	<u>egulation & Licensino</u> For DEFICIENCIES	(X1) PROVIDER/SUPPLII	ER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	RVEY
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€ 000	Initial Comments			L 000			
	A Licensure survey on January 5 throug following deficiencie record reviews, resi sampled residents.	gh January 12, 2015 es are based on obs	5. The servations,				
L 051	3210.4 Nursing Fac	ilities		L 051	Please begin typing your responses he	re:	
	A charge nurse sha following:	all be responsible fo	r the				
	(a)Making daily res and emotional statu required nursing int	us and implementing	s physical g any				
	(b)Reviewing medic accuracy in the tran and adherences to	nscription of physici	an orders,				
	(c)Reviewing reside appropriate goals a them as needed;	ents' plans of care f and approaches, an	or d revising				l
	(d)Delegating respondirect resident nurs	onsibility to the nurs sing care of specific	sing staff for residents;				i:
	(e)Supervising and employee on the u	l evaluating each nu nit; and	ursing				
	her designee infor	ector of Nursing Ser med about the statu met as evidenced	is of residents		,		
	five (5) of 37 samp	nterviews and recor sled residents, it was ff failed to provide the for the residents to est practicable	s determined he necessary				

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health R	equiation & Licensing	Administration		<u></u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
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L 051	evidenced by failure administration for as physician for three (resident received he physician and collabthe necessary care resident. Residents' The findings include 1. Facility staff failed (chew or swallow) oprescribed by the physician and collabthe following: A. A review of the crevealed the following. A. A review of the crevealed the following instructions: dx [diagnatury 2, 2015: "a 1 tablet po 1 time a dx: stroke." C. A review of the crevealed the following anuary 2, 2015: "a 1 tablet po 1 time a dx: stroke."	d psychosocial well- being as to: clarify the route of spirin prescribed by the 3) residents; ensure that one (1) aspice care as ordered by the porate with hospice to coordinate and services for one (1) the #65, 103, 104, 146, and 159.		 Residents #65, #103 and #146 suffer any harm from this defic practice. All residents on chewable Asplidentified and clarification of or administer the medication ches swallowed was established. All licensed nurses were in-set 1/31/15 on the administration of chewable medication. QA/Designee will conduct wee for ninety days to ensure that medications are administered Further findings of this matter discussed in the weekly, montiquarterly QA meeting for six medications. 	rin were rders to wed or rviced on of ekly audits all per order. will be hly and	2/16/15

Health Re	egulation & Licensino	Administration			(X3) DATE SURVEY
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L 051	Continued From pa	ge 2	L 051		
	clarified the aspirin direction on whethe chewed or swallow	view was conducted on January			
	9, 2015 at approxing #13 and Employee mentioned orders for regarding how the Employee #13 statemedication by mouresident. Employee administer the medication the medication by mouresident.	mately 11:30 AM with Employee #3 regarding the above for aspirin. When queried aspirin was to be administered, and he/she would administer the with to be swallowed by the #3 stated he/she would dication by mouth to be chewed both acknowledged the			
	administration for a	to clarify the oral method of aspirin prescribed for the ical record was reviewed on			
	2. Facility staff faireceived hospice	led to ensure that Resident #104 care as ordered by the physician.			
	record, the physic treatment for the radmit Resident to Agency). Dx. [Dia Obstructive Pulmor's orders dated Jefor continued Hos				
	evidence of hospi	ent #104 's clinical record lacked ice nursing assessments and/or Further review of a			

