

Admissions: 202-574-5780 Admissions Fax: 202-574-5792

August 29, 2014

Cassandra Kingsberry, RN Supervisory Nurse Consultant Health Care Facilities Division District of Columbia Department of Health (DOH) Health Regulation and Licensing Administration 899 North Capitol Street, NE, 2nd Floor Washington, DC 20002

Dear Ms. Kingsberry:

Subject: Survey Plan of Correction

Enclosed is the plan of correction for Specialty Hospital of Washington – Capitol Hill Nursing Center addressing the deficiencies found during the annual licensure survey conducted on July 8 through July 18, 2014. We are alleging compliance as of September 12, 2014.

If you have any question, please don't hesitate to contact me at (202) 527-0901 or 202-629-5464.

Sincerely,

Maria Allen Nursing Home Administrator Enclosure (3)

cc.: Susan Bailey, SHW-Capitol Hill Sharon W. Lewis, DHA, RN-BC, CPM, DOH-HRLA

<u>CENTER</u>	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES			<u>OMB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED
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F 000	conducted on July 8 deficiencies are bas review, resident and	S ality Indicator Survey (QIS) was through July 18, 2014. The ed on observation, record staff interviews for 36 sampled (8) of 40 supplemental	F 0(00 Responses begins or	n page 3	
	Acronyms that may Abbreviations AMS - Altered M ARD - assessme BID - Twice-a-G B/P - Blood Pre cm - Centimeters CMS - Centers for Services CNA- Certified N CRF - Commun D.C District of D/C discontinue DI - deciliter DMH - Departme EKG - 12 lead E EMS - emergenc g-tube Gastrosto ventilation/Air condir FU/FL Full Uppe ID - Intellectua IDT - interdiscip INR - Internation L - Liter Lbs - pounds (n	essure s or Medicare and Medicaid Aurse Aide hity Residential Facility Columbia ent of Mental Health flectrocardiogram y medical services (911) omy tube HVAC - Heating tioning er /Full Lower al disability blinary team hal Normalised Ratio unit of mass)				
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
	l	Mana lile		Nursing Home Administrator		8/29/201

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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	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>DMB NO</u>	. 0938-0391
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F 000	MAR - Medicatio MD- Medical I MDS - Minimum Mg - milligrams mL - milligrams mm/Hg - milligrams mm/Hg - millimeters MRR- Medication Neuro - Neurolog NP - Nurse Pr OBRA - Omnibus PASRR - Preadmis Review Peg tube - Percutan PO-by mouth POS - physiciar Prn - As neede Pt - Patient Q- Every QIS - Quality In Rp, R/P- responsible RAI- Resident ROM- Range of TAR - Treatmen CAA- Care Asse	n Administration Record Doctor Data Set s (metric system unit of mass) (metric system measure of s per deciliter s of mercury Regimen Review ical actitioner Budget Reconciliation Act sion screen and Resident neous Endoscopic Gastrostomy n's order sheet ed dicator Survey e party Assessment Instrument	F	000			
F 156 SS=D	RIGHTS, RULES, S The facility must info in writing in a langua understands of his o regulations governin responsibilities durin	483.10(b)(1) NOTICE OF ERVICES, CHARGES form the resident both orally and age that the resident or her rights and all rules and ing resident conduct and ing the stay in the facility. The povide the resident with the	F	156	Refer to page 4 for response F156		

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Facility ID: CAPITOLHILL

If continuation sheet Page 2 of 77

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F 156	Continued From page notice (if any) of the §1919(e)(6) of the A made prior to or upor resident's stay. Rec any amendments to writing. The facility must infe entitled to Medicaid of admission to the resident becomes e and services that ar services under the S resident may not be services that the fac resident may be char charges for those se resident when chan services specified in this section. The facility must infe the time of admission resident's stay, of se and of charges for the charges for services by the facility's per of	ge 2 State developed under act. Such notification must be on admission and during the ceipt of such information, and it, must be acknowledged in orm each resident who is benefits, in writing, at the time nursing facility or, when the ligible for Medicaid of the items e included in nursing facility State plan and for which the charged; those other items and cility offers and for which the arged, and the amount of ervices; and inform each ges are made to the items and n paragraphs (5)(i)(A) and (B) of orm each resident before, or at on, and periodically during the ervices available in the facility hose services, including any a not covered under Medicare or		156	DEFICIENCY)		
	legal rights which in A description of the						
	for establishing eligi right to request an a	requirements and procedures bility for Medicaid, including the assessment under section mines the extent of a					

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If continuation sheet Page 3 of 77

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To CAPITOL HILL NURSING CENTER To CONST. AVE. NE WASHINGTON, DC 20002 Mail In Construction Image: International internation			095027	B. WING			07/ ⁻	18/2014
CAPTIOL HILL NURSING CENTER WASHINGTON, DC 20002 (PA) ID PREFIX TAG IEACH DEFICIENCY UNITS E PRECODED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION PIE PREFIX TAG IPROVIDENTIFYING INFORMATION PIE CROSS-REFERENCED TO THE APPROPRIATE OWNETTON DETICENTIANES PRECODED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION PIE TAG PROVETING INFORMATION OWNETTON BALES F 156 Continued From page 3 couple's non-exempt resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. F 156 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency. The State licensure office, the State ombudsman program, the property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility, writhen information, and provide to residents and applicants for admission oral and writhen information about hwo to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG CEACH-DENEMOV MUST BE PRECEDED BY PULL REGULATORY OR LSCIDENTFYING INFORMATION PREFIX TAG CEACH-CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMETION DATE F 156 Continued From page 3 couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. F 156 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit, and a statement that the resident my file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specially, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	CAPITOL	HILL NURSING CENT	ER					
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	F 156	couple's non-exemp institutionalization a spouse an equitable cannot be considered the cost of the institu- care in his or her pro- Medicaid eligibility le A posting of names, numbers of all pertir groups such as the agency, the State lic ombudsman program network, and the Me statement that the re- the State survey and concerning resident misappropriation of and non-compliance requirements. The facility must infor specialty, and way of responsible for his of The facility must pro- written information, applicants for admis about how to apply f Medicaid benefits, a previous payments of	the resources at the time of and attributes to the community e share of resources which ed available for payment toward utionalized spouse's medical occess of spending down to evels. addresses, and telephone nent State client advocacy State survey and certification censure office, the State m, the protection and advocacy edicaid fraud control unit; and a esident may file a complaint with d certification agency abuse, neglect, and resident property in the facility, with the advance directives orm each resident of the name, of contacting the physician or her care. ominently display in the facility and provide to residents and esion oral and written information for and use Medicare and and how to receive refunds for covered by such benefits.	F	156			

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 4 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	Based on record re (1) of 36 sampled re facility staff failed to Medicare Non-cove Resident #57. The findings included According to a " His January 22, 2014 re admitted to the facili included: " Conges: Artery Disease, and Bypass Graft [times According to an inte February 26, 2014 of [discharged] home of with nursing for med health aide, OT (Oc (Physical Therapy) f Physician ' s order of " Rehabilitation Scree (Occupational Therapy) f A review of the clinic #57 was started on 2014 and was disch February 3, 2014, s 2014 and occupatio 2014. A review of the clinic	view and staff interview for one esidents, it was determined that ensure that the "Notice of rage " letter was provided to es: story and Physical " dated evealed; Resident #57 was ity with diagnoses which tive Heart Failure, Coronary Status Post Coronary Artery 3]. erim physician 's order dated directed, " Resident may be on Friday February 28, 2014 dication management, home cupational therapy), PT for safety evaluation " dated January 22, 2014 directed, een: PT (Physical Therapy), OT apy) and Speech Therapy eat as indicated. " cal record revealed Resident skilled services on January 23, narged from physical therapy on peech therapy on February 5, nal therapy on February 7, cal record lacked evidence that are Non-coverage " letter was	F	156	 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 1. Resident #57 no longer resides in facility, therefore; no further meas could be taken. 2. Business Office Coordinator will a residents discharged from Medica ensure "Notice of Medicare non-cohas been provided. 3. Business Office Coordinator or de will audit monthly Medicare discharensure "Notices of Medicare non-coverage" have been provided. 4. Business Office Coordinator or de will document findings and presen Quality Assurance Committee for evaluation, and recommendations for a period of three months. 	the ures udit re to overage" signee arges to signee t to the review,	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 5 of 77

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CAPITOL	HILL NURSING CENT	ER			VASHINGTON, DC 20002		
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F 156	Additionally, there we the clinical record the provided. A face-to-face interve Employees #7 and # approximately 1:00 aforementioned con were not given the in resident ' s discontin clinical record was re Facility staff failed to	e last day of skilled services. vas no documented evidence in at verbal notification was view was conducted with #22 on July 17, 2014 at	F ·	156			
F 253 SS=E	SERVICES The facility must promaintenance service sanitary, orderly, an This REQUIREMEN Based on observati environmental tour of approximately 10:00 facility failed to provimaintenance service sanitary, orderly, an evidenced by: air co in six (6) of 46 resid missing slats in thre	EKEEPING & MAINTENANCE wide housekeeping and es necessary to maintain a d comfortable interior. T is not met as evidenced by: ons made during an of the facility on July 10, 2014 at 0 AM, it was determined that the ide housekeeping and es necessary to maintain a d comfortable interior as ntrol fans that failed to blow air ent's rooms, window blinds with e (3) of 46 resident's rooms, on three (3) of three (3) floor	F	253	Refer to page 7 for response F253		

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If continuation sheet Page 6 of 77

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CAPITOL HILL NURSING CENTER			w	ASHINGTON, DC 20002		
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bathroom of room #6143, tv	r in one (1) of 46 intrance doors in seven marred walls in nine (9) in two (2) of three (3) of water faucets in two (2) it functioning in six (6) of ng rooms 6128, #6112, #5144. sing slats in four (4) of 46 he fourth, fifth and sixth eas. Illuminate in the following of , two (2) of two (2) in the wo #6133 and one (1) of two n the bathroom of room er was veral resident's rooms	F2	253	 483.15(h)(2) HOUSEKEEPING & MAINTENA SERVICES Response to #1-8 1. Air control fans have been fixed in rooms #6144, #6143, #6128, #6112, #5144. Window slats have been replaced in room #6128, #6112, #5127, #4143; Shower room floors on the fourth, fifth and sixth floor with stripped and waxed by housekeeping. Cellights have been replaced in rooms #614, #6143, #6133, #6128; The wall light and room #5119 will be replaced; The entrance to resident's rooms #5116, #5110, #5102, and #4106 will be painted; The walls in refrooms #6143, #6104, #5147, #5133, #41 #4146, #4133, #4104 will be painted. The the activity rooms in the 4th and 5th floor walls in the bathroom in room #4116 will The hot water faucet in rooms #6129 and have been fixed. 2. Maintenance Director or designee will co environmental round to identify any issue air control fans, window blinds, floors, cellights, entrance doors, walls, and faucet 1 3. Environmental rounds will be conducted of by a work group including Maintenance Director or designee. Housekeeping Director or designee, Housekeeping Director or designee, Coordinator or designee, Resident Care Coordinator or designee to identify any maintenance or housekeeping issues. Maintenance a binder on each floor to enstaff can document maintenance needs. 4. Maintenance Director will document finding present to the Quality Assurance Commit review, evaluation and recommendations monthly for a period of three months. 	#6153, ms om II be biling 2, cover in ce door , #4150 esident's 55, e walls in and the be fixed; #4121 nduct an s with ling eaks. monthly birector esignee, e sure mgs and tee for	9.12.2014

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Facility ID: CAPITOLHILL

If continuation sheet Page 7 of 77

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F 253 F 272	 7. Walls in resident's rooms #6143, #6104 #5133, #4155, #4 room on the fifth floor activity room on the fifth floo	5102, #4157, #4150 and #4106. s rooms were marred including 4, #5147, 146, #4133, #4104, the activity or, the ne fourth floor and the bathroom cet in rooms #6129 and #4121 were made in the presence of mployee		253	Refer to page 7 for response F253 Refer to page 10 for response F272		
SS=F	comprehensive, acc reproducible assess functional capacity. A facility must make of a resident's needs assessment instrum The assessment mu Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-be	ment of each resident's a comprehensive assessment s, using the resident ent (RAI) specified by the State. Ist include at least the following: mographic information;					

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If continuation sheet Page 8 of 77

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F 272	Disease diagnosis a Dental and nutritions Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of si the additional asses areas triggered by th Data Set (MDS); an	and health conditions; al status; and procedures; ummary information regarding sment performed on the care the completion of the Minimum	F 2	272	Refer to page 10 for response F272		
	A. Based on record nine (9) of 36 sampl supplemental reside facility staff failed to Care Area Assessm Minimum Data Sets [V0200A] for nine (9 # 48, #55, #58, #95, supplemental reside S83, S119, S123. The findings include According to Chapte Manual, " for each to	er 4 of the MDS 3.0 Users ' riggered care area, indicate the the CAA documentationCAA					

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Facility ID: CAPITOLHILL

If continuation sheet Page 9 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	include information in risks and any referra area " 1. Facility staff failed date of Care Area A under Section V [VC Summary" of the Mi Resident #38. A review of Resider Minimum Data Set of the Care Areas and triggered for #2 Cog Urinary Incontinence Falls, #12 Nutritiona #16 Pressure Ulcers The record revealed CAA information [fo 15, and 16] was blat There was no evide documented the loc regarding information The clinical record Is documentation regara and any referrals re A face-to-face intervent Employee #7 on Jul regarding the CAA is acknowledged that is related to the CAA in the context of the loc regarding the CAA information [for 15, and 16] was blat There was no evide documentation regara and any referrals re	on the complicating factors, als for the resident for this care d to provide the location and assessment [CAA] information 0200A], "Care Area Assessment nimum Data Set [MDS] for at #38's significant change dated June 18, 2014 revealed 'addressed ' in Care Plan gnitive Loss, #3 Visual Loss, #6 e and Indwelling Catheter, #11 al Status, #15 Dental Care and s. d that the location and date of r care areas # 2, 3, 6, 11, 12, ank. nce that the facility staff ation in the clinical record on related to the CAA ' s.		272	 483.20(b)(1) COMPREHENSIVE ASSESSMI Response to A#1-17 1. MDSs for residents #38, #42, #48, #58, # #111, #134, S50, S65, S83, S119 will b corrected. Residents #55, #113, S123, S no longer resides in the facility, therefore further measures could be taken. 2. MDS coordinator will audit residents' MD ensure V-section is complete. 3. MDS coordinator or designee will audit M a monthly basis for completion. 4. MDS coordinator will document findings a present to the Quality Assurance Commi review, evaluation, and recommendation monthly for a period of three months. 	495, e 16, S26 ; no Ss to IDSs on and ttee for	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 10 of 77

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<u> </u>	S FOR MEDICARE	& MEDICAID SERVICES			(DWR NO	. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		095027	B. WING _			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)
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F 272	Continued From page	ae 10	F2	272			
		ered. The clinical record was					
	of Care Area Asses	o provide the location and date sment [CAA] information on (MDS) under Section V					
	Assessment (CAA)	d to document on the Care Area Summary the location and date elated to the CAA was obtained.			Refer to page 10 for response F272		
	Set dated February Areas and 'addresse #3 Visual Function, (Activities of Daily L Urinary Incontinence	t #42's annual Minimum Data 3, 2014 revealed that Care ed ' in Care Plan triggered for, #4 Communication, #5 ADL iving) /Functional Status,, #6 e /Catheter, #11 Falls, #12 al Care, and #16 Pressure					
		l that the location and date of r care areas #3, 4, 5, 6, 11, 12, nk.					
	There was no evide documented where related to the CAA's	in the clinical record information					
		acked evidence of rding complicating factors, risks, ated to the triggered care areas.					
		view was conducted with y 14, 2014 at 11:43 AM					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 11 of 77

