Brinton Woods

Health & Rehabilitation Center at Dupont Circle

January 15, 2016

Sharon Williams Lewis, DHR, RN-BC,CPM
Interim Senior Deputy Director
District of Columbia Department of Health
899 North Capitol Street, NE., 2nd Floor
Washington, DC 20002

Dear Ms. Lewis

Enclosed is our plan of correction which constitutes our written and credible allegation of compliance based on the deficiencies cited during our December 11, 2015 annual survey.

At Brinton Woods Health & Rehabilitation Center at Dupont Circle, we are grateful to you and your entire staff for the professional guidance we received during the survey process. Again, thank you for helping us serve our seniors.

Sincerely,

Olayinka Oyekoya, 1/15/16
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRINTON WOODS HEALTH & REHAB CENTER AT DUPONT CIRC	2131 O STREET NW WASHINGTON, DC 20037

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F 000	INITIAL COMMENTS	F 000		

An unannounced Quality Indicator Survey was conducted at Brinton Woods Health & Rehab Center at Dupont Circle from December 7, 2015 through December 11, 2015. Survey activities consisted of a review of 40 resident clinical records during Stage 1; review of 29 sampled residents during Stage 2; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families, and facility staff. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

The 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
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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	1/15/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
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

F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 2 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on December 10, 2015 at approximately 10:00 AM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: marred walls in 10 of 52 residents' rooms surveyed, dusty bathroom vents in four (4) of 52 residents' rooms surveyed and an inoperative wall clock in one (1) of 52 resident' s rooms surveyed. The findings include: 1. Walls in 10 of 52 residents' rooms were marred (rooms #104, 119, 307, 314, 404, 407, 412, 415, 507, and 516). 2. Bathroom vents were dusty in four (4) of 52 residents' rooms (rooms #103,117, 219, and 508). 3. In one (1) of 52 resident rooms surveyed, the wall clock displayed the time of 3:00 o'clock, however the actual time was 10:30 AM. Employee #11 and/or Employee #18 were present at the time of the observations and acknowledged the findings.	F 253	1. The marred and scuffed walls in rooms 104, 119, 307, 314, 404, 407, 412, 415, 509, and 516 were immediately scheduled for repainting. 2. Other rooms in the facility were checked on 12/15/15 and none was found with this deficient practice. 3a. Maintenance staff were in-serviced on stained and marred wall on 12/15/15 and the need to maintain these within compliance. 3b. The Director of Maintenance/Designee will conduct weekly rounds for ninety days to ensure compliance. 4a. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	1/19/16
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272		

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F 272	Continued From page 3 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by:	F 272		

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F 272	Continued From page 4 Based on record review and staff interview for one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to accurately code the quarterly Minimum Data Set (MDS) under Section Q (Participation in Assessment and Goal Setting) to reflect the discharge status of Resident #155. The findings include: Facility staff failed to accurately code section Q on Resident #155's quarterly MDS for discharge planning. A review of the clinical record revealed that a "Community Transition Referral" form was submitted to the Government of the District of Columbia, Office on Aging on October 22, 2015. A review of Resident #155's quarterly MDS dated November 13, 2015, revealed that Section Q "Assessment and Goal Setting" [Q0600] Referral was coded as " No " referral has been made to the local contact agency. On December 10, 2015 at approximately 2:30 PM, a face-to-face interview was conducted with Resident #155 when queried about discharge plans the resident stated, "All I want to do is to go home, they know this and keep saying they are working on it, but I' m still here. " On December 11, 2015 at approximately 11:00 AM, a face-to-face interview was conducted with Employee #10. He/she stated, "[Resident #155] was set to go home in October 2015 but his/her family members at last minute refused to accept responsibility for twenty-four hour care that would be required. Although there was a	F 272	1. The Q section of the MDS was immediately modified to reflect resident #155 discharged potential. 2. An Audit of section Q of MDS's was completed on 12/15/15 and none was found with this deficient practice. 3a. Social Services staff were in-serviced accurately on coding of the Q section of the MDS on 12/17/15 to reflect discharge potential of residents. 3b. QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	1/19/16

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F 272	Continued From page 5 recommendation for placement in an assisted living community setting there are no plans to discharge him/her from the facility at this time". Employee #10 acknowledged the aforementioned findings. Facility staff failed to code the Minimum Data Set (MDS) to reflect the resident's discharge status and wishes. The clinical record was reviewed on December 11, 2015.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for	F 280		