Health Re	egulation & Licensing	Administration		(X3) DA	ATE SURVEY
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€ 051	also failed to reveal of the hospice nurs. A face-to-face inter Employee #2 at app 12, 2015. The emplack of hospice nurs record. He/she reschart and that I shot their nursing docum. A review of the hospice services of their nursing documentation or exidential unit with hospice services of documentation or exident #104. We documentation in the stated, "They keep another location]. If faxed over here?" informed the emplainformation needed accessible. The endetermine the frequency based on an asset The record was represented the spice of the state of the record was represented the state of the state	uency Grid" in the clinical record any consistent documentation es' visits. view was conducted with proximately 10:00AM on January alloyee was queried regarding the sing documentation in the clinical ponded that hospice had its own auld look in the hospice chart for	f	 Resident #104 and #159 did not suany harm from this deficient practice. Review of all medical records of horesidents was conducted and none noted with this deficient practice. An in-service was conducted on 1/with facility and hospice staff on coordination and collaboration of collaboration of collaboration and collaboration of collaboration. QA/Designee will conduct bi-week audits for ninety days to ensure compliance. Further findings on this matter will 	ese. espice e was 31/15 eare.
				discussed in the weekly, monthly a quarterly QA meetings for six mon	and

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	Continued From pa	ge 4	L 051		
L 051	to the facility on Oci including Anemia, E Hearth Failure, Hyp Dementia. Addition Disturbance, Vitami for Palliative Care. Review of the Octo timed 10:00 PM, re following: "Patient Hospice with a dx of Review of the Nove progress notes rev supportive hospice. On January 8, 201 face-to-face intervite Employee #13 who facility coordinates care for Resident # hospice attendants [Activities of Daily provides music the resident. When as hospice nurse cooprovided no answer hospice notes, helplans and notes at He/she admitted to they were. On January 8, 201 face-to-face intervites admitted to the plans and notes at He/she admitted to the plans and notes and note	tober 14, 2013 with diagnoses Deep Venous Thrombosis, pertension, and Non-Alzheimer 's al diagnoses included Speech in B deficiency, and Encounter ber 14, 2013 Interim Order Form evealed an order that directed the admitted to [company name] of Dementia"	o ce		

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 01/12/2015 B. WING HFD02-0001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2131 O STREET NW BRINTON WOODS HEALTH & REHAB CENTER WASHINGTON, DC 20037 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 051 L 051 Continued From page 5 the hospice binder for review. Review of the hospice "Visit Frequency Grid," indicated the following: November 11, 2014 - The resident was to receive planned visits by the nurse once a week. December 3, 2014 - The resident was to receive planned visits by the nurse twice a week. December 23, 2014 -The resident was to receive planned visits by the nurse once a week. Review of the hospice sign in sheet revealed the following: November 2014- no printed name with credentials or signed names with credentials of the hospice December 2014-December 20, 2014, there was one printed and signed name with credentials of hospice nurse. Review of the clinical record lacked documented evidence of hospice nursing assessments and notes from November 12, 2014 to January8, 2014. January 2014- no printed name with credentials or signed names with credentials of the hospice nurse. The clinical record lacked documented evidence that the facility staff collaborated with hospice to provide the necessary care and services to the resident. On January 8, 2014, at approximately 2:40 PM, a face-to-face interview was conducted with the hospice representative who acknowledged the above mentioned findings. When asked if visits

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 01/12/2015 B. WING HFD02-0001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2131 O STREET NW BRINTON WOODS HEALTH & REHAB CENTER WASHINGTON, DC 20037 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 051 Continued From page 6 L 051 were made by the hospice nurse during the above mentioned dates, he/she stated although they did not sign in, he/she knew they made visits. When asked to provide the hospice nursing assessments and notes for the resident from November 12, 2014 to January 8, 2014, he/she could not provide the information. He/she communicated that the assessments and notes were in the hospice office. On January 8, 2014, at approximately 3:00 PM, a face-to -face interview was conducted with Employee #3 who acknowledged the aforementioned findings. Facility staff failed to collaborate with hospice to coordinate the necessary care and services for the resident. The clinical record was reviewed on January 8, 2015. B. Based on clinical record review and staff interviews for 1 (one) of 37 sampled residents it was determined that the facility staff failed to clarify a medication order to include an accurate indication for the use of Benzotropine (Cogentin) [an Anticholinergic medication used to treat symptoms of involuntary movement]. Resident #110. The findings include: Mosby 's Nursing Drug Reference 2014 Cogentin an Anticholinergic /Antiparkinsonian medication to control extrapyramidal [neurological network that causes involuntary reflexes and movements] disorders. Facility staff failed to clarify a medication order to