PRINTED: 08/19/2014 FORM APPROVED

	<u>CENTER</u>	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>OMB NO</u>	<u>). 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CAPITOL HILL NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFINITION TO THE PREFIX (X5) COMPLETING (EACH CORRECTIVE ACTION SHOULD BE DEFINITION TO THE PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFINITION TO THE PREFIX SHOULD BE DEFINITION TO THE PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFINITION TO THE PREFIX SHOULD BE DEFINITION TO TH				. ,				
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DEFICIENCY)		(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
F 272 Continued From page 11 regarding the CAA summary of the MDS. He/she acknowledged that the data and location of information related to the CAA was not documented. He/she further stated that the * system * [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information on Minimum Data Sets (MDS) under Section V (V0200A). Refer to page 10 for response F272 3. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200A]. "Care Area Assessment Summary" of the Minimum Data Set (MDS) for Resident #48. Refer to page 10 for response F272 A review of Resident #48's significant change Minimum Data Set dated February 14, 2014 revealed the Care Area and 'addressed' in Care Plan triggered for #1 Delirium, #2 Cognitive Loss, #3 Visual Loss, #6 Uninary incontinence and Indwelling Catheter, #11 Faik, #12 Nutritional Status, #14 Dehydration/Fluid Maintenance, #16 Pressure Ulcers, and #17 Psychotropic Medication Use. The record revealed that the location and date of CAA documentation information (for care areas # 1, 2, 3, 5, 6, 1, 1, 1, 1, 4, 16, and 17] were blank. There was no evidence that the facility staff documented the location in the clinical record regarding information related to the CAA's.	F 272	regarding the CAA a acknowledged that information related documented. He/sh system " [computer information was ent reviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A]. 3. Facility staff failed date of Care Area A under Section V [V0 Summary" of the Mi Resident #48. A review of Resider Minimum Data Set revealed the Care A Plan triggered for # #3 Visual Loss, #5 Functional Status, # Indwelling Catheter Status, #14 Dehydr Pressure Ulcers, ar Use. The record revealed CAA documentation 2, 3, 5, 6, 11, 12, 14 There was no evide documented the loc	summary of the MDS. He/she the date and location of to the CAA was not e further stated that the " "] went down when the CAA ered. The clinical record was 4, 2014. o provide the location and date sment [CAA] information on 6 (MDS) under Section V ed to provide the location and assessment [CAA] information 0200A], "Care Area Assessment inimum Data Set [MDS] for th #48's significant change dated February 14, 2014 Areas and ' addressed ' in Care 1 Delirium, #2 Cognitive Loss, ADL (Activities of Daily Living) #6 Urinary Incontinence and , #11 Falls, #12 Nutritional ation/Fluid Maintenance, #16 ad #17 Psychotropic Medication d that the location and date of n information [for care areas # 1, 4, 16, and 17] were blank.	F	272			

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Facility ID: CAPITOLHILL

If continuation sheet Page 12 of 77

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	S FOR MEDICARE	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
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		095027	B. WING			07/	18/2014
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	011	10/2014
				7(00 CONST. AVE. NE		
	HILL NURSING CENT	ER		N	ASHINGTON, DC 20002		
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F 272	Continued From pag	-	Fź	272			
		rding complicating factors, risks lated to the triggered care areas.					
	Employee #7 on Jul regarding the CAA s acknowledged that t information related t documented. He/sh system " [computer	e further stated that the "] went down when the CAA ered. The clinical record was					
	of Care Area Asses	o provide the location and date sment [CAA] information on (MDS) under Section V					
	#58 ' s Minimum Da V, " Care Area Asso include the location	d to accurately code Resident ta Set (MDS) under Section " essment (CAA) Summary to and date where information care areas could be located on			Refer to page 10 for response F272		
	Data Set with an AR of April 3, 2014 rever 'addressed ' in Care Loss/Dementia, #3 ' Communication, #6	Urinary Incontinence /Catheter, tion Status, #15 Dental Care,					
	The record revealed	I that the location and date of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 13 of 77

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CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES			(DMB NO	. 0938-0391
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				v	VASHINGTON, DC 20002		0.(-)
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F 272	Continued From page CAA information [for 15, and 16] was black	r care areas #2, #3, 4, 6, 11, 12,	F	272			
	There was no evide documented where related to the CAA's	in the clinical record information					
		acked evidence of rding complicating factors, risks, lated to the triggered care areas.					
	Employee #7 on Jul regarding the CAA s acknowledged that t information related t documented. He/sho system " [computer	e further stated that the "] went down when the CAA ered. The clinical record was					
	Assessment (CAA)	o document on the Care Area Summary the location and date elated to the CAA was obtained.					
	date of Care Area A under Section V [V0	d to provide the location and ssessment [CAA] information 200A], "Care Area Assessment nual Minimum Data Set [MDS]			Refer to page 10 for response F272		
		it #55's significant change dated June 18, 2014 revealed					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 14 of 77

PRINTED: 08/19/2014 FORM APPROVED

<u>CENTER</u>	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	<u>. 0938-0391</u>
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		095027	B. WING			07/	/18/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			700 CONST. AVE. NE WASHINGTON, DC 20002		
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F 272	the Care Areas and triggered for #2 Cog #6 Urinary Incontine Psychosocial Well-k #12 Nutritional State Dehydration/Fluid M Ulcers. The record revealed CAA information [fo 12, 14, and 16] was There was no evide documented the loc information related to the clinical record I documentation rega and any referrals re A face-to-face interv Employee #7 on Jul regarding the CAA s acknowledged that information related to documented. He/sh system " [computer information was ent reviewed on July 14 Facility staff failed to of Care Area Asses Minimum Data Sets [V0200A].	'addressed ' in Care Plan gnitive Loss, #4 Communication, ence and Indwelling Catheter, #7 being, #10 Activities, #11 Falls, us, #13 Feeding Tube(s), #14 faintenance, and #16 Pressure d that the location and date of r care areas # 2, 4, 6, 7, 10, 11, blank. Ince that the facility staff ation in the clinical record to the CAA ' s. acked evidence of urding complicating factors, risks lated to the triggered care areas. <i>v</i> iew was conducted with by 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was	F	272	2		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 15 of 77

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CAPITOL HILL NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (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 OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x6) (COMPLET TAG F 272 Continued From page 15 date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #95. F 272 A review of Resident #95 's annual Minimum Data Set dated December 28, 2013 revealed that Care Areas and 'addressed' in Care Plan triggered for, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Refer to page 10 for response F272								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CAPITOL HILL NURSING CENTER 700 CONST. AVE. NE WASHINGTON, DC 20002 WASHINGTON, DC 20002 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (COMPLET TAG F 272 Continued From page 15 date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #95. F 272 A review of Resident #95 's annual Minimum Data Set dated December 28, 2013 revealed that Care Areas and 'addressed' in Care Plan triggered for, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Refer to page 10 for response F272			095027	B. WING			07/	18/2014
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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 272 Continued From page 15 date of Care Area Assessment [CAA] information under Section V [V0200A], " Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #95. F 272 Refer to page 10 for response F272 A review of Resident #95 's annual Minimum Data Set dated December 28, 2013 revealed that Care Areas and 'addressed' in Care Plan triggered for, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 F 272	CAPITOL	HILL NURSING CENT	ER					
date of Care Area Assessment [CAA] information under Section V [V0200A], "Care Area Assessment Summary" of the annual Minimum Data Set [MDS] for Resident #95. Refer to page 10 for response F272 A review of Resident #95 's annual Minimum Data Set dated December 28, 2013 revealed that Care Areas and 'addressed' in Care Plan triggered for, #5 ADL (Activities of Daily Living) Functional Status, #6 Urinary Incontinence /Catheter, #11 Falls, #12 Refer to page 10 for response F272	PRÉFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
 Nutlinon, #10 Pressule Olders, and #17 Psychotropic Medication Use. The record revealed that the location and date of CAA information [for care areas # 5, 6, 11, 12, 16, and 17] was blank. There was no evidence that facility staff documented where in the clinical record information related to the CAA's could be found. The clinical record lacked evidence of documentation regarding complicating factors, risks, and any referrals related to the triggered care areas. A face-to-face interview was conducted with Employee #7 on July 14, 2014 at 11:43 AM regarding the CAA summary of the MDS. He/she acknowledged that the date and location of information related to the CAA was not documented. He/she further stated that the "system" [computer] went down when the CAA information was entered. The clinical record was reviewed on July 14, 2014. Facility staff failed to provide the location and 	F 272	date of Care Area A under Section V [VC Assessment Summa Data Set [MDS] for A review of Resider Set dated Decembe Areas and 'addresse ADL (Activities of Da Urinary Incontinence Nutrition, #16 Press Psychotropic Medic The record revealed CAA information [fo and 17] was blank. There was no evide documented where related to the CAA's The clinical record Is documentation rega and any referrals re A face-to-face interv Employee #7 on Jul regarding the CAA's acknowledged that information related to documented. He/sh system " [computer information was ent reviewed on July 14	Assessment [CAA] information (200A], " Care Area ary" of the annual Minimum Resident #95. At #95 's annual Minimum Data er 28, 2013 revealed that Care ed' in Care Plan triggered for, #5 aily Living) Functional Status, #6 e /Catheter, #11 Falls, #12 oure Ulcers, and #17 ation Use. A that the location and date of r care areas # 5, 6, 11, 12, 16, nce that facility staff in the clinical record information s could be found. acked evidence of urding complicating factors, risks, lated to the triggered care areas. <i>v</i> iew was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was 4, 2014.	F	272	2		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 16 of 77

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 17 of 77

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CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES				<u>) MB NO</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	 system " [computer information was entireviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Setss [V0200A]. 8. Facility staff failed date of Care Area A under Section V [VC Summary" of the Mi Resident #113. A review of Resider Data Set dated Dec Care Areas and ' ad for #2 Cognitive Loss Communication, #5 Functional Status, # Indwelling Catheter, #10 Activities, #12 N Tube (s), #14 Dehyd Dental Care, and #1 The clinical record r date of CAA docum areas #2, 3, 4, 5, 6, was blank. 	e further stated that the "] went down when the CAA ered. The clinical record was , 2014. o provide the location and date sment [CAA] information on (MDS) under Section V d to provide the location and assessment [CAA] information 0200A], "Care Area Assessment nimum Data Set [MDS] for at #113's Admission Minimum ember 27, 2013 revealed the ldressed ' in Care Plan triggered as, #3 Visual Loss, #4 ADL (Activities of Daily Living) 66 Urinary Incontinence and , #7 Psychosocial Well-being, Nutritional Status, # 13, Feeding dration/Fluid Maintenance, # 15 16 Pressure Ulcers. evealed that the location and entation information [for care 7, 10, 12, 13, 14, 15, and 16] nce that the facility staff ation in the clinical record	F	272	Refer to page 10 for response F272		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 18 of 77

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CENTER	<u>IS FOR MEDICARE (</u>	& MEDICAID SERVICES				<u> JMB NO</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE		
				v	VASHINGTON, DC 20002		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES "BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag	ge 18	F	272			
		acked evidence of rding complicating factors, risks ated to the triggered care areas.					
	Employee #7 on Jul regarding the CAA s acknowledged that t information related t documented. He/sh system " [computer	e further stated that the "] went down when the CAA ered. The clinical record was					
	to face interview wa regarding the aforer on the Care Area As	approximately 3:20 PM, a face s conducted with Employee #2 nentioned missing information sessment (CAA) Summary, He/she acknowledged the					
	of Care Area Asses	o provide the location and date sment [CAA] information on (MDS) under Section V					
	date of Care Area A under Section V [V0	to provide the location and ssessment [CAA] information 200A],"Care Area Assessment nimum Data Set [MDS] for			Refer to page 10 for response F272		
	Minimum Data Set o	t #134's significant change dated March 20, 2014 revealed ' addressed ' in Care Plan . (Activities of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 19 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 272	Incontinence and Im #12 Nutritional Statu Maintenance, #16 P Psychotropic Medica The clinical record re date of CAA informa 12, 14, 16, and 17] w There was no evide documented the loca information related to The clinical record la documentation rega and any referrals rel A face-to-face interv Employee #7 on Jul regarding the CAA se acknowledged that to information related to documented. He/sho system " [computer information was enter reviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A]. 10. Facility staff failed	onal Status, #6 Urinary dwelling Catheter, #11 Falls, us, #14 Dehydration/Fluid Pressure Ulcers, and # 17 ation Use. evealed that the location and ation [for care areas #, 5, 6, 11, was blank. nce that the facility staff ation in the clinical record to the CAA's. acked evidence of rding complicating factors, risks lated to the triggered care areas. view was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was , 2014. o provide the location and date sment [CAA] information on (MDS) under Section V	F	272	Refer to page 10 for response F272		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 20 of 77

PRINTED: 08/19/2014 FORM APPROVED

	<u>(SFOR MEDICARE (</u>	& MEDICAID SERVICES			(<u>JMR NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			07/ ⁻	18/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	. HILL NURSING CENT	ER			00 CONST. AVE. NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Assessment Summa [MDS] for Resident a A review of Resident Minimum Data Set of revealed that Care A Plan triggered for, # communication, #6 I #7 Psychosocial we Activities, #12 Nutrit Ulcer. The record revealed CAA information [for 12, 16] was blank. There was no evided documented where related to the CAA's The clinical record la documentation rega and any referrals rel A face-to-face interv Employee #7 on July regarding the CAA s acknowledged that to information related to documented. He/she system " [computer information was enter reviewed on July 14 Facility staff failed to of Care Area Assess	ary " of the Minimum Data Set #S-16. ht #S16's significant change dated February 1, 2014, Areas and 'addressed ' in Care 2 Cognitive Loss/Dementia, #4 Urinary Incontinence /Catheter, II being, #10, #11 Falls, tional Status, #16 Pressure 4 that the location and date of r care areas #2, 4, 6, 7, 10, 11, nce that facility staff in the clinical record information a could be found. acked evidence of rrding complicating factors, risks, lated to the triggered care areas. <i>v</i> iew was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was	F	272	Refer to page 10 for response F27	2	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 21 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

					(. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING			07/ ⁻	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag [V0200A].	ge 21	F	272			
	#S-26 ' s Minimum E V, " Care Area Asse include the location	ed to accurately code Resident Data Set (MDS) under Section " essment (CAA) Summary to and date where information care areas could be located on			Refer to page 10 for response F272		
	Minimum Data Set of that Care Areas and triggered for, #1 Del Loss/Dementia, #3 V communication, #6 #11 Falls, #12 Nutrit						
		that the location and date of care areas #1, #2, 3, 4, 6, 11, blank.					
	There was no evider documented where related to the CAA's	in the clinical record information					
		acked evidence of rding complicating factors, risks, ated to the triggered care areas.					
	Employee #7 on July regarding the CAA s	iew was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she he date and location of o the CAA was not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 22 of 77

