION NOWING.	A. BUILDING:						
			B. WING	B. WING		17/2016			
		HFD02-0011				.,,			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
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L 201	Continued From pag	ge 24	L 201						
	2. A review of the c #133 was admitted 2012. The personal July 15,2015 indicat	clinical record revealed Resident to Facility on November 17, property inventory form dated ted the last date the resident 's ded in the medical record.							
	There was no evide a quarterly inventory clothing, belongings	ence the medical record included y of the resident 's personal s, and valuables.	1						
	Employee #5 at app 18, 2016. During th queried regarding the residents clothing, the employee responde resident 's personal CNA and that the far	rview was conducted with proximately 2:00PM on August are interview the employee was ne process for monitoring the belongings, and valuables. The ed, "On admission all of all property is documented by acility does not routinely monitoringings on an ongoing basis."							
	Employees #2 at an 18, 2016, The empl	e interview was conducted with oproximately 3:45 PM on Augus loyee acknowledged that dings. The record was reviewed 3.	t						
	#158 was admitted The personal prope September 24, 201	linical record revealed Resident to Facility on March 28, 2014. erty inventory form dated 4 indicated the last date the ry was recorded in the medical							

Health R	Regulation & Licensing	Administration				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
 BRINTON	N WOODS HEALTH & F	REHAR OF	THERN AVE			
	1	WASHING	TON, DC 20	932 PROVIDER'S PLAN OF CORRECTION		(X5)
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L 201	Continued From pag	ge 25	L 201			
	There was no evide	nce the medical record included of the resident's personal				
	Employee #4 at app 18, 2016. During the queried regarding the residents clothing, be employee responde resident 's personal CNA and that the fa	view was conducted with roximately 3:00PM on August e interview the employee was the process for monitoring the elongings, and valuables. The d, "On admission all of property is documented by cility does not routinely monitoringings on an ongoing basis".				
	Employees #2 at ap 18, 2016. The employees	e interview was conducted with proximately 3:45 PM on August byee acknowledged that ings. The record was reviewed				
L 214	located, equipped, a functional, healthful, supportive environm and the visiting publ This Statute is not r Based on observation approximately 3:00 l facility failed to ensuremain free of accidents.	e designed, constructed, and maintained to provide a safe, comfortable, and tent for each resident, employee ic. The made on August 16, 2016 at PM, it was determined that the tent hazards as evidenced by a the bathroom of one (1) of 37	L 214	1. No residents were harmed or e by the findings 2. Light cover in room #307 was replaced immediately on 8/16/16 3. Audit was conducted on all rebathroom light covers on 8/17/16. Housekeeping staff instructed to no maintenance of any light covers no missing immediately	sidents'	10/02/16

FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 08/17/2016 HFD02-0011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX TAG DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 4. Environmental service director and/or 10/02/16 L 214 L 214 Continued From page 26 designee will audit weekly. All finding and The findings include: corrective action, will be reported to QA Committee monthly x3. QA committee will The cover to the ceiling light in the bathroom of determine the need for further audit or resident room #307 was missing and its electrical action. 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 306 L 306 3245.10 Nursing Facilities 1. No residents were harmed by the 10/02/16 findings A call system that meets the following requirements shall be provided: Call cord in resident room #126 was immediately replaced in room #126 on (a)Be accessible to each resident, indicating signals 8/16/16. Pull cord was immediately from each bed location, toilet room, and bath or replaced in third floor shower room on shower room and other rooms used by residents; 8/16/16 (b)In new facilities or when major renovations are Audit was conducted in all rooms made to existing facilities, be of type in which the and shower rooms on all floors for call call bell can be terminated only in the resident's bells and pull cords room: 4. An audit of all call bells will be (c)Be of a quality which is, at the time of installation, conducted on a quarterly basis. consistent with current technology; and 5. Maintenance director and/or designee (d)Be in good working order at all times. will audit weekly. All finding and corrective action, will be reported to QA Committee This Statute is not met as evidenced by: monthly x3. QA committee will determine the need for further audit or action. Based on observations made on August 16, 2016 at approximately 3:00 PM, it was determined that the facility falled 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