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	Cogentin (Benzotro Initial physician 's Start Cogentin 0.5 BID [twice a day] for Current physician ' Cogentin (Benztro) PO 2 [two] Times a instructions: for ps The clinical record that the facility star include the accura Cogentin (Benzotro On January 9, 20 face-to-face interve Employee #4 who Facility staff failed	e indication for the use of opine) for Resident #110. order: July 22, 2014, 10:27 AM, " mg [milligrams] po [by mouth] or psychosis/agitation. " s order: January 2, 2015, pine) Oral Tablet 0.5mg 1 Tablet a day 9am, 5pm special ychosis/agitation. " lacked documented evidence of clarified the medication order to the indication for the use of ophine). Is at approximately 2:30 PM, a niew was conducted with acknowledged the findings. It to clarify a medication order to the indication for the use of the indication or the use o	L 051	 la. Resident #10 did not suffer ar from this deficient practice. 1b. Clarification of Cogentin was Include its indication of use. 2. All other residents on Cogent Tropine) were reviewed and rnoted with this deficient pract 3a All nurse managers and char were in-serviced on 1/31/15 tappropriate indication of med 3b QA/Designee will conduct biaudits for ninety days to ensicompliance. 4. Further findings of this matter discussed in the weekly, mor quarterly QA meetings for six 	done to in (Benzo none was ice. ge nurses o include lication use. weekly ure r will be nthly and	2/16/15
r 098	from spoilage, sa served in accorda forth in Title 23, 5 Regulations (DCI This Statute is n	hall be clean, wholesome, free fe for human consumption, and ance with the requirements set Subtitle B, D. C. Municipal MR), Chapter 24 through 40. ot met as evidenced by:	L 099	 All dented pans were immedidentified, removed and disc 1/30/15. Director of Food Service chand pans and none was not deficient practice. 	ecked all pot	
	was determined prepare and district applications as evi	rations made on January 8, 2015, that the facility failed to store, ribute food under sanitary idenced by dented food service as one (1) of one (1) round pan		3a All Food Services staff we on 1/31/15 on the identifica disposal of dented pans.	re in-serviced	s

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 01/12/2015 B. WING HFD02-0001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2131 O STREET NW BRINTON WOODS HEALTH & REHAB CENTER WASHINGTON, DC 20037 (X5) COMPLETÉ DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L 099 3b Food Service Director/Designee will Continued From page 8 L 099 conduct random audits bi-weekly for and one (1) of one (1) half-size deep pan, five (5) of ninety days to ensure compliance. five (5) one-quarter size pans that were stored wet and dented and low final rinse temperatures from 4. Further findings on this matter will be the dishwashing machine that were sporadically discussed in the weekly, monthly and documented and not acted upon for nine (9) of 13 2/16/15 quarterly QA meeting six months. months in 2014 and 2015. The findings include: One of one round pan was dented. 1. All five one quarter size pans were identified and immediately rewashed and 2. Five of five one-quarter size pans were stored wet and dented. air dried. One of one half-size deep pan was dented. 2. Dietary department checked all pans on 1/15/15 and none was noted with this 4. Final rinse temperatures for the dishwashing deficient practice. machine were documented at less than 180 degrees Fahrenheit on numerous occasions for 9 of 3a Director of Food Services in-serviced all 13 months in 2014 and 2015. A review of the dietary staff on 1/31/15 on proper air dishwashing machine logs revealed that final rinse drying and storage of pans. temperatures, which are recorded once in the morning and once in the afternoon, were below the 3b Director of Food Service / Designee will expected minimum temperature of 180 degrees conduct weekly audits for ninety days to Fahrenheit during the following instances. ensure compliance. Three (3) times in January 2015 Further findings on this matter will be Twenty-two (22) times in December 2014 discussed in the weekly monthly and Six (6) times in November 2014 2/16/15 quarterly QA meetings for six months. Twice (2) in October 2014 Fourteen (14) times in August 2014 Three (3) times in July 2014 Three (3) times in June 2014 1. No resident was harmed by this deficient Seven (7) times in May 2014 practice. Three (3) times in February 2014. 2. The dish machine temperature log book There was no evidence that the low temperatures was immediately checked and no other noted above were acted upon. deficient practice was noted.