PRINTED: 08/19/2014 FORM APPROVED

	<u>KS FOR MEDICARE</u>	& MEDICAID SERVICES				<u> JINIR INO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF F	ROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITO	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	system " [computer information was enti- reviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A]. 12. Facility staff faile #S-40 ' s Minimum I V, " Care Area Asse include the location related to triggered of the clinical record. A review of Residen Minimum Data Set of revealed that Care A Plan triggered for, # Visual Function, #4 Incontinence /Cathe #10 Activities, #12 N Tube, #14 Dehydrat Pain. The record revealed CAA information [fo 12, 13, 14, 16, 19] w There was no evide documented where related to the CAA's The clinical record Is documentation rega	e further stated that the "] went down when the CAA ered. The clinical record was , 2014. o provide the location and date sment [CAA] information on (MDS) under Section V ed to accurately code Resident Data Set (MDS) under Section " essment (CAA) Summary to and date where information care areas could be located on the two significant change dated December 11, 2013, Areas and 'addressed ' in Care 2 Cognitive Loss/Dementia, #3 communication, #6 Urinary eter, #7 Psychosocial well being, Autritional Status, #13 Feeding ion, #16 Pressure Ulcer, #19 If that the location and date of r care areas #2, 3, 4, 6, 7, 10, vas blank. Ince that facility staff in the clinical record information is could be found.	F	272			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 23 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u> JMR NO</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095027	B. WING _			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION DATE
F 272	Continued From page	ge 23	F	272			
	care areas.						
	Employee #7 on Jul regarding the CAA s acknowledged that t information related t documented. He/sho system " [computer information was entr reviewed on July 14	e further stated that the "] went down when the CAA ered. The clinical record was					
	of Care Area Asses	sment [CAA] information on (MDS) under Section V					
	#S-50 ' s Minimum I V, " Care Area Asso include the the locat	ed to accurately code Resident Data Set (MDS) under Section " essment (CAA) Summary to tion and date where information care areas could be located on			Refer to page 10 for response F272		
	Minimum Data Set of that Care Areas and triggered for, #2 Cog Function, #4 commu Function/Rehabilitat	tion Potential, #6 Urinary eter, #11 Falls, #12 Nutritional					
		that the location and date of r care areas #2, 3, 4, 5, 6, k.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 24 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

<u>CENTER</u>	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			07/	18/2014
	ROVIDER OR SUPPLIER	ER		700	EET ADDRESS, CITY, STATE, ZIP CODE CONST. AVE. NE SHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	documented where related to the CAA's The clinical record is documentation rega and any referrals re A face-to-face interv Employee #7 on Jul regarding the CAA's acknowledged that information related t documented. He/sh system " [computer information was ent reviewed on July 14 Facility staff failed to of Care Area Asses Minimum Data Sets [V0200A]. 14. Facility staff faile #S-65 ' s Minimum I V, " Care Area Asses include the location related to triggered the clinical record. A review of Resider Minimum Data Set of that Care Areas and triggered for, #2 Con /Catheter, #11 Falls	nce that facility staff in the clinical record information acked evidence of rding complicating factors, risks, lated to the triggered care areas. view was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was	F 2	272	Refer to page 10 for response F272		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 25 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

					(. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag	ge 25	F	272			
		I that the location and date of r care areas #2, 6, 11, 12, 14,					
	related to the CAA's The clinical record la documentation rega	in the clinical record information could be found.					
	Employee #7 on Jul regarding the CAA s acknowledged that t information related t documented. He/she system " [computer	e further stated that the "] went down when the CAA ered. The clinical record was					
	of Care Area Assess	o provide the location and date sment [CAA] information on (MDS) under Section V					
	#S-83 ' s Minimum I V, " Care Area Asse include the location	ed to accurately code Resident Data Set (MDS) under Section " essment (CAA) Summary to and date where information care areas could be located on			Refer to page 10 for response F272		
	A review of Residen	t #S-83's significant change					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 26 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	<u>RS FOR MEDICARE (</u>	& MEDICAID SERVICES			(<u>) MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
0(4) 15	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag Minimum Data Set of that Care Areas and triggered for, #2 Cog ADL [Activities of Da Potential, #6 Urinar Falls, #12 Nutritiona Maintenance, #16 P Drug Use. The record revealed CAA information [for 14, 15, 16, 17] was There was no evide documented where related to the CAA's The clinical record la documentation rega and any referrals rel A face-to-face interv Employee #7 on Jul regarding the CAA s acknowledged that to information related to documented. He/sho system " [computer information was enter reviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A].	ge 26 dated June 20, 2014 revealed d'addressed ' in Care Plan gnitive, #Visual Function, #5 aily] functional/Rehabilitation y Incontinence /Catheter, #11 d Status, #14 Dehydration/fluid ressure Ulcer, #17 Psychotropic d that the location and date of r care areas #2, 5, 6, 11, 12, 13, blank. Ince that facility staff in the clinical record information could be found. acked evidence of rding complicating factors, risks, lated to the triggered care areas. view was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was , 2014. o provide the location and date sment [CAA] information on (MDS) under Section V		272			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 27 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				<u> JMR NO</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095027	B. WING _			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE		
				v	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 272	Summary to include information related to located on the clinic A review of Resident Minimum Data Set of revealed that Care A Plan triggered for, # of Daily] functional/F Urinary Incontinence Nutritional Status,# Dehydration/fluid Ma #16 Pressure Ulcer, The record revealed CAA information [for 14, 15, 16, 17] was There was no evided documented where related to the CAA's The clinical record la documentation rega and any referrals rel A face-to-face interv Employee #7 on Jul regarding the CAA so acknowledged that to information related to documented. He/sho	 ¹ Care Area Assessment (CAA) the location and date where o triggered care areas could be al record. t #S-119's significant change dated November 19, 2013 Areas and 'addressed ' in Care 2 Cognitive, #5 ADL [Activities Rehabilitation Potential, #6 e /Catheter, #11 Falls, #12 13 Feeding tube, #14 aintenance, #15 Dental Care, #17 Psychotropic Drug Use. I that the location and date of r care areas #2, 5, 6, 11, 12, 13, blank. Ince that facility staff in the clinical record information could be found. acked evidence of rding complicating factors, risks, lated to the triggered care areas. view was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of 	F2	272			

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PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

	S FUR MEDICARE	X IVIEDICAID SERVICES			L L L L L L L L L L L L L L L L L L L		0930-0391			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		095027	B. WING			07/ [,]	18/2014			
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
CAPITOL	HILL NURSING CENT	ER	700 CONST. AVE. NE WASHINGTON, DC 20002							
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 272	reviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A]. 17. Facility staff faile #S-123 's Minimum " V, " Care Area Ass include the location related to triggered of the clinical record. A review of Residen Minimum Data Set of that Care Areas and triggered for, #2 Coo Function, #4 commu Incontinence /Cather #10 Activities, #12 N Ulcer. The record revealed CAA information [for 12,16] was blank. There was no evider documented where in related to the CAA's " CAA worksheets "	ered. The clinical record was , 2014. b provide the location and date sment [CAA] information on (MDS) under Section V ed to accurately code Resident Data Set (MDS) under Section sessment (CAA) Summary to and date where information care areas could be located on t #S-123 's significant change lated January 15, 2014 revealed l'addressed ' in Care Plan gnitive Loss/Dementia, #3 Visual unication, #6 Urinary ter, #7 Psychosocial well being, Jutritional Status, #16 Pressure	F	272	Refer to page 10 for response F272					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 29 of 77

PRINTED: 08/19/2014 FORM APPROVED

	RS FOR MEDICARE	& MEDICAID SERVICES			(<u>) MB NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	00 CONST. AVE. NE		
	HILL NURSING CENT	ER		V	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	 areas. A face-to-face interv Employee #7 on Jul regarding the CAA s acknowledged that information related t documented. He/sho system " [computer information was entureviewed on July 14 Facility staff failed to of Care Area Assess Minimum Data Sets [V0200A]. B. Based on record three (3) of 36 samp that facility staff failed Data Sets [MDS] for status under Section splint devices under and Procedures and under Section B. F The findings includes 1. Facility staff failed 44's annual Minimum 2014 under Section of natural teeth. During a face-to-face 	view was conducted with y 14, 2014 at 11:43 AM summary of the MDS. He/she the date and location of to the CAA was not e further stated that the "] went down when the CAA ered. The clinical record was , 2014. b provide the location and date sment [CAA] information on (MDS) under Section V review and staff interview for bled residents it was determined ed to accurately code Minimum to one (1) resident ' s use of Section O - Special Treatments d one (1) resident ' s vision Residents #44, 136 and 140.	F	272	 483.20(b)(1) COMPREHENSIVE ASSESSMEN Response to B1-3 Residents #44, 136, 140 1. MDSs for residents #44, and #136s will be corrected. Resident # 140 has been discha 2. MDS coordinator will audit Section L, Secti and Section B for accuracy. 3. MDS coordinator or designee will audit MD a monthly basis for completion. 4. MDS coordinator will document findings an present to the Quality Assurance Committer review, evaluation, and recommendations monthly for a period of three months. 	urged. on O, Ss on d	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 30 of 77

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CENTER	<u> XS FOR MEDICARE </u>	& MEDICAID SERVICES			<u> </u>	<u>) MB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		095027	B. WING _			07/ [,]	18/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
CAPITOL	HILL NURSING CENT	ER		700 CONST. AVE. NE WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	DN SHOULD B		(X5) COMPLETION DATE
F 272	10:00AM he/she wa chewing or eating puteeth, missing teeth, loose teeth)? The missing teeth and opened his/her teeth (edentulous). A review of the clinic Notes dated Octobe documented the foll exam [examination]. screening is negative A review of Section resident 's annual Missing teeth 2014 revealed that of was coded and Section tooth fragment(s) (eight and the Employee #7 at app 2014. After reviewing MDS, the employee the MDS (Oral/Dent reflect that the resid employee then state corrections. The red 2014. Facility staff failed to resident 's MDS for 2. Facility staff failed to	s queried, " Do you have any roblems (could be due to no , and oral lesions, broken or esident responded, "Yes. " The he/she had difficulty chewing mouth to reveal gums and no cal record revealed Dental Care er 23, 2013 the dentist owing statement: "Annual . Edentulous, oral cancer re. " L (Oral/Dental Status) of the <i>A</i> inimum Data Set (MDS) with erence Date (ARD) of July 5, option " Z ", none of the above tion L0200B (No natural teeth or dentulous) was blank. <i>View</i> was conducted with roximately 2:00PM on July 15, ng a copy of the completed acknowledged that Section L of al Status) was not coded to ent was edentulous. The ed, "We will make the cord was reviewed on July 14,	F 2	272 Refer to page 30 for respo	nse F272B		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 31 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

	S FUR MEDICARE	X MEDICAID SERVICES			(. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING _			07/	18/2014
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			0 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Review of Resident Assessment Referen revealed that under and Procedures] OO as " 0 " indicative tha "Splint or brace assi A review of the restor revealed: May 27, 2014 ROM/ 28, 2014 ROM/Splint/Br ROM Splint/Brace a ROM/Splint/Brace a Splint/Brace applica The "Restorative Nut the facility utilized for number of days and reviewed for the AR through June 04, 20 facility staff recorded splint and brace ass There was no evider MDS dated June 4, include special treat A face-to-face inter Employee #7 on Juli 3:15 PM. After revie acknowledged that t	hts or brace assistance. #136 's Quarterly MDS with an nce Date (ARD) of June 6, 2014 Section O [Special Treatments 500 Resident #136 was coded at the resident did not receive stance." prative nursing flow sheets (Splint/Brace application; May t/Brace application; May 29, ace application; May 30, 2014 pplication; June 2, 2014 pplication; June 3, 2014 ROM tion; June 4, 2014 ROM	F 2	272	Refer to page 30 for response F272E	3	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 32 of 77

PRINTED: 08/19/2014
FORM APPROVED
MB NO 0038-0301

<u>CENTER</u>	S FOR MEDICARE	<u>& MEDICAID SERVICES</u>			l	<u> </u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
		ED		7	00 CONST. AVE. NE		
	HILL NURSING CENT	ER		v	VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag July 12, 2014. 3. Facility staff faile #140 's MDS for vis According to Chapte Manual page B-10 resident is unable to directions for testing s eye movements to follow movement of measures of visual a assessing whether of ability. For residents highly impaired." According to the clin admitted with diagno Respiratory Failure, Diabetes Mellitus Ty [status post] Corona Hypotension. According to the 5-d System) assessmen B0100: Vision, Res Impaired - sees larg newspapers/books a (corrective lenses - o glass) used was coo A face-to-face interv Employee #7 on July 2:00 PM. A query w related to vision. Er	d to accurately code Resident sion. er 3 of the MDS 3.0 Users ' "special population: If the o communicate or follow your y vision. Observe the resident ' o see if his or her eyes seem to objects or people. These gross acuity may assist you in or not the resident has any s who appear to do this, code 3 hical record, Resident #140 was oses that included: Chronic Cerebral Vascular Accident, ype 2, Coronary Artery Disease, iry Artery bypass Graft and lay PPS (Prospective Payment it dated March 8, 2014 Section ident #140 was coded as (1) e print, but not regular print in and B1200. Corrective Lenses contact, glasses, or magnifying led " No."		272			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 33 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

		X MEDICAID SERVICES			(. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING _			07/ ⁻	18/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	resident would blink light, but he/she see adequate was the p did not wear glasses	his/her eyes. I did not shine a m to have vision. So " roper choice for vision, he/she	F 2	272			
F 273 SS=D	483.20(b)(2)(i) COM 14 DAYS AFTER AI A facility must conduct assessment of a rest after admission, exc there is no significar physical or mental c section, "readmission following a temporat for therapeutic leave This REQUIREMEN Based on record re (1) of 36 sampled re facility staff failed to admissions RAI (Re OBRA (Omnibus Bu admissions RAI (Re OBRA within 14 day admission. According to the Ce	 uct a comprehensive ident within 14 calendar days luding readmissions in which ht change in the resident's ondition. (For purposes of this n" means a return to the facility ry absence for hospitalization or a.) T is not met as evidenced by: view and staff interview for one esidents, it was determined that conduct the required sident Assessment Instrument) dget Reconciliation Act) (1) resident. Resident #140 o conduct the required sident Assessment Instrument) rs of Resident #140 's 	F 2	273	Refer to page 35 for response F273		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 34 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095027	B. WING			07/18/2014	
NAME OF PROVIDER OR SUPPLIER CAPITOL HILL NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONST. AVE. NE WASHINGTON, DC 20002				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 273	Admission Assessm Admission assessm assessment for a ne circumstances, a rei completed by the er of admission to the resident is the reside OR the resident had and was discharged OBRA Admission as been admitted to thi return not anticipate admitted to this facil anticipated and did discharge. A review of the clinic Resident #140 was February 20, 2014; facility on February 4, 2014. The reside According to the ME records, Resident # Data Set), Section A Entry/discharge rep A1600. Entry Date into the facility): 3/4, Type of Entry (2) Rei type of Assessment 20140326 (March 20 Status (08). Deceas	2013, page 2-18: 01. ent (A0310A=1). The ent is a comprehensive ew resident and, under some turning resident that must be ad of day 14, counting the date nursing home as day 1 if: this ent 's first time in this facility, I been in this facility previuously I prior to completion of the assessment OR, this resident has s facility and was discharged d, OR, the resident has been ity and was discharged returned not return within 30 days of Cal records revealed that admitted to the facility on discharged to an acute care 22, 2014 and returned on March int expired on March 26, 2014. DS (Minimum Data Set) tracking 140 had an MDS (Minimum A0310: Type of Assessment: F. porting coded (01) Entry record; (date of this admission/reentry 2014 (March 4, 2014), A1700. eentry. MDS, Section A0310: : 2000. Discharge Date 6, 2014), A2100. Discharge	F	273	 483.20(b)(2)(i) COMPREHENSIVE ASSESSM 14 DAYS AFTER ADMIT Resident #140 expired; therefore, no furth measures could be taken. A review of the transmission summary shows that reside #140's 14-day assessment was initially completed on 2/22/2014 as he was admit 2/20/2014 and was treated as a short sta resident. Enclosed is the transmission red document latter statement (See attachme MDS coordinator will audit Medicare MDSs ensure that the 14 day MDS has been completed. MDS coordinator or designee will audit Medicare MDSs monthly to ensure 14 da has been completed. MDS coordinator will document findings a present to the Quality Assurance Commit review, evaluation, and recommendations monthly for a period of three months. 	ner MDS ht ted on y cord to ent A) s to y MDS und tee for	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 35 of 77