Health Regulation & Licensing Administration (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 08/17/2016 HFD02-0011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 306 Continued From page 27 bells in the shower room on the third floor that lacked a pull cord. The findings include: The call bell in resident room #126, one (1) of 37 resident 's rooms did not initiate an alarm when tested. 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. 10/02/16 1. No residents were harmed or affected L 410 L 410 3256.1 Nursing Facilities by the findings. 2. The privacy curtains in rooms #143, Each facility shall provide housekeeping and 227, 242, 319 and #341 were either maintenance services necessary to maintain the exterior and the interior of the facility in a safe, replaced or re-attached on 8/16/16. The sanitary, orderly, comfortable and attractive bathroom exhaust in rooms #108, 307 and manner. 319, were cleaned on 8/16/16. As well as This Statute is not met as evidenced by: the floors of each shower rooms on all three unit, were cleaned on 8/17/16. The Based on observations made on August 16, 2016 at approximately 3:00 PM, it was determined that the hopper on the third floor soiled utility room facility failed to provide housekeeping and was repaired on 8/16/16 maintenance services necessary to maintain a sanitary environment as evidenced by loose privacy 3. An audit was conducted of the curtains in five (5) of 37 residents' rooms, dusty bathrooms exhaust vents, the shower exhaust vents in three (3) of 37 residents' rooms, rooms floors and privacy curtains on soiled shower floors in one (1) of three shower 8/17/16 Housekeeping has been rerooms and one (1) of three clinical sink hopper in instructed to check exhaust vents, shower the facility that failed to flush when tested. rooms for cleanliness and curtains daily The findings include: 4. Maintenance will also check exhaust vent monthly when cleaning a/c filters on Privacy curtains were detached and hanging off resident room units EVS director will the hooks in five (5) of 37 residents' rooms inspect curtains, exhaust vents, hoppers, and shower room floors on a weekly basis.

<u>Health R</u>	<u>egulation & Licensino</u>	Administration		CONCEDUCTION	(X3) DATE SUR	VEY I			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	COMPLETED				
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BRINTON	BRINTON WOODS HEALTH & REHAB OF WASHINGTON, DC 20032								
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE			
L 410	including rooms #12 2. Bathroom exha in three (3) of 37 res 319). 3. The floor to one in the facility was so 4. A clinical sink h room on the third flofunctioning as intensink hoppers in the These observations	43, 227, 242, 319 and #341. ust vents were soiled with dust sidents' rooms (#108, 307 and e (1) of three (3) shower rooms biled. sopper located in the soiled utility for failed to flush and was not ded, one (1) of three (3) clinical	L 410	5. Maintenance director and/or de- will audit weekly. All finding and co action, will be reported to QA Com- monthly x3. QA committee will dete the need for further audit or action.	rrective mittee ermine	10/02/16			
L 442	electrical, and patie operating condition. This Statute is not Based on observati approximately 9:15 facility failed to mai good working condition (4) broken burntwo (2) of eight (8) missing handle, and gauge and power li reach-in refrigerato walk-in freezer. The findings included.	aintain all essential mechanical, ant care equipment in safe met as evidenced by: ons made on August 11, 2016 at AM, it was determined that the antain essential equipment in a evidenced by one (1) of the grates from the gas stove, steam wells covers with a malfunctioning temperature ght from one (1) of one (1) r, and a torn air curtain in the	L 442	1. No residents or staff were harm effected by the findings 2. On 8/11/16 the torn air curtain in freezer and the steam table cove missing handles were replaced. On 08/12/16 the broken burner grate were replaced. The malfunctioning temp gauge and power light on reaching refrigerator is being assessed for replacement. Hanging analog thermometer located on the inside reach - in refrigerator.	n a walk- ers with n was perature repair or	10/02/16			

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ____ B. WING HFD02-0011 08/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE **BRINTON WOODS HEALTH & REHAB OF** WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 3. On August 11, 2016 a walk through of 10/02/16 L 442 Continued From page 29 the kitchen was conducted by the assistant Food Service Director to check 2. One (1) of four (4) steam table well lid from the all Kitchen equipment were in safe steam table in the main dining room and one (1) of Operating condition. four (4) steam table well lid from the steam table on the third floor were missing a handle. 4. The Food Service Director and/or designee will conduct random observation 3. The built-in thermometer and the power light audits on all kitchen equipment to ensure from one (1) of one (1) reach-in/prep refrigerator in they are in safe operating condition. the main kitchen were out of service. Broken equipment will be reported to maintenance for repair. One (1) of seven (7) air curtains from one (1) of one (1) walk-in freezer was torn. 5. The Food Service Director and/or designee will audit weekly. All finding and These observations were made in the presence of corrective action, will be reported to QA Employee #14 who confirmed the findings. Committee monthly x3. QA committee will determine the need for further audit or action.