PRINTED: 02/02/2015 FORM APPROVED Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 01/12/2015 B. WING HFD02-0001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2131 O STREET NW BRINTON WOODS HEALTH & REHAB CENTER WASHINGTON, DC 20037 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG L 099 3a Director of Food Services in-serviced all Continued From page 9 L 099 dietary staff on 1/31/15 on the accuracy During a face to face interview with Employee # 10 of proper temperature range and on January 8, 2015 at approximately 9:30 AM, documentation in the temperature log he/she confirmed the findings and stated that some book. of the newer staff members needed to be re-educated about the dishwashing machine logs. 3b. The food service director will conduct He/she stated that the dishwashing machine had daily audit of the temperature log book been operating normally and the low temperatures for ninety days to ensure accuracy and that were sporadically documented above were compliance. incorrect. These observations were made in the presence of Further findings of this matter will be Employee #10 who acknowledged the findings. discussed in the weekly, monthly and 2/16/15 quarterly QA meeting for six months. L 201 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

diagnoses:

screening, admitting diagnoses, and final

from the attending physician;

(f)Date of discharge, and condition on discharge;

(g)Hospital discharge summaries or a transfer form

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	(h)Medical history, diagnosis, prognosi	allergies, physical examination, is and rehabilitation;				
	(i)Vaccine history, i information about in vaccine preventable	f applicable, and other pertinent mmune status in relation to e disease;				
	(j)Current status of	resident's condition;				
	at the time of obse changes in the resi medication or treat renewed or when t	ess notes which shall be written rvation to describe significant ident's condition, when ment orders are changed or he resident's condition remains a status quo condition;				
	discharge, which s attending physicial diagnoses, course	edical experience upon thall be summarized by the nand shall include final of treatment in the facility, on of illness, medications on ation to which the resident was				
	(m)Nurse's notes with the resident's policies of the nur	which shall be kept in accordanc medical assessment and the sing service;	e			
	ongoing reports o	resident's assessment and f physical therapy, occupational herapy, podiatry, dental, ation, dietary, and social services	; 			
	(o)The plan of car	re;				
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L 201	(q)A current inventor clothing, belonging This Statute is not A. Based on record three (3) of 37 same that the facility's state accurate, and organized and practices as e	and advance directives; and bry of the resident's personal is and valuables. met as evidenced by: If review, and staff interview for apled residents, it was determined aff failed to maintain complete, anized clinical records in accepted professional standards yidenced by failure to ensure that	L 201	 Resident 42, 51 and61 ABN/d letters were placed in their charts. All other resident charts were and none noted with this deficient practice. All social workers were in-second in the placement of A forms/denial letters in resident audits for ninety days to ensure. 	checked cient rviced on ABN ats charts.	
	documentation rela Notice of Non-cove closed clinical reco Residents #42, #5	ated to Advanced Beneticiary erage was incorporated into the ords for three (3) residents. 1, and #61.		compliance. 4. Further findings on this matter discussed in the weekly, mor quarterly QA meetings for six	nthly and	6/15
	Beneficiary Notice closed clinical record that the resident was August 29, 2014 was September 11, 20 Resident #42 's a documented evid	is were incorporated into the ord for Resident #42. ent #42's clinical record revealed was admitted to the facility on with diagnoses which included Encase, Hemiparesis, Generalized is Diabetes Mellitus, and of the clinical record revealed that is discharged from the facility on				