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F 280	Continued From page 6 one (1) of 29 Stage 2 sampled residents, it was determined that facility staff failed to review and revise the care plan to include one (1) resident ' s decline in locomotion on the unit. Resident #44. 2. The findings include: A review of the July 2015, quarterly MDS (Minimum Data Set) dated July 27, 2015 and the October 2015 quarterly MDS dated October 26, 2015 revealed in "Section G, Functional Status, G0110 Activities of Daily Living (ADL) Assistance in the following areas: E. Locomotion on unit - how the resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair was coded in July: (1) Supervision - oversight, encouragement or cueing. In October: (2) Limited Assistance-resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance. In July and October for Self -Performance the resident was coded a (2) one (1) person assist for ADL support provided. A review of the resident's care plan revealed a focus area for "Resident is dependent on staff for activities r/t [related/to] cognitive deficits/physical/mobility impairments." However, facility staff failed to include goals, approaches and interventions to address the resident's decline in locomotion on the unit. There was no evidence in the clinical record that facility staff addressed the resident's decline with locomotion.	F 280	1. A decline in locomotion on the unit care plan was immediately put in place for resident #44. 2.Care plans for all residents with any changes in the G section of the MDS' were reviewed on 12/15/15 and none was found with this deficient practice. 3a. Nurse managers were in-serviced on 12/17/15 on the implementation of care plans to reflect changes in the G section. 3b. QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	1/19/16

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F 280	Continued From page 7 A face-to-face interview was conducted with Employee #19 on December 11, 2015 at approximately 10:50 AM. A query was made regarding what type of ADL assistance does he/she provide to the resident. He/she stated, "The resident does not need much assistance from me, he/she can ambulate short distances, however he/she may get our assistance sometimes when he/she may be going to an activity, we may assist him/her wheeling into the elevator". A face-to-face interview was conducted on December 11, 2015 at approximately 11:00 AM with Employee #4 and Employee #10. After review of the care plan both acknowledged that the care plan lacked specific care approaches and interventions to address the decline with locomotion on the unit for the resident. The record was reviewed on December 11, 2015.	F 280		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations made on December 10, 2015 at approximately 2:30 PM, it was determined that the facility failed to maintain essential equipment in proper working condition as evidenced by low wash temperatures from the dishwashing machine that measured below 150 degrees Fahrenheit (F).	F 456		

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F 456	Continued From page 8 The findings include: The dishwashing machine failed to reach the minimum recommended wash temperature of 150 degrees Fahrenheit (F) as per regulations during observations on December 10, 2015 at approximately 2:30 PM. According to the Food and Drug Administration (FDA) 2013 Food Code, Section 4-501.110, the temperature of the wash solution for a conveyor type dishwashing machine " may not be less than" 150 degrees F. A review of a work order from a [commercial kitchen repair service representative] on December 11, 2015 at approximately 10:30 AM, revealed that a burnt element in the pre-wash tank of the dishwashing machine caused the low wash temperatures. At the time of the observation, the final rinse temperature consistently exceeded 180 degrees F and settled at 192 degrees F. These observations were made in the presence of Employee #9 who acknowledged the findings.	F 456	1. The commercial kitchen repair service vendor was immediately notified on temperatures below 150 degrees Fahrenheit. 2 The burnt element in the pre-wash tank of the dishwashing machine was replaced immediately and low wash temperatures are currently noted to be less than 150 degrees Fahrenheit. 3a. Dietary staff were in-serviced on 12/17/15 on the need to monitor and ensure that the temperature of the wash solution is not less than 150 degrees Fahrenheit. 3b. QA/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly and quarterly QA meetings for six months.	1/19/16
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on December 10,	F 468		

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F 468	Continued From page 9 2015 at approximately 10:00 AM, it was determined that the facility failed to ensure that handrails were firmly secured in residents areas as evidenced by loose handrails on the third, fourth and fifth floor. The findings include: 1. The handrail located next to room #301 was loose and needed to be tightened. 2. The handrail next to room #404 was not firmly secured to the wall. 3. Handrails located across from the two (2) small elevators on the fifth floor were not securely attached to the wall. These observations were made in the presence of Employee #11 and/or Employee #18 who acknowledged the findings.	F 468	1. The handrails near rooms 307, 401, and 501 were immediately identified and firmly secured. 2. Handrails in the facility were inspected by the Director of Maintenance on 12/15/15 and none was found with this deficient practice. 3a. Maintenance staff were in-serviced on monitoring of handrails and the need to ensure handrails are firmly secured. 3b. The Director of Maintenance/Designee will conduct bi-weekly audits for ninety days to ensure compliance. 4. Further findings on this matter will be discussed in the weekly, monthly, and quarterly QA meetings for six months.	1/19/16