PRINTED: 08/19/2014 FORM APPROVED

	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO	OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095027	B. WING		07	/18/2014		
	ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 700 CONST. AVE. NE WASHINGTON, DC 20002		,10,2011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE		
F 273 F 279	2014 until discharge Admissions MDS.	of March 26, 2014 without an	F 27 F 27					
SS=D	COMPRÉHENSIVE A facility must use t develop, review and comprehensive plar The facility must de plan for each reside objectives and time medical, nursing, ar needs that are iden assessment. The care plan must be furnished to attat highest practicable psychosocial well-b and any services th under §483.25 but a resident's exercise o including the right to §483.10(b)(4).	CARE PLANS he results of the assessment to I revise the resident's		 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1. Immediately upon notification of care plan was initiated for resid indicate use of continues oxyge 2. An audit will be conducted by R 	ent #136 to In use			
	(1) of 36 sampled re facility staff failed to and approaches to			 on residents on oxygen to ensu a care plan for continues oxyge 3. RCC's/ designee will audit care residents on oxygen use month 4. Reports of the audits will be rep management committee weekly monthly for a period of 3 month evaluation, and recommendatio 	re that they have n use. plans of ly. ported to the risk v and then to QA s for review,	9.12.2014		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111 Facility ID: CAPITOLHILL

If continuation sheet Page 36 of 77

PRINTED: 08/19/2014 FORM APPROVED

	S FOR MEDICARE	MEDICAID SERVICES		OMB NO. 0938-0391			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			07/ [.]	18/2014
	ROVIDER OR SUPPLIER	ER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONST. AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	Resident #136 who oxygen therapy for s According to the adr Set) with an ARD (A date of March 13, 20 Condition; J1100 Sh was coded (C) trout under Section O: Sp and Programs O 010 was coded as receiv resident. According to the qua June 04, 2014 revea shortness of breath flat, under Section J under Section O 010 coded as receiving of A review of Residen July 15, 2014 lacked identification, goals a resident ' s respirato medication regimen shortness of breath. A face-to-face interv 2013 at 12:30 PM w the above, He/she a	to develop a care plan for was receiving continuous shortness of breath. mission's MDS (Minimum Data ssessment Reference Date) 014, Section J: Health oortness of Breath (dyspnea) ole breathing when lying flat and becial Treatments, Procedures, 00 [Respiratory Treatments] ving oxygen therapy while a arterly MDS with an ARD date of aled that Resident #136 was or trouble breathing when lying 1100 [Shortness of Breath] and 00 [Respiratory Treatments] bygen therapy while a resident. t #136 ' s care plan updated d evidence of problem and approaches to manage the try status. The resident's included continuous oxygen for iew was conducted on July 11, ith Employee #3. After review of	F	279	Refer to page 36 for response F279		
F 280 SS=D		0(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged	F2	280			
EORM CMS 250	67(02-99) Previous Versions O	bsolete Event ID: 83C111		Ea	cility ID: CAPITOL HILL If continue	otion aboat	Page 37 of 77

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 37 of 77

PRINTED: 08/19/2014 FORM APPROVED

				L.		0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		_	(X3) DATE S COMPL	
	095027	B. WING _		_	07/1	8/2014
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
HILL NURSING CENT	ER		700 CONST. AVE. NE			
			WASHINGTON, DC 20	0002		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD E		(X5) COMPLETION DATE
incompetent or othe under the laws of the planning care and tr treatment. A comprehensive ca within 7 days after th comprehensive asse interdisciplinary tear physician, a register the resident, and oth disciplines as deterr and, to the extent pr the resident, the res legal representative	rwise found to be incapacitated e State, to participate in eatment or changes in care and are plan must be developed ne completion of the essment; prepared by an n, that includes the attending red nurse with responsibility for ner appropriate staff in nined by the resident's needs, racticable, the participation of ident's family or the resident's ; and periodically reviewed and	F 2	80			
Based on record re (1) of 36 sampled re facility staff failed to plan to include aspir application of function braces. Resident #4 The findings include A. Facility staff failed care plan to include braces. According to an inte	view and staff interview for one esidents, it was determined that amend Resident #42 ' s care ration precautions and onal ROM [range of motion] 42 :: d to amend Resident #42 ' s application of functional ROM rim physician ' s order dated		Refer to page 3	39 for response F280		
	Continued From page incompetent or othe under the laws of the planning care and tr treatment. A comprehensive car within 7 days after th comprehensive asses interdisciplinary tear physician, a register the resident, and oth disciplines as deterr and, to the extent pr the resident, the res legal representative revised by a team of assessment. This REQUIREMEN Based on record re (1) of 36 sampled re facility staff failed to plan to include aspir application of function braces. Resident #4 The findings include A. Facility staff failed braces.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 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 one (1) of 36 sampled residents, it was determined that facility staff failed to amend Resident #42 ' s care plan to include aspiration precautions and application of functional ROM [range of motion] braces. Resident #42 The findings include: A. Facility staff failed to amend Resident #42 ' s care plan to include application of fu	OPEDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN O95027 B. WING	De DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 095027 STREET ADDRESS.CITY, ST 700 CONST. AVE. NE WASHINGTON, DC 22 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFIYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFIYING INFORMATION) Continued From page 37 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 one (1) of 36 sampled residents, it was determined that facility staff failed to amend Resident #42 's care plan to include aspiration precautions and application of functional ROM praces. Resident #42 The findings include: Refer to page A cording to an interim physician 's order dated	procencies construction (*) PROVIDERSUPPLICE/LINE (x2) MULTIPLE CONSTRUCTION OWDER OR SUPPLIER 095027 ISTREET ADDRESS, CITY, STATE, ZIP CODE TOW CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE TOO CONST. AVE. NE WILL NURSING CENTER SUMMARY STATEMENT OF DEPICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE (EACH DEPICIENT MUST BE FREESDED BY FULL REQULATORY OR LGC DENTFYING INFORMATION) PDEPX TAC PROVIDERS PLAN OF CORRECTION (EACH DEPICIENT MUST BE FREESDED BY FULL REQULATORY OR LGC DENTFYING INFORMATION) PDEPX TAC PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY) Continued From page 37 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. F 280 F 280 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. Refer to page 39 for response F280 Refer to page 39 for response F280 This REQUIREMENT is not met as evidenced by: Care plan to include application of functional ROM traces.	predenciencies connection (X1) PROVIDERSUPPUERCUA Destrict on NUMBER: 095027 (X2) MULTIPLE CONSTRUCTION A BUILDING 0774 (Y2) MULTIPLE CONSTRUCTION A BUILDING 0776 (Y2) MULTIPLE CONSTRUCTION A BUILDING 0776 (Y2) MULTIPLE CONSTRUCTION A BUILDING 0776 (Y2) MULTIPLE CONSTRUCTION A BUILDING 0776 (Y2) MULTIPLE CONSTRUCTION 0776 (Y2) MULTIPLE CONSTR

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 38 of 77

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<u>CENTER</u>	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u>0</u> N	<u>//B_NO. 0938-0391</u>		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			07/18/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE			
CADITO	HILL NURSING CENT	-ED		700 CONST. AVE. NE				
	HILL NORSING CENT	ER	WASHINGTON, DC 20002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE		
F 280	[Physical Therapy] sto] [patient] at maxim Functional maintena donning/doffing BLE extremities Range of AM, Off at 3:00 PM, PM. " The comprehensive included the followin of Motion, Interventi aids/supportive devia bilateral lower extreme evidence that the cat the schedule for app A review of the June Administration Recconinitials in the allotted were being applied a from June 5 - June 3 maintenance Progra [bilateral lower extreme 9:00 AM, off at 3:00 PM A review of the clinit the care plan was re- interventions to spen- of the ROM braces.	care plan dated April 28, 2014 ons included, " use ces provide passive ROM to mities; however, there was no are plan was revised to include oblication of the ROM braces.	F 2	 483.20(d)(3), 483.10(k)(2) PLANNING CARE-REVIS Response to #A & #B 1. Resident #42's care p to include application and aspiration precau 2. Audit will be conducted functional ROM braced aspiration precautions plans and Physicians 3. RCC's or designee with and care plans of resis ROM braces to ensur- planned appropriately Care plans of residen precautions will be au that the care plans are needed. 4. RCC's will document in monthly for a period or 	SE CP blan was updated/amen of functional ROM brac tions ad on residents receiving as and on those that are s to ensure that their ca orders are up to date. ill audit Physician orders idents that are on functi that they are cared that they are that they are cared that they are that they are that they are that they are that t	ded es g o on re s o nal e 5 9.12.2014		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 39 of 77

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING _			07/	18/2014
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	'ER	_		00 CONST. AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Employee #3 on Jul 10:30 AM. After revi acknowledged that to the application of RC was reviewed on Ju B.Facility staff failed plan to include aspir According to an inter June 11, 2014 at 11 skilled services disc current diet puree w aspiration precaution precautions when fe straw, seated uprigh and solids. "	view was conducted with y 11, 2014 at approximately iewing the clinical record; he/she the care plan did not incorporate OM braces. The clinical record ly 11, 2014. It to amend Resident #42 ' s care ration precautions. erim physician ' s order dated :40 AM directed, " Speech continue 6/11/14- Continue with with thin liquids. Follow strict ns. Please follow aspiration beding- small bites/sips via at for meals, alternate liquids a care plan dated April 28, 2014 ng problems: Alteration in lated to chewing problem as d feeding ability, Approach Plan- uth) intake; Provide PO diet per cal record lacked evidence that mended to include the strict ns. o amend Resident #42 ' s care	F 2	280	Refer to page 39 for response F280		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 40 of 77

PRINTED: 08/19/2014
FORM APPROVED
MB NO 0038-0301

CENTER	<u>S FOR MEDICARE </u>	& MEDICAID SERVICES				<u>)MB NO.</u>	<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/ [.]	18/2014
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE		
				N	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	ge 40 riew was conducted with	F 2	280			
	Employee #3 on Jul 10:30 AM. After revi acknowledged that t	y 11, 2014 at approximately ewing the clinical record; he/she the care plan was not amended tion precautions. The clinical					
F 309 SS=E	483.25 PROVIDE C HIGHEST WELL BE	ARE/SERVICES FOR ING	F:	309			
	provide the necessa maintain the highest and psychosocial we	receive and the facility must any care and services to attain or t practicable physical, mental, ell-being, in accordance with the essment and plan of care.					
	This REQUIREMEN	T is not met as evidenced by:					
	interview, and staff i sampled residents, i staff failed to: follow application of antien resident with pedal anticoagulant medic with physician's orde consultation in acco for one (1) resident (1) resident. Residen	ation, Lovenox in accordance ers; obtain a psychiatric rdance with physician's orders and clarify a diet order for one nts' #44, #127 and #134.			Refer to page 42 for response F309		
	1. Facility staff faile	d to follow a physician ' s					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 41 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 309	for Pedal Edema. A review of the resid Physician 's Order 3 date of December 1 Stockings daily for F last signed by the pl The resident was ob in his/her room and stockings) wearing s 9:00AM to 12:00PM A face-to-face interv assigned CNA Emp 12:30PM on July 15 queried whether he/ his/her assigned res "Yes, as long as the was then queried wh wearing Teds. The probably discontinue the room. I will che discontinued I will pr reviewed on July 15 Facility staff failed to apply Ted stockings 2. Facility staff failed Lovenox in accordan	44 to apply Ted stockings daily dent 's clinical record revealed a Sheet (POS) with an initial order 3, 2013 which directed, "Ted Pedal Edema." The order was hysician on July 8, 2014. Deserved sitting in a wheel chair in the Day Room (without Ted socks from approximately on July 15, 2014. New was conducted with the loyee #29 at approximately , 2014 The employee was she applied Ted stockings for sidents. He/she responded y have an order." The employee hy Resident #44 was not employee stated, "They were ed. I did not see any [Teds] in tock and if they are not ut them on. " The record was	F	309		ed on the the RCC 127 no bx; chiatrist #134's Thin be ure or on carts ers for signee chiatrist th the nudit ician's an thly to bckings,	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 42 of 77

PRINTED: 08/19/2014 FORM APPROVED

<u>CENTER</u>	<u>(SFOR MEDICARE</u>	& MEDICAID SERVICES			(<u> אראס אראס</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	700 CONST. AVE. NE		
	HILL NURSING CENT	ER		V	VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Respiratory Failure, Intracranial Hemorri An interim order dat directed: " Lovenox (everyday). Dx Antio A review of the Janu Administration Reco Lovenox 30mg was and 31. A review of the Febr nurses ' initials wer indicated the reside mg SQ daily at 9:00 2014. There was no evide staff administered th through January 31. effects to the reside A face-to-face interv Employees #5 and # approximately 2:00 aforementioned find reviewed on July 11 3a. Facility staff faile consultation in acco for Resident #134.	" Left hemiplegia, Chronic Bilateral Pulmonary Embolism, nage and Hypertension. " ed January 28, 2014 at 4:00 PM 30mg SQ (subcutaneously) QD coagulation Tx (Treatment). " uary 2014 Medication ord (MAR) lacked evidence that administered on January 29, 20 ruary 2014 MAR revealed e in the allotted spaces which nt was administered Lovenox 30 AM on February 1, 2, and 3, nce in the clinical record that the ne Lovenox from January 29 There were no untoward nt. view was conducted with #6 on July 11, 2014 at PM. He/she acknowledged the lings. The clinical record was , 2014. ed to obtain a psychiatric rdance with physician's orders	F	309	Refer to page 42 for response F309		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 43 of 77