	equiation & Licensing	Administration	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	
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- ·		illed nursing or rehabilitation				
	services may be de	nied nataling of rendomicators				
	services may be de	S11100.				
	A face-to-face inter	view was conducted with				
	Employee #9 on Ja	anuary 12, 2015, at approximately	/			
	11:40 AM. He/she	acknowledged the findings and				
	stated that copies of	of the Advanced Beneficiary Medicare Non-coverage forms				
	Notices/ Notice of I	e residents' closed records but	1			
	were kent in a bind	der in the Social Service's office.	1			1
	The record was rev	viewed on January 12, 2015.	1			
	1					
	Facility staff failed	to ensure that documentation				
!	related to Advance	ed Beneficiary Notice was				
		he closed clinical record for				
!	Resident #42.					
	2. Facility staff faile	ed to ensure that Advanced				
	→ Beneficiary Notice:	s were incorporated into the				
	closed clinical reco	ord for Resident #51.	· [
	1	4E41a aliciaal ragged on	1			
	A review of Reside	ent #51's clinical record on				
	January 12, 2015,	, revealed that he/she was cility on July 10, 2014.				
	admitted to the lat	Unity Off Doily To, 20 TH				
	Further review of t	the clinical record revealed the				
	resident was disch	harged from the facility on Augus	t			
	29, 2014.					
		Jacob elisioni record locked				
	Resident #51 's c	closed clinical record lacked ence that he/she received notice	of			
	documented evide	hts once the provider determined				
	nis/ner appear rigi	g or rehabilitation services may b	e			
1	i denied.	9 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				1
1						
	A face-to-face inte	erview was conducted with	.			
	Employee #9 on .	January 12, 2015 at approximate	<u>'</u> У			
	10:29 AM. He/sh	ne acknowledged the findings and	,			
	stated that copies	s of the				
						1

Health Re	equiation & Licensing	Administration			(X3) DATE SUF	NEV.
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	COMPLET	
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		- 1	
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		HFD02-0001	B. WING		01/12/	2015
		ethest ADD	RESS, CITY, STATE	: ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER		REET NW	, w.,		
BRINTON	WOODS HEALTH & F		TON, DC 2003	7		
				PROVIDER'S PLAN OF CORREC	TION	(X5)
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			<u> </u>			
L 201	Continued From pa		L 201			
£ 201			1			
	Advanced Beneficia	ary Notices/ Notice of Medicare				
	Non-coverage form	s were not kept in the resident's were kept in a binder in the	1		1	
	Social Service's off	ice. The record was reviewed on				
	January 12, 2015.	100.			İ	
	Facility staff failed	to ensure that documentation				
	related to Advance	d Beneficiary Notices were				
		ne closed clinical record for	1			
	Resident #51.		1			
	3. Facility staff faile	ed to ensure that Advanced	1		•	
	Beneficiary Notices	s were incorporated into the	1			
	closed clinical reco	ord for Resident #61.	1 1		İ	
		ent #61's clinical record on				
ļ	A review of Reside	revealed that he/she was	}			
	admitted to the fac	ility on July 28, 2014 and was				
ļ	discharged from th	ne facility on September 9, 2014.				
			1			
	Resident #61 's cl	losed clinical record lacked	₅			
	documented evide	ence that he/she received notice of the once the provider determined	<u>" </u>			
	that skilled nursing	or rehabilitation services may be	e			
	denied.	,				
			1		,	
	A face-to-face inte	erview was conducted with				
	Employee #9 on J	anuary 12, 2015 at approximatel	^y			
	10:29 AM. He/sne	e acknowledged the findings s of the Advanced Beneficiary				
	Notices/ Notice of	Medicare Non-coverage forms				
	were not kept in the	ne resident's closed records but				l
	were kept in a bin	der in the Social Service's office.				
	The record was re	eviewed on January 12, 2015.				!
		Les anaura that documentation				
	Facility staff failed	to ensure that documentation ed Beneficiary Notices were	ļ			
	incorporated into	the closed clinical record for				
	incorporated into					

2/16/15

PRINTED: 02/02/2015 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: B. WING HFD02-0001 01/12/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2131 O STREET NW **BRINTON WOODS HEALTH & REHAB CENTER** WASHINGTON, DC 20037 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (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 201 L 201 Continued From page 14 Residents #56, #68, #86, #99 and #191 Resident #61. did not suffer any harm from this deficient practice. B. Based on record review and staff interview for five (5) of 37 sampled residents, it was determined All other residents were personal property that the facility staff failed to ensure that Residents' Inventory forms were reviewed and none Personal Property Inventory forms were revised noted with the deficient practice. quarterly in accordance with Title 22 DCMR 3231.12 (s). Residents #56, #68, #86, #99, and 3a An in-service was conducted for nursing #191. staff on 2/3/15 on updating personal property inventory forms and honoring of The findings include: residents preferences in general and handling of laundry in particular.

According to Chapter 32, Title 22B Long Term Care Licensure Regulations, the District of Columbia Municipal Regulations (DCMR), section 3231.12 stipulates: "Each facility shall ensure that each medical record shall include the following information:...(s) A quarterly inventory of the resident's personal clothing, belongings, and valuables".

1. The facility staff failed to ensure that Resident # 56's Personal Property Inventory was revised quarterly.

A review of Resident #56's clinical record on January 9, 2015, revealed that he/she was admitted to the facility on July 31, 2012.

Additional review of the clinical record revealed Resident #56's Personal Property Inventory was last revised on August 7, 2013.

Additionally, the clinical record contained Resident Personal Property forms dated November 27, 2014 and November 28, 2014, which detailed specific items and did not contain updated comprehensive itemizations of the

Health Regulation & Licensing Administration

3b QA/Designee will conduct bi-weekly

compliance.

rounds for ninety days to ensure

Further findings of this matter will be

discussed in the weekly, monthly and

quarterly QA meeting for six months.

Health Re	egulation & Licensing	Administration		ONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		COMP	LETED
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NAME OF PR	OVIDER OR SUPPLIER		RESS, CITY, STAT	E, ZIP CODE		
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BRINTON			TON, DC 2003	PROVIDER'S PLAN OF CORR	ECTION	(X5) COMPLETE
(X4) ID PREFIX TAG	TEACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE
L 201	Continued From page	ge 15	L 201			
	resident's personal valuables.	clothing, belongings, and				
	that the facility cond	acked documented evidence ducted a quarterly inventory of all sonal clothing, belongings, and				
	The facility staff fail Personal Property	ed to ensure that Resident 56's nventory was revised quarterly.				
	2. The facility staff 68's Personal Prop quarterly.	failed to ensure that Resident # erty Inventory was revised				
	A review of Reside January 9, 2015, re to the facility on Ja	nt #68's clinical record on evealed that he/she was admitted nuary 21, 2012.				
	Additional review of Resident #68's Pelast revised on Apr	of the clinical record revealed rsonal Property Inventory was ril 27, 2013.				
	that the facility cor Resident #68's pe valuables.	lacked documented evidence inducted a quarterly inventory of rsonal clothing, belongings, and erview was conducted with anuary 8, 2015, at approximately	,			
	3:30 PM. He/she	acknowledged the findings. eviewed on January 9, 2015.				
	The facility staff fa	ailed to ensure that Resident #68 Inventory was revised quarterly	's -			
1			1			

Health R	equiation & Licensing	Administration			10100000	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETED	
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	(EACH DEFICIENCY MUS OR LSC IDE	REHAB CENTER 2131 O STI WASHING ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	RESS, CITY, STATEREET NW FON, DC 200 PREFIX TAG		D BE	(X5) COMPLETE DATE
L 30	ten degrees Fahren ninety-five degrees This Statute is not Based on observati between 11:00 AM 2015 at approximat that the facility faile maintenance servic sanitary, orderly, ar evidenced by low w 44 resident's rooms. The findings includ 1. Water temper rooms surveyed we Fahrenheit (F) as rewater temperatures. Room # 403 = 92.8 Room # 402 = 84.0 Room # 303 = 93.4 Room # 302 = 90.3 Room # 203 = 84.0 These observation Employee #11 and 3245.10 Nursing Family A call system that shall be provided: (a)Be accessible to from each bed loc shower room and	met as evidenced by: ons made on January 8, 2015 and 4:30 PM and on January 9, ely 9:30 AM, it was determined d to provide housekeeping and es necessary to maintain a nd comfortable interior as vater temperatures in five (5) of s. e: etures in five (5) of 44 residents' ere less that 95 degrees equired by Title 22 DCMR. The s were as follows: 8 degrees F 1 degrees F 2 degrees F 3 degrees F 3 degrees F 5 degrees F 6 degrees F 7 degrees F 8 swere made in the presence of 8 Employee #12.		 1a Cold water temperatures in re 403, 402, 303, 302 and 203 w Immediately restored to comp between 95-110 degrees by regas valve by American Boiler 2. All other rooms in the facility of checked and none noted with deficient practice. 3a. The Director of Maintenance the staff on 1/31/15 on the act water temperature per regula 3b. Director of Maintenance/Desconduct daily rounds for nine ensure compliance. 4. Further findings on this matter discussed in the weekly, mor quarterly QA meetings for six 	vere pliance eplacing the on 1/8/15 were this in-serviced curacy of tion. signee will ety days to er will be onthly and	2/16/15