PRINTED: 08/19/2014 FORM APPROVED

STATE MENU OF DERGENCIES AND PLANE OF DERGENCIES ADDITION (N1) PROVIDER CINC IN A BULING (N1) PLANE OF A BULING (N1) P	CENTER	<u>SFOR MEDICARE 8</u>	& MEDICAID SERVICES			C	MB NO	. 0938-0391
INJUST OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, 2P CODE TOO CONST. AVE. NE WASHINGTON, DC 20002 Interview OWIND: TAG [EACH DEFICIENCY WITH FUNCTION OR LSC IDENTIFYING INFORMATION] Image: Deficiency with the readulation or LSC IDENTIFY IDENTIFYING IDENTIFY IDENTIFYING INFORMATION] Image: Deficiency with the readulation or LSC IDENTIFYING IDENTIFYING IDENTIFYING IDENTIFYING IDENTIFYING IDENTIFYING IDENTIFYING I	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS (CT) STRE. 2 P CODE CAPTOL HILL NURSING CENTER OW 10 PREFIX TAG (EACH DEFICIENCY UNITS EP PRECODED BY TUL REGULATORY OR USC IDENTIFYING INFORMATION) PIL PREFIX TAG (EACH DEFICIENCY UNITS EP PRECODED BY TUL REGULATORY OR USC IDENTIFYING INFORMATION) PIL F 309 Continued From page 43 diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostomy, Peg [feeding tube]. F 309 A review of the clinical record revealed a psychiatric consultation note dated February 11, 2014 with recommendations to start the resident on 2010ht [Sertraline] 50mg [milligrams] for depression. F 309 On July 14, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee 43; who was asked to provide the follow-up psychiatry note. He/she was unable to produce the document from the clinical record and acknowledged that there was no progress note from the psychiatris since the initial consultation [February 11, 2014]. On July 14, 2014, at approximately 3:15 PM, a face-to-face interview was conducted with Resident #1434 to discuss the approximated by he/she was visited by the psychiatrist. He/she explained that he/she had not spoken to the psychiatrist. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. 3b. Facility staff failed to follow through on a			095027	B. WING			07/ [.]	18/2014
CAPTIOL HILL NURSING CENTER WASHINGTON, DC 20002 (Mu) ID PREFIX TAG (EACH DEFICIENCY UNSTEP RECEDENCIES (EACH DEFICIENCY) UNSTEP RECEDENCIES OR LSC IDENTIFYING INFORMATION PIE PREFIX TAG IPPROVIDENTIFYING INFORMATION OWNETON CONSECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OWNETON DEFICIENCY F 309 Continued From page 43 diagnoses: Carebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostowy, Peg [feeding tube]. F 309 F 309 A review of the clinical record revealed a psychiatric consultation note dated February 11, 2014 with recommendations to start the resident on Zolotit [Sertraline] 50mg [milligrams] for depression. F add A physician 's order dated March 1, 2014 directed, ' psychiatric re-evaluation of Sertraline.' Refer to page 42 for response F309 On July 14, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee #3, who was asked to provide the follow-up psychiatry note. He/she was unable to produce the document from the clinical record and acknowledged that there was no progress note from the psychiatris tince the initial consultation [February 11, 2014]. On July 14, 2014, at approximately 31:5 PM, a face-to-face interview was conducted with Resident #1434 to discuss the approximated ap he/she was visited by the psychiatrist. He/she explained that he/she had not spoken to the psychiatrist. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. 3b. Facility staff failed to follow through on a	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFX TAG CEACH EDREMENT MAY INFORMATION PREFX TAG CEACH EDREMENT A CODENTIFYING INFORMATION COMPLETE COMPLETE COMPLETE F 309 Continued From page 43 diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Steep Apnea, Tracheostomy, Peg [feeding tube]. F 309 A review of the clinical record revealed a psychiatric consultation note dated February 11, 2014 with recommendations to start the resident on Zoloft [Sertraline] 50mg [milligrams] for depression. F 309 A physician 's order dated March 1, 2014 directed, '' psychiatric re-evaluation of Sertraline.' F Refer to page 42 for response F309 On July 14, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee #3, who was asked to provide the follow-up sychiatric tree-waluation (February 11, 2014). Refer to page 42 for response F309 On July 14, 2014, at approximately 31:5 PM, a face-to-face interview was conducted with Employee #3 who was acouncied form the psychiatris since the initial consultation [February 11, 2014]. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. 3b. Facility staff failed to follow through on a 3b. Facility staff failed to follow through on a	CAPITOL	HILL NURSING CENT	ER					
 diagnoses: Cerebral Vascular Accident (stroke) 2008, Pontine Hemorrhage 2013, Left Hemiplegia, Hypertension, Obstructive Sleep Apnea, Tracheostomy, Peg [feeding tube]. A review of the clinical record revealed a psychiatric consultation note dated February 11, 2014 with recommendations to start the resident on Zoloft [Settraline] 50mg [milligrams] for depression. A physician 's order dated March 1, 2014 directed, " psychiatric re-evaluation of Settraline." On July 14, 2014 at approximately 11:40 AM, a face-to-face interview was conducted with Employee #3, who was asked to provide the follow-up psychiatry note. He/she was unable to produce the document from the clinical record and acknowledged that there was no progress note from the psychiatris since the initial consultation [February 11, 2014]. On July 14, 2014, at approximately 3:15 PM, a face-to-face interview was conducted with Resident #134 to discuss the approximate day he/she was visited by the psychiatrist. He/she explained that he/she had not spoken to the psychiatrist. There was no evidence that facility staff followed the physician's order for Resident #134 to have a psychiatric consultation. 3b. Facility staff failed to follow through on a 	PRÉFIX	(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL REGULATORY	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	F 309	diagnoses: Cerebral 2008, Pontine Hemo Hypertension, Obstr Tracheostomy, Peg A review of the clinic consultation note da recommendations to [Sertraline] 50mg [m A physician ' s order " psychiatric re-evalu On July 14, 2014 at face-to-face intervier Employee #3, who v follow-up psychiatry produce the docume acknowledged that to the psychiatrist since [February 11, 2014]. On July 14, 2014, at face-to-face intervier #134 to discuss the visited by the psychi he/she had not spok There was no evider physician's order for psychiatric consultat	I Vascular Accident (stroke) prrhage 2013, Left Hemiplegia, ructive Sleep Apnea, [feeding tube]. cal record revealed a psychiatric ated February 11, 2014 with o start the resident on Zoloft nilligrams] for depression. r dated March 1, 2014 directed, uation of Sertraline." approximately 11:40 AM, a w was conducted with was asked to provide the r note. He/she was unable to ent from the clinical record and there was no progress note from e the initial consultation t approximately 3:15 PM, a w was conducted with Resident approximate day he/she was iatrist. He/she explained that cen to the psychiatrist. nce that facility staff followed the r Resident #134 to have a tion. ed to follow through on a	F	309			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 44 of 77

PRINTED: 08/19/2014 FORM APPROVED

<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES			(<u> JNIB INO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			700 CONST. AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	revealed the followin Accident (stroke) 20 Left Hemiplegia, Hy Apnea, Tracheoston A review of the clinic recommendations o Review' dated May 2 thin liquids." A review of the 'Phy 28, 2014 revealed a following: "NAS [No dx [diagnosis] of HT The July 2014 'Phys the following diet or Diagnosis, PT [patie good intake" and Ma diet." On July 14, 2014 at mechanical soft food Resident #134's bed On July 14, 2014 at face-to-face intervie Employee #3 regard acknowledged that t mechanical soft with physician's order for	ident #134. vsical dated February 9, 2014 ng diagnoses: Cerebral Vascular 08, Pontine Hemorrhage 2013, pertension, Obstructive Sleep ny, Peg Tube [feeding tube]. cal record revealed dietary n the 'Quarterly Nutrition 28, 2014 for "mechanical soft sician's Order Form' dated May diet order that directed the Added Salt] diet order related to N [hypertension]." sician's Order Form' revealed ders: February 28, 2014 - " ent] eating po [by mouth] food, ay 28, 2014 - "No added salt approximately 9:40 AM, ds were observed on the tray at dside. approximately 9:45 AM, a w was conducted with ling the resident's diet. He/she he resident's diet was o thin liquids and there was no the mechanical soft diet. o follow through on a dietitian ' s	F	309			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 45 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

		& MEDICAID SERVICES	-			<u>. 0938-0391</u>	
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095027	B. WING		07/	/18/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	HILL NURSING CENT	FR		700 CONST. AVE. NE			
			, I	WASHINGTON, DC 20002		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309 F 323 SS=D	HAZARDS/SUPER The facility must ens environment remain is possible; and eac	ident #134. ACCIDENT	F 3(
	A.Based on an observironmental tour of approximately 10:00 facility staff failed to accident hazards as (1) unlocked door to where various mech The findings include 1. The door to the sp sixth floor was unloc accessible to res 2. Floor tiles located access door on the sp	orinkler control room on the ked and idents. I in front of the shower room fourth floor aged and wet and presented a		 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Response to #A1, 2 Immediately upon notification of this of the sprinkler control room door was lo Maintenance Director is obtaining bid the tiles and leaky pipes. Maintenance Director will conduct an environmental sound to identify and a hazardous conditions. Environmental rounds will be conduct by a work group including Maintenance or designee, Housekeeping Director of Administrator or designee, Resident O Coordinator or designee to identify an hazardous conditions or unlocked medication/treatment carts. Maintenan have a work order binder on each floo other staff document maintenance ne Maintenance Director will document fin present to the Quality Assurance Con review, evaluation, and recommendat for a period of three months. 	cked. The s to repair ddress ed monthly e Director r designee, are y nce will r to ensure eds. ndings and mittee for	9.12.2014	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 46 of 77

		AND HUMAN SERVICES				FORM	: 08/19/2014 APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			. 0938-0391 SURVEY LETED
	095027		B. WING			07/18/2014	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER		-	0 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	These observations Employee #1 and En #15 who acknowled B. Based on observa (1) of 36 sampled re the facility staff failed safe and secure stor minimize loss or dive evidenced by the wo meds) observed una #42' s door during a The findings include On July 15, 2014 at wound care observa cart was observed o unlocked and unattee inside the room perf The wound cart cont medications: Drawer #1 and Draw 1% Cream, Risanue (10) Arzol - Silver Ni 75%/Potassium Nitr. was labeled " POIS Drawer #3: Ammoni Drawer #4: Ketocon	were made in the presence of mployee lged the findings. ation and staff interviews for one sidents, it was determined that d to maintain medications under rage and limited access to ersion of all medications as bund cart (containing prescribed attended outside of Resident wound care treatment. : approximately 9:45 AM, a tion was conducted. The wound utside of Resident #42 ' s door inded, while Employee #23 was orming the dressing change. tained the following ver #2: Scissors, Clotrimazole Ointment (multiple tubes), ten trate Applicators (Silver Nitrate - ate 25%). The front of the tube	F	323	 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Response to #B Resident #42 1. Immediately upon notification of this deficient the medication cart was locked. 2. Administrator will conduct a round to ensure treatment carts are maintained locked. 3. Environmental rounds will be conducted m by a work group including Maintenance Dir or designee, Housekeeping Director or des Administrator or designee to identify any hazardous conditions or unlocked medication/treatment carts. Maintenance v have a work order binder on each floor to a other staff document maintenance needs. RNs/LPNs will be re-in-serviced to lock tre and medication carts. 4. The Administrator will document findings a present to the Quality Assurance Committer review, evaluation, and recommendation n for a period of three months. 	re onthly rector signee, vill ensure atment nd ee for	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 47 of 77

PRINTED: 08/19/2014 FORM APPROVED

	S FUR MEDICARE	& MEDICAID SERVICES			l		. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING	B. WING		07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	face-to-face intervie Employee # 3 and E findings. Both emplo aforementioned find Facility staff failed to	n dressing supplies approximately 9:45 AM, a w was conducted with imployee # 23 regarding the oyees acknowledged the ings. o maintain medications under rage and limited access to	F	323			
F 329 SS=D	UNNECESSARY DI Each resident's drug unnecessary drugs. drug when used in e duplicate therapy); o without adequate me indications for its us consequences whic reduced or discontir reasons above. Based on a compret resident, the facility have not used antipe these drugs unless a necessary to treat a and documented in who use antipsycho reductions, and beh	GIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of adverse h indicate the dose should be nued; or any combinations of the must ensure that residents who sychotic drugs are not given antipsychotic drug therapy is specific condition as diagnosed the clinical record; and residents tic drugs receive gradual dose avioral interventions, unless ated, in an effort to discontinue	F	329	Refer to page 48 for response F329		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 48 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

			r				. 0330-0331
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
-	OF PROVIDER OR SUPPLIER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONST. AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From pag	ge 48	F	329			
	Based on record re (1) of 36 sampled re facility staff failed to reduction (GDR) wa anti-depressant med The findings include Facility staff failed to reduction [GDR] wa antidepressant med #95. A review of the phys Resident #95 was p medication Prozac 7 (originated April 2, 2 An interim physician 9:00 PM directed, " every] am (morning) The psychiatry cons revealed, " Report n on Alpraolam (Xana denies being depres Medication Psych- 2 mg po q am for depro order, [Decrease] Xa	 b ensure that a gradual dose s attempted for the use of an ication, Prozac for Resident sician 's orders revealed that rescribed the antidepressant 10 mg everyday for depression 2013). a 's order dated May 23, 2014 at Prozac 20 mg po [by mouth of or depression. sultation dated April 1, 2014 requested regarding: Follow up x- anti anxiety) [He/she] ssed, suicidal or homicidal (anax 0.25mg BID, Prozac 10 ression. Plan: Continue Prozac anax 0.25mg po qd. " 			 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Response to Resident #95 Resident #95 will be started on a gradual or reduction of the anti-depressant Prozac. RCCs will conduct an audit of pharmacist's recommendations to ensure gradual dose reduction per recommendation. RCCs or designee will conduct monthly au pharmacist's recommendations. RCCs will document findings and report to Quality Assurance Committee for review, evaluation, and recommendations monthly period of three months. 	dits of the	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 49 of 77

PRINTED: 08/19/2014 FORM APPROVED

	KS FUR MEDICARE	& MEDICAID SERVICES			l		. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	 "March 18, 2014- Seirregularities and/or April 18, 2014- See irregularities and/or A review of the phar revealed the followin "February 19, 2014 alprazolam 0.25mg consider a gradual of decreasing to 0.25 r response: I accept the following modific psychiatry. Signed "April 18, 2014 reven has received Fluoxen management of dep Recommendation: Freduction, perhaps of (Prozac) 10mg even monitoring for re-ern withdrawal symptom the current dose, ple describing a dose recontraindicated. Phy seen by Psychiatrist Wanted to continue Employee #30. " The clinical record la dose reduction for th Prozac. A face-to-face interview Employee #30 on Ju 3:30 PM regarding to 	See report for any noted recommendations report for any noted recommendations. " " "macy consultation reports ng: - [Resident #95] has received daily since 4/2013. Please dose reduction, perhaps mg at bedtime Physician ' s he recommendations above with cation(s): [Follow-up] with by Nurse Practitioner." aled, Comment: [Resident #95] etine (Prozac) 10mg for pressive symptoms since 4/2013. Please consider a gradual dose decreasing to Fluoxetine y other day, while concurrently hergence of depressive and/or ns. If therapy is to continue at ease provide rationale	F	329			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 50 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	<u>SFOR MEDICARE (</u>	& MEDICAID SERVICES				<u> JMR NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING	B. WING		07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ËR			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 329	psychiatrist had alre April 1, 2014 and wr	ge 50 as dated April 18, 2014, "The eady evaluated the resident on rote a note stating [he/she] to continue on the same dose	F	329	Refer to page 48 for response F329		
	Employee #17 on Ju 12:45 PM regarding April 18, 2014 recom He/she stated, " Th document [his/her] of psychiatrist needs to response to accept of clinical record was m Facility staff failed to	view was conducted with July 18, 2014 at approximately the consultation report dated nmending the GDR for Prozac. e nurse practitioner did comments; however, the o address the GDR and indicate or decline with rationale. " The reviewed on July 18, 2014. D ensure that a gradual dose s attempted for the use of an ication.					
F 371 SS=E	The facility must - (1) Procure food from considered satisfact authorities; and	OCURE, SERVE - SANITARY m sources approved or tory by Federal, State or local distribute and serve food under	F	371	Refer to page 52 for response F371		
	Based on observati	IT is not met as evidenced by: ions made on July 11, 2014 at 0 AM, it was determined					
	· · ·						1

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 51 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

		PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391					
. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
B. WING		07/18/2014					
	STREET ADDRESS, CITY, STATE, ZIP CODE						

AND PLAN OF	A. BUILDING					COMPLETED		
095027 B. WING				07/ [,]	7/18/2014			
	ROVIDER OR SUPPLIER	ER		70	REET ADDRESS, CITY, STATE, ZIP CODE 0 CONST. AVE. NE ASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 371	under sanitary condi of one (1) hotel pan uncovered on the co 16 ounces bottle of a inside one (1) of one soiled cooking utens braser, two (2) of tw four (4) of four (4) si of five (5) six-inch de soiled air curtain fron a soiled and blemist The findings include 1. One (1) of one (1) stored uncovered or 2. A half-full bottle o inside the ice machin 3. Cooking utensils a braser and two (2) o pans were dented an 4. Cooking utensils a six-inch deep third p six-inch deep half pan 5. One (1) of two (2) dishwashing machin and needed to be cla	I to store and prepare food tions as evidenced by one (1) of cooked pasta that was stored de production table, a half-full apple juice that was stored e (1) ice machine, dented and/or sils such as one (1) of one (1) o (2) four-inch deep third pans, x-inch deep third pans, five (5) eep half pans, one (1) of two (2) m the dishwashing machine and hed kitchen floor. hotel pan of cooked pasta was a the code production table. f apple juice was observed me in the kitchen. Such as one (1) of one (1) f two (2) four-inch deep third and needed to be replaced. Such as four (4) of four (4) ans and five (5) of five (5) ans were soiled and dented. air curtain from the ne was soiled with food debris	F 3	71	 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY Response to #1-6 1. Immediately upon notification, the pasta was covered, the bottle of apple juice was disca and Ice machine emptied, clean and sanitiz 7/18/2014. The dented braser and 4' deep J were discarded and replaced. The dented s cooking utensils have been replaced. The a curtain was cleaned. The kitchen floor was stripped, cleaned and waxed. The kitchen f tiles will be changed as necessary. 2. Dietary staff were reeducated on 7/24/2014 the importance of following sanitation/infect control practices within the dietary area. Dir of Dietary will conduct an environmental rou ensure sanitary conditions. 3. Director of Dietary or designee will conduct environmental rounds on a monthly basis. 4. Director of Dietary will document findings an present to the Quality Assurance Committe review, evaluation, and recommendations monthly for a period of three months. 	rded eed on pans soiled air loor on ion rector und to	9.12.2014	
						ļ		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 52 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFINANCE AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/18/2014	
NAME OF PROVIDER OR SUPPLIER CAPITOL HILL NURSING CENTER				70	REET ADDRESS, CITY, STATE, ZIP CODE 10 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX (EACI TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 386 SS=D F 386 SS=D F 386 F 386 CAR The p progu treatu of thi at ea exce polys admi after This Base (1) of the n of ca Resid goal The f A rev revea meas for an	e observations loyee #12 and E owledged the fi 40(b) PHYSICIA E/NOTES/ORD physician must ram of care, inc ments, at each is section; write is section; write is section; write accharide vacc nistered per ph an assessment REQUIREMEN ed on record re- f 36 sampled re- nedical team fai re as it relates to dent #127 whos was consistent! findings includir view of the clinic aled the medical sures to maintai nticoagulation the	d spots and discolored tiles. were made in the presence of Employee #1 who ndings. AN VISITS - REVIEW VERS review the resident's total luding medications and visit required by paragraph (c) , sign, and date progress notes on and date all orders with the rea and pneumococcal sines, which may be ysician-approved facility policy t for contraindications. T is not met as evidenced by: view and staff interview for one sidents, it was determined that led to review the total program to anticoagulation therapy for se therapeutic anticoagulant y subtherapeutic. ng cal record for Resident #127 I team failed to implement in the desired therapeutic range		371	 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS Response to #1-6 Resident #27 is no longer receiving Lovena Resident #27 is receiving Coumading and H PT/INR levels are within therapeutic range. RCCs will review residents on anticoagular ensure PT/INR levels are within therapeutic range. Nursing has implemented a new Coumadin Tracking form. Staff Development nurse wil service RNs and LPNs on the use of this tra form. Resident Care Coordinators will audi tracking form on a monthly basis. RCCs will document findings and present to Quality Assurance Committee for review, evaluation, and recommendations monthly period of three months. 	ts to ts to tin- acking t to the	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 53 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEROIENCIES (M) PERVICER (UIA) IDENTIFICATION NUMBER: (P2) MULTIPLE CONSTRUCTION A EULIDING (P2) MULTIPLE CONSTRUCTION A EULIDING A EULIDING A EULIDING A E	<u> </u>	S FUR MEDICARE	& MEDICAID SERVICES			l		. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE CAPITOL HILL NURSING CENTER Image: Continued From page 53 If ach Deprocently must be reference by PRULK REQULATIONY OR LSC IDENTIFYING INFORMATION Image: Colspan="2">PROVIDER OPTICE ACIDES (CROSS-REFERENCE) F 386 Continued From page 53 F 386 February 11, 2014 revealed Resident #127 's diagnoses included: "Left hemiplegia, Chronic Respiratory Failure, Bilateral Putmonary Embolism, Deep Vein Thrombosis, Anemia, Intracranial Hemorrhage and Hypertension." F 386 A review of physician 's orders revealed the resident 's medication regimen included anticoagulant therapy as follows: F 386 Physician 's orders signed June 20, 2014 [initiated April 30, 2014] directed Waffarin sodium (Cournadin) 6mg tablet daily for putmonary embolism. See page 53 for response to F386 Physician orders signed June 20, 2014 [initiated April 30, 2014] directed Waffarin sodium (Cournadin) 6mg tablet daily for putmonary embolism. See page 53 for response to F386 Physician orders signed June 20, 2014 [initiated May 12, 2014] directed: The signeater than 2.0 then check PT/INR evy week then D/C (discontinue) Lovenox." (Note: physician 's orders for May -July 2014 lacked evidence of an order for Lovenox] Consulting physician [Putmonologist] progress notes included the following: May 11, 2014 at 9:40 AM, "INR remains subtrapeutic, must adjust Cournadin [to] get INR consistently greater than 2.0 to 3.0. May 12, 2014, "Needs therapeutic INR (last 577/14 subtrapeutic) Continue Lovenox until INR [greater than] 2.0 and less than 3.0.								
CAPITOL HILL NURSING CENTER 700 CONST. AVE. NE WASHINGTON, DC 20002 PREFX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IP PREFX (EACH CORRECTIVE ACTION BHOLD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IP IP CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IP IP CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY DOWN OR LISC IDENTIFYING INFORMATION) DOWN DEFICIENCY F 386 Continued From page 53 February 11, 2014 revealed Resident #127 's diagnoses included: "Left hemiplegia, Chronic Respiratory Failure, Bilaterai Pulmonary Embolism, Deep Vein Thromosis, Anemia, Intracranial Hemorrhage and Hypertension." F 386 See page 53 for response to F386 Physician 's orders signed June 20, 2014 [initiated April 20, 2014 directed: "Please check PT/INR [Prothombin Time and International Normalized Ratio] Monday-Wednesday-Friday until PT/INR is consistently greater than 2.0. Notify [Medical Doctor] regarding INR result. Once INR is greater than 2.0 then check PT/INR Revery week then D/C (discontinue) Lovenox." [Note: physician 's orders for May - July 2014 lacked evidence of an order for Lovenox] Consulting physician [Pulmonologist] progress notes included the following: May 11, 2014 at 9:40 AM. "INR remains subtherapeutic, Continue Lovenox until INR [greater than 2.0 to 3.0. May 12, 2014, "Needs therapeutic INR (last 5/7/14 subtherapeutic). Continue Lovenox until INR [greater than 2.0 to 3.0.			095027	B. WING			07/	18/2014
CAPITOL HILL NURSING CENTER WASHINGTON, DC 2002 (M) ID PREFIX TAG IEAOH DEFICIENCY MUST FERECENSED FULL REGULTORY OR LSE DEMIFETING INFORMATION ID PROVIDENSE TAN OF CORRECTION (EAOH DEFICIENCY MUST FERECENSED BY FULL REGULTORY OR LSE DEMIFETING INFORMATION) ID PROVIDENSE TAN OF CORRECTION (EAOH DEFICIENCY MUST FERECENSED BY FULL REGULTORY OR LSE DEMIFETING INFORMATION) ID PROVIDENSE TO THE APPROPRIATE Comment Comment Comment (Counter Comment (Counter Comment) F 386 Physician 's orders signed June 20, 2014 (initiated April 30, 2014) (intercted Waffan sodium (Counter Comment) Consistently greater than 2.0. Notify (Medical Doctor) regarding INR result. Done INR is greater than 2.0. then check PT/INR is consistently greater than 2.0. Notify (Medical Doctor) regarding INR result. Done INR is greater than 2.0. then check PT/INR represes notes included the following: See page 53 for response to F386 May 11, 2014 at 9:40 AM, "INR remains subtherapeutic, must adjust Countain (Io) get INR consistently greater than 2.0 to 3.0. May 11, 2014, "Needs therapeutic INR (last 5/7/14 subtherapeutic, Continue Lovenox until INR (greater than 12.0 and less than 3.0.	NAME OF PI	ROVIDER OR SUPPLIER	•	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CMULD PRETR/ TAG Continued From page 53 February 11, 2014 revealed Resident #127 's diagnoses included: "Left hemiplegia, Chronic Respiratory Failure, Bilaterai Pulmonary Embolism, Deep Vein Thrombosis, Anemia, Intracranial Hemorrhage and Hypertension." F 386 For the APROPRIATE Deficiency State of the State					7	00 CONST. AVE. NE		
PHEFIX TAG IEACH ORRECTIVE ACTION MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTRING INFORMATION PHEFIX TAG IEACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE OF THE APPROPRIATE COMPLETING DEFICIENCY F 386 Continued From page 53 February 11, 2014 revealed Resident #127 's diagnoses included: "Left hemplegia, Chronic Respiratory Failure, Biateral Pulmonary Embolism, Deep Vein Thrombosis, Anemia, Intracranial Hemorthage and Hypertension." F 386 See page 53 for response to F386 A review of physician 's orders revealed the resident 's medication regimen included anticoagulant therapy as follows: See page 53 for response to F386 Physician 's orders signed June 20, 2014 [initiated May 12, 2014] directed Warfarin sodium (Coumadin) 6mg tablet daily for pulmonary embolism. See page 53 for response to F386 Physician orders signed June 20, 2014 [initiated May 12, 2014] directed '' Please check PT/INR Ratio] Monday-Wednesday-Friday until PT/INR is consistently greater than 2.0. Notify [Medical Doctof] regarding INR result. Once INR is greater than 2.0 then check PT/INR every week then D/C (discontinue) Lovenox." [Note: physician 's orders for May - July 2014 lacked evidence of an order for Lovenox] Consulting physician [Pulmonologist] progress notes included the following: May 11, 2014, at 9:40 AM, "INR remains subtherapeutic, Continue Lovenox until INR [greater than 2.0 to 3.0. May 12, 2014, "Needs therapeutic INR (last 5/7/14 subtherapeutic). Continue Lovenox until INR [greater than] 2.0 and less than 3.0.		HILL NURSING CENT	ER		V	VASHINGTON, DC 20002		
February 11, 2014 revealed Resident #127 's February 11, 2014 revealed Resident #127 's diagnoses included: "Left hemiplegia, Chronic Respiratory Failure, Bilateral Pulmonary Embolism, Deep Vein Thrombosis, Anemia, Intracranial Hemorrhage and Hypertension." A review of physician 's orders revealed the resident 's medication regimen included anticoagulant therapy as follows: See page 53 for response to F386 Physician 's orders signed June 20, 2014 [initiated April 30, 2014] directed Warfarin sodium (Coumadin) fing tablet daily for pulmonary embolism. See page 53 for response to F386 Physician orders signed June 20, 2014 [initiated May 12, 2014] directed: "Please check PT/INR fis consistently greater than 2.0. Notify [Medical Doctor] regarding INR result. Once INR is greater than 2.0 then check PT/INR every week then D/C (discontinue) Lovenox." [Note: physician 's orders for May - July 2014 lacked evidence of an order for Lovenox] Consulting physician [Pulmonologist] progress notes included the following: May 11, 2014 at 9:40 AM, "INR remains subtherapeutic, must adjust Coumadin [to] get INR consistently greater than 2.0 to 3.0. May 12, 2014, " Needs therapeutic INR [last 5/7/14 subtherapeutic). Continue Lovenox until INR [greater than 2.0 and less than 3.0.	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
	F 386	February 11, 2014 r diagnoses included: Respiratory Failure, Deep Vein Thrombod Hemorrhage and Hy A review of physicia resident 's medicati anticoagulant therap Physician 's orders April 30, 2014] direc (Coumadin) 6mg tat embolism. Physician orders sig May 12, 2014] direc [Prothrombin Time a Ratio] Monday-Wed consistently greater Doctor] regarding IN than 2.0 then check (discontinue) Lovent for May - July 2014 Lovenox] Consulting physician notes included the fer May 11, 2014 at 9:4 subtherapeutic, music consistently greater May 12, 2014, " Ne subtherapeutic). Co [greater than] 2.0 ar	evealed Resident #127 ' s " Left hemiplegia, Chronic Bilateral Pulmonary Embolism, psis, Anemia, Intracranial (pertension. " In ' s orders revealed the on regimen included by as follows: signed June 20, 2014 [initiated ted Warfarin sodium olet daily for pulmonary and June 20, 2014 [initiated ted: " Please check PT/INR and International Normalized Inesday-Friday until PT/INR is than 2.0. Notify [Medical IR result. Once INR is greater PT/INR every week then D/C ox." [Note: physician ' s orders lacked evidence of an order for In [Pulmonologist] progress ollowing: 40 AM, "INR remains st adjust Coumadin [to] get INR than 2.0 to 3.0. eds therapeutic INR (last 5/7/14 ntinue Lovenox until INR ad less than 3.0.	F	386	See page 53 for response to F386		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 54 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & ME				(. 0930-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	095027	B. WING			07/ ⁻	18/2014
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL HILL NURSING CENTER				00 CONST. AVE. NE /ASHINGTON, DC 20002		
PREFIX (EACH DEFICIENCY MUST BE P	IENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY YING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 " May 28, 2014, " Status embolism)/history of Dee get INR greater than 2 July 10, 2014 10 AM, " with INR [for approximat INR greater than 2.0 and Coumadin to keep INR g than 3.0 [history of pulm Thrombosis] " Progress notes recorded physician (team) include July 11, 2014, " Family p plan] pulmonary embolis checks [Pulmonologist n of Rx [medication regime A review of physician 's months of May - July 20 resident 's Coumadin do However; the resident 's July) remained subthera greater than 2.0 - 3.0] as June 2, 2014- INR 1.3; J 6, 2014- INR 1.7; June 18, 	umadincontinue Lovenox post PE (pulmonary ep Vein Thrombosis (DVT) 2.0 - 3.0 " remains subtherapeutic tely] 30 days! Need to keep d less than 3.0adjust greater than 2.0 and less nonary embolism/Deep Vein d by the primary care ed: meeting [assessment & sm on Coumadin PT/INR named] to decide the length en (anticoagulant)] " s interim orders for the 014 revealed that the osages were modified. s PT/INR levels (June - apeutic [below target goal of s follows: June 4, 2014- INR 1.3; June 9, 2014- INR 1.4; June 25, 7, 2014- INR 1.6; June 30, - INR 1.5; July 7, 2014 - INR 1.3.	F	386	See page 53 for response to F386		