		A 1				
Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED			
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	HFD02-0001					
NAME OF PR	OVIDER OR SUPPLIER		RESS, CITY, STAT	re, zip code		1
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				PROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETE
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L 306	call bell can be tern room; (c)Be of a quality w consistent with curre (d)Be in good work. This Statute is not Based on observat between 11:00 AM that the facility fails system in good wo call bells in six (6) not emit an alarm w. The findings included 1. Resident call the in six (6) of 44 resis 507, # 508, # 5135. These observations.	cilities, be of type in which the hinated only in the resident's which is, at the time of installation, tent technology; and ing order at all times. met as evidenced by: ions made on January 8, 2015 and 4:30 PM, it was determined at to maintain resident's call bell rking condition as evidenced by of 44 resident 's rooms that did when tested. le: bells did not operate as intended dent's rooms including rooms # 3, # 518B, # 517A and # 207. Ins were made in the presence of d/or Employee #12.	L 306	 Call cords in rooms 507, 508, 517A and 207 were identified immediately replaced and temproper operation on 1/8/15. All call lights in the facility we checked and none was note deficient practice. All maintenance staff were in on 1/12/15 on proper function bells. The Director of Maintenance will check call bell daily for niensure proper functioning. Further findings on this matt discussed in the weekly, modaily QA meetings for six moderns. 	d and sted for ere ed with this enserviced ening of call ell/Designee inety days to er will be enthly and	2/16/15
£ 41	Each facility shall maintenance servexterior and the insanitary, orderly, o	provide housekeeping and ices necessary to maintain the aterior of the facility in a safe, comfortable and attractive of met as evidenced by: ations made on January 8, 2015 M and 4:30 PM and on January				

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Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 01/12/2015 B. WING HFD02-0001 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2131 O STREET NW **BRINTON WOODS HEALTH & REHAB CENTER** WASHINGTON, DC 20037 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 410 L 410 Continued From page 20 9, 2015 at approximately 9:30 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 soiled bathroom vents in five (5) of 44 residents' rooms surveyed and one (1) of two (2) damaged over-bed table in one (1) of 44 resident's room surveyed. The findings include: 1. Bathroom vents were soiled with dust particles in five (5) of 44 residents' rooms Rooms #518, #505, # 405, # 319 and # 308. 2. One (1) of two (2) over-bed table in room #320 was worn at the seams and needed to be replaced in one (1) of 44 resident's room surveyed. These observations were made in the presence of Employee #11 and Employee #12. L 426 L 426 3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: 1. The chairs in room 420 was immediately Identified and removed from Based on observations made during the survey, it the resident's room and discarded. was determined that the facility failed to maintain an effective pest control program as evidenced by 2a All chairs located in residents rooms in crawling and flying insects observed in the facility the entire building were checked and

throughout the survey.

none noted with this deficient practice.