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Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 55 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 095027 **B** WING 07/18/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONST. AVE. NE CAPITOL HILL NURSING CENTER WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 386 Continued From page 55 See page 53 for response to F386 F 386 Employee #30 [Nurse Practitioner] on July 16, 2014 at approximately 2:30 PM. He/ she stated that the pulmonologist was spoken with regarding the INR being greater than 2.0 and less that 3.0 because of the resident 's history of bilateral pulmonary embolism. A telephone interview was conducted with the pulmonologist on July 16, 2014 at approximately 5:00 PM regarding the aforementioned sub-therapeutic lab values. He/she stated that the resident 's INR should be maintained between 2.0-3.0 because the resident had bilateral pulmonary embolism. Further stated; he/she has talked Employee #30 regarding this repeatedly. A follow-up telephone conversation was conducted with Employee #16 [primary care physician] on July 17, 2014 at approximately 1:00 PM regarding the aforementioned concerns. He/she stated the INR should be maintained between 2.0-3.0 and the pulmonologist had been writing notes repeatedly regarding maintaining the INR range between 2.0 and 3.0. Facility staff failed to review the resident 's total program of care to ensure the desired therapeutic goal for anticoagulant therapy was obtained. The medical team documented directives [orders and progress notes] related to an anticoagulant medication, Lovenox that was not included in the resident 's current medication regimen. The clinical record was reviewed on July 17, 2014. F 412 483.55(b) ROUTINE/EMERGENCY DENTAL F 412 SERVICES IN NFS SS=D

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Facility ID: CAPITOLHILL

If continuation sheet Page 56 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

PRINTED: 08/19/2014 FORM APPROVED

<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES	-		(<u>. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER	-		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				70	0 CONST. AVE. NE		
	HILL NURSING CENT	ER		W	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES ' BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	outside resource, in this part, routine (to State plan); and em the needs of each re assist the resident in arranging for transp office; and must pro damaged dentures to This REQUIREMEN Based on record re interviews for two (2) was determined that recommended denta Residents' #44 and The findings include 1. Facility staff failed recommended denta During a face-to-fac on July 10, 2014 at resident was asked have any chewing o to no teeth, missing loose teeth]? He/sh resident opened his his/her gums and sa to have some dentu whether his/her gum	must provide or obtain from an accordance with §483.75(h) of the extent covered under the ergency dental services to meet esident; must, if necessary, n making appointments; and by ortation to and from the dentist's mptly refer residents with lost or to a dentist. IT is not met as evidenced by: view and staff and resident t) of 36 sampled residents, it t facility staff failed to provide al services for two (2) residents. #95.	F	412	 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS Response to #1 & 2 Resident #44, #95 1. Resident #44 was seen by dentist on 7/17 who determined that she is not a good candidate for dentures as she does not fo commands due to her dementia. Resident #95 has been scheduled for appointment with the oral surgeon on 9/1² 2. RCCs will review consult folder and dentist progress notes to identify residents who n follow-up. 3. RCCs or designees will review consult fold and dentist's progress notes monthly to en additional services are followed through 4. RCCs will document findings and present Quality Assurance Committee for review, evaluation, and recommendations monthly period of three months. 	llow l/14. st's eed der nsure to the	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 57 of 77

PRINTED: 08/19/2014
FORM APPROVED
MB NO 0038-0301

CENTERS FOR MEDICARE & MEDICAID SERVICES					0	<u>) MB NO.</u>	<u>. 0938-0391</u>
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			07/ [,]	18/2014
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
0(4) 15		ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	THE PRECEDED BY FULL REGULATORY	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	exam were, "Edentu negative." Under "R statement was docu Medicaid, will attemp upper/full lower) der On October 11, 201 not interested in der states that he/she ha alright w/o [without] [Responsible Party]. documentated inforr On October 23, 2013 exam. Edentulous. negative." No additi dentist noted on the There was no docum followed up with the residents oral status A face-to-face interv resident's RP at app 2014. The RP was discussed the possil relative with anyone and added that "It w remember exact tim wanted the dentures	2011, comments from the initial llous, oral cancer screening is Recommendations" the following imented; "If patient has pt to fabricate FU/FL, (full ntures. 1 the dentist wrote, "Patient is ntures at this time. [He/she] as never had false teeth and ate them. Will call RP.	F 4	412	See page 57 for response to F412		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 58 of 77

PRINTED: 08/19/2014
FORM APPROVED
OMB NO 0038-0301

	CENTERS FOR MEDICARE & MEDICAID SERVICES				(<u>. 0938-0391</u>		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		095027	B. WING			07/	18/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 412	F 412 Continued From page 58 Review of the dietary records revealed that the resident receives a Regular, Mechanical Soft diet and that his/her weight is stable.		F	412	See page 57 for response to F412				
	Employee #4 at app 2014. In response t 's complaint of sore the employee stated the RP had advised	iew was conducted with roximately 12:00PM on July 14, o a query regarding the resident gums and a need for dentures I that neither the resident nor him/her of the problem. The If I was aware, I would have see the resident."							
	Employee #32 at ap 2014. The employe unaware of the resid soreness/pain to the for the resident to ha added, " I will evalu	e gums and of the RP 's desire ave dentures. The employee ate the resident 's gums and regarding the dentures." The							
		ed to follow-up and/or provide al services for one resident.							
		I to provide follow-up dental ner for Resident #95.							
	approximately 12:14	erview on July 9, 2014 at PM, Resident #95 was ave any chewing or eating							

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 59 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTER	<u>IS FOR MEDICARE (</u>	& MEDICAID SERVICES				<u>DMB NO</u>	. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			07/ [,]	18/2014
NAME OF PI	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	0.7	
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	oral lesions, broken responded, "Yes, b dentist came in Octo to be readjusted [I dentures. "Resider he/she had any toot mouth sores, or den responded, "Yes." front tooth going a Proceeded to query mouth/facial pain wi "No. " Review of Resident an annual history ar which included diag Obstructive Pulmon Hypertension, Diabe The physician's m 22, 2013 at 9:00 AV stable COPD, Pulmo trach - on BIPAP (B Pressure) 24 hours.	due to: no teeth, missing teeth, or loose teeth? He/she because of missing teeth. The ober and [I] was fitted and had I] still has not received the nt further stated when asked if th problems, gum problems, nure problems, he/she ' Stated, " I have a cavity in my across the gum line. " Tresident if she/he had any ith no relief? He/she responded, #95's clinical record revealed nd physical dated April 6, 2014 noses of COPD (Chronic ary Disease), Pulmonary etes and Hypertension	F	412			

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 60 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

			-		(. 0930-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
		095027	B. WING			07/	18/2014	
	ROVIDER OR SUPPLIER	ER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 100 CONST. AVE. NE VASHINGTON, DC 20002	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 412	August 13, 2013- To # #23, 25. PAP [per discomfort. Patient h Discussed with patie Patient doesn ' t war Rx [prescription]: An 8 hours x 7 days. August 22, 2013 rev Upper/Partial Lower	ge 60 book 1 PA [periapical radiograph] riapical panaramic], abscess no has abscess near #23. ent need for possible extraction. nt RCT [root canal treatment]. noxicillin 500mg, 1 tablet every realed, " Trying PU/PL (Partial). Will need to reset teeth. May straction. Patient on Aspirin	F	412	See page 57 for response to F412			
	AM directed, " Denta toothache. " A review of the phys	r dated June 26, 2014 at 9:30 al consultation for resident with sician ' s notes from August not indicate that the resident						
	A nurses ' note date revealed, denies pai given for consult wit toothache. "	ed June 26, 2014 at 1:45 PM in or discomfort New orders h dental for complain of notes revealed resident denied						
	The clinical record la had received any de	acked evidence that the resident ental visits between						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 61 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

							. 0930-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PR	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER		I	00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	Continued From pag August 22, 2013 and		F	412	See page 57 for response to F412		
	revealed the nurse of	's appointment scheduling log called the dentist office on July office will place on list. "					
	Employees #6 and # approximately 12:45	cerns. Employee #5 contacted					
	1:35 PM revealed, ' reference to dental of called to dentist on a dentist, dentist in fac who reported that it secondary to BIPAP referred to oral surg Appointment is bein was informed that [s and there was no fo me that she would fa consultation done in ordered for resident po [times] 7 days for is not complain of pa Resident #95 update	es' note dated July 14, 2014 at ' Spoke with Employee #32 in consult ordered on 6/26/14 and 7/1/14. Resident not seen by cility 7/10/14. Spoke with dentist is difficult to see resident (, and that resident should be eon at [hospital named]. g scheduledEmployee #32 he/he] last saw resident in 8/13 llow up. Employee #32 informed ax a note in regards to [his/her] 8/13. Employee #32 has to start on Clindamycin 150mg toothache. Resident presently ain or discomfort at this time ed on plan and is in agreement hospital] earliest appointment					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 62 of 77

PRINTED: 08/19/2014 FORM APPROVED

	S FOR MEDICARE	& MEDICAID SERVICES			(. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/ ⁻	18/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 412	Prior to telephone d noted on July 14, 20 evidence that an ora warranted secondar	iscussion and documentation 014, the clinical record lacked al surgeon appointment was y to resident being on BIPAP.	F	412	See page 57 for response to F412		
	Employee #32. His/ 7/17/14 consult: Ref for evaluation and tr abscessed teeth inc	follow-up visit was conducted by /her dental note revealed, " fer patient to [hospital named] eatment of necrotic and cluding #23, 25. Rx: Clindamycin n) q (every) 8 hours [times] 7					
	timeliness on an ord Resident #95 who h there was no eviden	nce that the facility acted with ler for a dental consultation for ad a " toothache " . In addition, nce the dentist made nents for follow-up on Resident					
	Employee #32 on Ju 11:00 AM. He/she s informed him/her that tooth pain. It was fut an abscess before a	view was conducted with Jly 18, 2014 at approximately tated, no one called him/her nor at the resident was having any rther stated that the resident had and was treated and there was lent. The clinical record was , 2014.					
F 431 SS=D	The facility must em	JGS & BIOLOGICALS ploy or obtain the services of a who establishes a system of	F	431			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 63 of 77

PRINTED: 08/19/2014 FORM APPROVED

STATE MENU OF DEPENDENCES MAD PLAND OF CORRECTION (M) IDENTIFICATION IDENTIFICATION MADE OF CORRECTION (M) OF QUALTER CONSTRUCTION A. BUILDING (M) OF QUALTER CONSTRUCTION ADDITION OF CORRECTION (M) OF QUALTER CONSTRUCTION ADDITION OF QUALTER CONSTRUCTION ADDITION OF ROWIDER OR SUPPLIES (M) OF QUALTER CONSTRUCTION ADDITION OF QUALTER CONSTRUCTION ADDITION OF ROWIDER OF MAN FORMATION (M) OF QUALTER CONSTRUCTION ADDITION OF QUALTER CONSTRUCTION OF QUALTER CONSTRUCTION ADDITION OF QUALTER CONSTRUCTION OF QUALTER ADDITION OF QUALTER CONSTRUCTION OF Q	CENTER	<u>RS FOR MEDICARE (</u>	& MEDICAID SERVICES			C	<u>) MB NO</u>	<u>. 0938-0391</u>
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE TOO CONST. AVE. NE WASHINGTON, DC 20002 CAPITOL HILL NURSING CENTER STREET ADDRESS, CITY, STATE, 2P CODE TOO CONST. AVE. NE WASHINGTON, DC 20002 If EACH DEPICIENTY WIDTE PRECEDENCES OR LSC IDENTFYING INFORMATION OR LSC IDENTFYING INFORMATION PRETX PROVIDER PROVIDER ON SPOULD E CROSS-REFERENCED TO THE APPROPRIATE DEPICIENTY TAG PROVIDER PROVIDER ON SPOULD E CROSS-REFERENCED TO THE APPROPRIATE DEPICIENTY (CROSS-REFERENCED TO THE APPROPRIATE ACCORDITION (CROST) (CROSS-REFERENCED TO THE APPROPRIATE ACCORDING TO THE APPROPRIATE (CROSS-REFERENCED TO THE APPROPRIATE ACCORDITION (CROST) (CROSS-REFERENCED TO THE APPROPRIATE (CROSS-REFERENCE) (CROSS-REFERENCED TO THE APPROPRIATE (CROSS-REFERENCED TO THE APPROPRIAT								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRITE, ZIP CODE CAPTOL HILL NURSING CENTER 700 CONST. AVE. NE WASHINGTON, DC 2002 (PALT) TAGE (EACH SUMMARY STATEMENT OF DEFICIENCIES OR LSC DENTFYING INFORMATION PREFIX PREFIX PROVIDER SPLANCE CORRECTION (CACH CORRECTIVE ATTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC DENTFYING INFORMATION DIE (CACH CORRECTIVE ATTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE ACT THE TADING AND THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE ACT THE ACTION AND THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE ACT THE ACT AND THE APPROPRIATE AND THE REFERENCES TO THE APPROPRIATE ACT THE SECONT APPROPRIATE AND THE APPROPRIATE ACT THE SECONT APPROPRIATE AND THE APPROPRIATE ACT THE SECONT APPROPRIATE AND THE APPROPRIME APPROPRIATE AND THE ACT AT THE TREE APPROPRIATE AND THE ACT AT THE SECONT APPROPRIATE AND THE APPROPRIATE APPROPRIATE APPROPRIATE ACT AND THE APPROPRIATE APPROPRIATE ACT AND THE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE ACT APPROPRIATE APPROPRIATE APPROPRIATE ACT APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIATE APPROPRIMETER APPRO			095027	B. WING _			07/	18/2014
CAPTOL HILL NURSING CENTER WASHINGTON, DC 20002 [PM_EFX] TAG (EACH DEFICIENCY UNSITE MERCENDER Y FULL REQULATORY OR LSC DENTEMPING INFORMATION) PB_D TAG PROVIDE SPLAN OF CORRECTION EACH CORRECTIVE SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION DEFICIENCY, Conjugation (EACH CORRECTIVE SPLAN OF CORRECTION SPLAN OF CORRECTIVE SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION DEFICIENCY, Conjugation (EACH CORRECTIVE SPLAN OF CORRECTION SPLAN OF CORRECTIVE SPLAN OF CORRECTION DEFICIENCY, COULD DEFICIENCY, COULD DEFICIENCY, COULT DEFICIENCY,	NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
CAPTOL HILL NURSING CENTER WASHINGTON, DC 20002 [PM_EFX] TAG (EACH DEFICIENCY UNSITE MERCENDER Y FULL REQULATORY OR LSC DENTEMPING INFORMATION) PB_D TAG PROVIDE SPLAN OF CORRECTION EACH CORRECTIVE SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION DEFICIENCY, Conjugation (EACH CORRECTIVE SPLAN OF CORRECTION SPLAN OF CORRECTIVE SPLAN OF CORRECTION CROSS-REFIGENCY, MERCENN SPLAN OF CORRECTION DEFICIENCY, Conjugation (EACH CORRECTIVE SPLAN OF CORRECTION SPLAN OF CORRECTIVE SPLAN OF CORRECTION DEFICIENCY, COULD DEFICIENCY, COULD DEFICIENCY, COULT DEFICIENCY,					700	CONST. AVE. NE		
(M4, ID) PMEED TAG SUMMARY SIXTEENESCENEED FULL REGULATORY TAG D PMEE	CAPITOL	HILL NURSING CENT	ER					
PREFX TG CEAH CORRECTIVE ACTIONS VIUL REGULATORY DR LSC IDENTIFYING INFORMATION PREFX TG CEAH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HELPPROPRIATE DEFICIENCY COMPLETON DATE F 431 Continued From page 63 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs is maintained and periodically records are in order and that an account of all controlled drugs, and include the appropriat accessory and cautionary instructions, and the expiration date when applicable. F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 1. The refrigerator in the 5 th foor medication storage room was replaced. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 8. RCCs will document findings and present to the Quality Assurance Committee for review, evaluation, and recommediators monthy for a period of three months. 9.12.2014		1						1
 Controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an accound of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and staff 	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	K	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
interview, it was determined that facility staff failed to consistently monitor and ensure medication refrigerator temperatures were between 36-46 degrees fahrenheit on one(1)	F 431	controlled drugs in s accurate reconciliati records are in order controlled drugs is r reconciled. Drugs and biological labeled in accordand professional principl accessory and cauti expiration date when In accordance with a facility must store al compartments unde and permit only auth access to the keys. The facility must pro- permanently affixed controlled drugs listed Comprehensive Dru Act of 1976 and oth except when the fac drug distribution sys stored is minimal an detected. This REQUIREMEN A. Based on observ- interview, it was det to consistently moni refrigerator tempera	Sufficient detail to enable an on; and determines that drug and that an account of all maintained and periodically Is used in the facility must be ce with currently accepted es, and include the appropriate onary instructions, and the n applicable. State and Federal laws, the I drugs and biologicals in locked r proper temperature controls, norized personnel to have ovide separately locked, compartments for storage of ed in Schedule II of the 1g Abuse Prevention and Control er drugs subject to abuse, stility uses single unit package terms in which the quantity and a missing dose can be readily IT is not met as evidenced by: vations, record review and staff ermined that facility staff failed tor and ensure medication tures were between 36-46	F 4	.31	 LABEL/STORE DRUGS & BIOLOGICALS The refrigerator in the 5th floor medication storage room was replaced. RCCs will check refrigerator temperatures medication storage rooms to ensure temperatures remain at 36-46 degrees Fahrenheit. Environmental rounds will be conducted monthly with the Resident Care Coordinai designee, Maintenance Director or designe Housekeeping Director or designee, and Administrator or designee. Staff Develop Nurse will re-in-service RNs and LPNs on need to monitor the temperatures in the medication refrigerators to maintain temperatures at 36-46 degrees Fahrenheit. RCCs will document findings and present Quality Assurance Committee for review, evaluation, and recommendations monthl 	tor or nee, ment the it. to the	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 64 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES			(<u> JNIB INO</u>	. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES ' BE PRECEDED BY FULL REGULATORY 'NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	5th floor medication 15, 2014 at approxim A review of the "Re July 15, 2014 reveal recorded as 32 degr After further review	medication refrigerator in the storage room was done on July mately 4:00PM. Efrigerator Storage Log " for led the temperature was rees F (Fahrenheit). of the Refrigerator Temperature owing recorded temperatures: 30 degrees F; 0 degrees F; 2 degrees F; 2 degrees F; 32 degrees F; 32 degrees F; 32 degrees F; 32 degrees F; 9 grees F	F	431	Refer to page 64 for response F431		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 65 of 77