Health Regulation & Licensing Administration (X3) DATE SURVE								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED			
AND PLAN U	CONTROLLOR		A, BUILDING					
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	OVIDER OR SUPPLIER	2131 O ST						
BRINTON WOODS HEALTH & REHAB CENTER WASHINGTON, DC 20037								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE			
L 201	Continued From pa	ge 16	L 201					
	The facility staff failed to ensure that Resident #86's Personal Property Inventory was revised quarterly.							
	A review of Reside January 8, 2015, re to the facility on Ju	nt #86's clinical record on evealed that he/she was admitted ne 29, 2011.						
	Resident #86's Per	of the clinical record revealed resonal Property Inventory was /10"[date incomplete].						
	I that the facility con	lacked documented evidence aducted a quarterly inventory of resonal clothing, belongings, and						
	Employee #7 on J	rview was conducted with anuary 8, 2015, at approximately acknowledged the findings.						
	The record was re	viewed on January 8, 2015.						
	The facility staff fa	tiled to ensure that Resident #86's Inventory was revised quarterly.	;					
	4. The facility staf #99's Personal Pr quarterly.	f failed to ensure that Resident operty Inventory was revised						
	January 9, 2015, to the facility on S	ent #99's clinical record on revealed that he/she was admitte September 26, 2008.	d					
	Additional review Resident #99's P	of the clinical record revealed ersonal Property Inventory was						
1			1					

Health Red	gulation & Licensing	Administration			(X3) DATE SURVE	Y T
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPLETED	.
AND PLAN OF	CORRECTION		A. BUILDING:			1
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	last revised April 26					!
	that the facility cond Resident #99's pers valuables.	lacked documented evidence ducted a quarterly inventory of sonal clothing, belongings, and viewed on January 9, 2015.				
	The facility staff fail #99's Personal Pro quarterly.	led to ensure that Resident # perty Inventory was revised				
;	The facility staff #191's Personal Pr quarterly.	failed to ensure that Resident roperty Inventory was revised				
	A review of Reside January 9, 2015, ro to the facility on Au	ent #191's clinical record on evealed that he/she was admitt ugust 8, 2013.	ed			
	Additional review of Resident #191's Plast revised on Aug	of the clinical record revealed Personal Property Inventory was gust 8, 2013.				
	that the facility cor	d lacked documented evidence inducted a quarterly inventory of personal clothing, belongings, ar	all ad			
	The facility staff fa s Personal Proper quarterly.	ailed to ensure that Resident#19 rty Inventory was revised	91 '			
L 23	5 3236.4 Nursing F	- -acilities	L 235			
	The temperature used by each res	of hot water of each fixture that ident shall be automatically	is			

Health Regulation & Licensing Administration		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY	,			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·		COMPLETED				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:						
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	NAME OF SPONIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NAME OF PE	ROVIDER OR SUPPLIER							
BRINTON WOODS HEALTH & REHAB CENTER 2131 O STREET NW WASHINGTON, DC 20037								
(X4) ID PREFIX TAG	ZEACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	OBE 19	(X5) COMPLETÉ DATE		
	Continued From parties findings included from parties and findings included from parties we located in room #42 rooms surveyed. For under the seat of the immediately removes according to Employ discarded. 2. A large flying in rooms #415 A and 7, 2015 at approximate flying nursing station on 8, 2015 at approximate of the parties of the first flying in the first flying nursing station on 8, 2015 at approximate of the first flying fly	ge 21 e: 2015, at approximately 3:00 PM, ere observed inside a chair 20, one (1) of 44 resident 's cod such as crackers was stored are chair. The chair was ed from the resident 's room and oyee # 12, it was immediately ensect was observed in the area of B and #415 C and D on January mately 1:00 PM. g insect was observed at the the fourth (4th.) floor on January	L 426	2b All environmental service star serviced on 1/22/14 on pest of 3. The Director of Environmental designee will conduct daily rouninety days to ensure complicated. Further findings on this matter discussed in the weekly, mon quarterly QA meetings for six 1. Rooms 415A, 415B, 415C, 41 nursing station were treated. Western Pest Control Complete and the weekly western Pest Conone noted with this deficient on 1/31/15 on Pest control abook located on all units. 3b. The Director of Environmental designee will conduct daily on ninety days to ensure complete. Further findings on this matter discussed in the weekly, mon quarterly QA meetings for six personners.	f were incontrol. al service or bunds for ance. er will be thly and a months. 15D and the for pest by any on 2/2/15 and the login tal service or checks for liance. er will be nthly and	2/16/15		