PRINTED: 08/19/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES		& MEDICAID SERVICES				<u> JMR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			700 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES " BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From pag	-			Refer to page 64 for response F431		
	maintenance depart	nce that facility staff notified the ment when the refrigerator 6 degrees Fahrenheit as tor log.					
	Employees #2 and # approximately 4:15 'Refrigerator Tempe employees acknowle	rview was conducted with #20 on July 15, 2014 at 5 PM. After reviewing the erature Log" form, Both vledged the aforementioned rvation was conducted July 15,					
F 441 SS=E		CONTROL, PREVENT	F	441	Refer to page 67 for response F441		
	Control Program des sanitary and comfor	must establish and maintain an Infection gram designed to provide a safe, d comfortable environment and to help development and transmission of d infection.			Relet to page of for response F441		
	Program under whic (1) Investigates, cor the facility; (2) Decides what pro should be applied to	ablish an Infection Control th it - atrols, and prevents infections in ocedures, such as isolation, an individual resident; and rd of incidents and corrective					
	that a resident need of infection, the facil	ad of Infection on Control Program determines s isolation to prevent the spread ity must isolate the resident. prohibit employees with a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 66 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			07/ [,]	18/2014
	ROVIDER OR SUPPLIER	ER		70	REET ADDRESS, CITY, STATE, ZIP CODE 0 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES ' BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 463 SS=D	communicable disea direct contact with re contact will transmit (3) The facility must hands after each dir hand washing is ind practice. (c) Linens Personnel must han transport linens so a infection. This REQUIREMEN Based on observati approximately 10:00 facility failed to store sanitary conditions a ounces bottle of app one (1) of one (1) icc The findings include A half-full bottle of a the ice machine in the These observations Employee #12 and fa acknowledged the fit 483.70(f) RESIDEN	 ase or infected skin lesions from esidents or their food, if direct the disease. require staff to wash their ect resident contact for which icated by accepted professional dle, store, process and is to prevent the spread of T is not met as evidenced by: ons made on July 11, 2014 at 0 AM, it was determined that the e and prepare food under as evidenced by a half-full 16 ble juice that was stored inside e machine. : apple juice was observed inside he kitchen. were made in the presence of Employee #1 who ndings. T CALL SYSTEM - 		441	 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1. Immediately upon notification, the apple ji bottle stored inside the ice machine was discarded. 2. Re-education of dietary staff was conduce 7/24/2014 reiterating the importance of following proper sanitization procedures. 3. Director of Dietary will conduct monthly environmental rounds identifying any infe control violations. 4. Director of Dietary will document findings present to the Quality Assurance Commit review, evaluation, and recommendations monthly for a period of three months. 	ed on ction and tee for	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 67 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

	S FUR MEDICARE				(. 0930-0391
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			0 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES ' BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 463	The nurses' station resident calls throug resident rooms; and This REQUIREMEN Based on an observenvironmental tour of approximately 3:00 facility staff failed to in good working com	must be equipped to receive th a communication system from toilet and bathing facilities. T is not met as evidenced by: vation made during an of the facility on July 10, 2014 at PM, it was determined that maintain resident's call system dition as evidenced by a ell in one (1) of 15 resident's por.	F	463	 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The call bell in room #5105 was repaired Maintenance Director or designee will co environmental rounds to ensure call bells rooms and bathrooms are working. Maintenance Director or designee, Direct Housekeeping or designee, Administrato designee, Resident Care Coordinator or designee will conduct monthly rounds. Maintenance will have a work order syste each unit for staff to document maintenan needs. Maintenance Director will document findi and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of months. 	nduct s in tor of r or em on nce ngs	9.12.2014
F 469 SS=D	after it was activated rooms. These observations Employee #1 and E #15 who acknowled 483.70(h)(4) MAINT CONTROL PROGR The facility must ma program so that the rodents.	lged the findings. AINS EFFECTIVE PEST	F	469			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 68 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 469 Continued From page 68 Based on observations made throughout the survey period from July 8 2014 through July 14, 2014, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen on the fourth, fifth and sixth floor. F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM 1. Pest control measures will be implemented to control flying insects on the fourth, fifth, and sixth floor. The findings include: F 100 S. Environmental round to ensure pest control issue related to flying insects has been resolved. 2. Maintenance Director will conduct an environmental round to ensure pest control issue related to flying insects has been resolved. 3. Environmental rounds will be conducted with a work group including Director of Maintenance or designee, Director of Housekeeping or designee, and Administrator or designee monthly. The Pest Control company will be required to communicate with maintenance and nursing staff prior to doing rounds.		S FUR MEDICARE				(<u> </u>	. 0930-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE OUT DUDUTE CAPITOL HILL NURSING CENTER STREET ADDRESS, CITY, STATE, 2IP CODE TOO CONST. AVE. NE WASHINGTON, DC 20002 TOO CONST. AVE. NE WASHINGTON, DC 20002 PREFIX TEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) OWNED PREFIX PROVIDER'S FLAN OF CORRECTION (EACH DEPICIENCY COMPLETO (CONST. AVE. NE F 469 Continued From page 68 F 469 PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE CONTROL PROGRAM OWNED (CONST. AVE. NE COMPLETO (CONST. AVE. NE COMPLETO (CONST. AVE. NE CONTROL PROGRAM DepICIENCY DepICIEN	AND PLAN OF CORRECTION		. ,					
CAPITOL HILL NURSING CENTER TWO CONST. AVE. NE WASHINGTON, DC. 2002 (M1)D TYC SUMMARY STATEMENT OF DEFICIENCES PREEX OR USC IDENTIFYING INFORMATION 0 PREIX TXC PROVIDER'S PLAN OF CORRECTIVE ACCESS (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) 0 PREEX TXC PROVIDER'S PLAN OF CORRECTIVE ACCESS (DUBLIC ECROSS-REFERCE) 0 PREEX (EACH DEFICIENCY) 0 DALE 0 OCMREEND (EACH DEFICIENCY) 0 DALE 0 OCMREEND (CONTROL PROGRAM 1 DEFICIENCY) 0 DALE 0 OCMREEND (CONTROL PROGRAM 1 DEFICIENCY 0 DALE 1 DEFICIENCY 0 DALE 0 DALE 0 DALE 0 DALE 0 DALE 0 DALE 0 DALE			095027	B. WING			07/	18/2014
CAPTOL HILL NURSING CENTER WASHINGTON, DC 20002 PAUID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION? D D D D D D D D D D D D D D D D D D D	NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
IEACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG IEACH DERICIENCY OTH APPROPRIATE DEFICIENCY Continued From page 68 Based on observations made throughout the survey period from July 8 2014 through July 14, 2014, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen on the fourth, fifth and sixth floor. F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM Pest control measures will be implemented to control flying insects on the fourth, fifth, and sixth floor. The findings include: F 469 483.75(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM . Pest control measures will be implemented to control flying insects on the fourth, fifth and sixth floor. . Maintenance Director will conduct an environmental rounds to ensure pest control issue related to flying insects has been resolved. F 514 F514 483.75(h)(1) RES SS=D F 514 82.75(h)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately document findings at coursely document findings at opresent to the Quality for a period of three monthy. 9.12.201	CAPITOL	. HILL NURSING CENT	ER		1			
 F 469 Continued From page 68 Based on observations made throughout the survey period from July 8 2014 through July 14, 2014, it was determined that the facility failed to maintain an effective pest control program as evidenced by flying insects seen on the fourth, fifth and sixth floor. The findings include: Flying insects were seen several times in resident's areas located on the fourth, fifth and sixth floor. These observations were made throughout the survey period from July 8, 2014 through July 14, 2014. F 514 F 514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. F 514 F clinical record must contain sufficient 	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	Based on observati survey period from 2 2014, it was determine maintain an effective evidenced by flying and sixth floor. The findings include Flying insects were areas located on the These observations survey period from 2 2014. 483.75(I)(1) RES RECORDS-COMPL The facility must maresident in accordant standards and pract accurately document systematically organt The clinical record not information to identific resident's assessment services provided; the screening conducted notes.	 ons made throughout the July 8 2014 through July 14, ined that the facility failed to e pest control program as insects seen on the fourth, fifth seen several times in resident's a fourth, fifth and sixth floor. were made throughout the July 8, 2014 through July 14, ETE/ACCURATE/ACCESSIBLE intain clinical records on each hce with accepted professional ices that are complete; tted; readily accessible; and hized. nust contain sufficient fy the resident; a record of the ents; the plan of care and he results of any preadmission d by the State; and progress 			 CONTROL PROGRAM Pest control measures will be implement control flying insects on the fourth, fifth, a sixth floor. Maintenance Director will conduct an environmental round to ensure pest cont issue related to flying insects has been resolved. Environmental rounds will be conducted work group including Director of Maintena designee, Director of Housekeeping or designee, Resident Care Coordinator or designee, and Administrator or designee monthly. The Pest Control company will I required to communicate with maintenan nursing staff prior to doing rounds. Director of Maintenance will document fir and present to the Quality Assurance Committee for review, evaluation, and recommendations monthly for a period of 	ed to and rol with a ance or be ce and ndings	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 69 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & ME	EDICAID SERVICES			(0930-0391
AND PLAN OF CORRECTION		. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	095027	B. WING			07/ [.]	18/2014
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL HILL NURSING CENTER				0 CONST. AVE. NE		
			W	ASHINGTON, DC 20002		
PREFIX (EACH DEFICIENCY MUST BE P	IENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY YING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
 one (1) of 36 sampled ret that facility staff failed to a complete; accurately d accessible; and systema as evideced by wound s for an active clinical record. The findings include: A review of the physiciar May 2, 2014- " Right Het saline, pat dry, apply sar mupirocin ointment follow gauze every day and prr June 17, 2014 at 5:01 Pl previous santyl + 2% Mu [right] heel wound treatm non-covered by insurance Cleanse with [Normal Sa apply santyl ointment witd day) and prn (as needed) On July 15, 2014 at apply State Agency Represent clinical record for Reside wound and skin sheets 3, 2014 were not located record. At this time Employees # to the wereabouts of the Employee #3 the retriev 	view and staff interview for esidents, it was determined o maintain clinical records in documented; readily atically organized manner, sheets not readily accessible ord. Resident #42 an's orders directed: eel: Cleanse with normal antyl ointment mixed with owed by maxorb and roller in (as needed)" PM-" D/C (Discontinue) uprocin TX (treatment) for ment secondary to ice. Right heel wound- ith dry dressing QD (every d). " proximately 12:30 PM the itive reviewed the active ent #42. During the reveiw, from April 30, 2014 to June	F	514	 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES Resident #42 has the wound and skin she the chart Resident #42 has the wound treatments documented on the wound skin treatment Resident #95 will have showers documen the log sheet. Resident #127 is no longer receiving Love Resident #134's order for nutritional supp was discontinued. Resident Care Coordinators or designee of resident charts, to ensure wound and skin are in the charts Resident Care Coordinators or designee of Treatment Administration Records, Medic Administration Records, to ensure wound treatments are documented on the wound treatment sheets, and that Lovenox order transcribed to the MAR Resident Care Coordinators or designee of shower logs and dietitian's consult folder ensure showers are documented and diet recommendations are followed through Staff Development nurse will re-in-service on the use of shower logs. Staff Develop nurse will re-in-service RNs/LPNs on tran of orders and on following consultant's recommendations. Resident Care Coordin or designee will audit resident charts, MA TARs, shower logs, and dietitian's consult monthly. Resident Care Coordinators will document findings and present to the Quality Assura Committee for review, evaluation, and recommendation monthly for a period of t months. 	eets on sheets. ted on enox. lements will audit a sheets will audit tal d skin s are will audit to sitian's e CNAs ment scription nators Rs, t folder ance	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>) MB NO</u>	<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		S	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	maintaining the wou record? " He/she re- rounds every week. and assess the wou nurse dress the resi- skin care sheet is co and e-mailed to the of nursing usually of manager prints it fro the resident ' s char Facility staff failed to systematically organ evidence by wound available on the act B. Based on a resid and clinical record r residents, it was def	ueried, "What is the process of and sheets in the active clinical esponded, "The wound team The wound nurse measures and. Afterwards, the charge dent's wound. The wound and ompleted by the wound nurse clinical managers and director ne-two days. The clinical om the computer and places it in t.	F 5	514	Refer to page 70 for response F514		
	wound treatment on sheets; failed to cor resident's baths and failed to transcribe a onto the Medication for one (1) resident; to discontinue nutrit June 2014 and July	to the wound skin treatment asistently document one (1) I showers onto the the log sheet; a physician's order for Lovenox Administration Record (MAR) and failed to transcribe an order ional supplements on to the 2014 Medication Administration resident. Residents' #42, #95,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 71 of 77

PRINTED: 08/19/2014 FORM APPROVED

<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES			(<u> JMR NO</u>	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HILL NURSING CENT	ER			00 CONST. AVE. NE		
				V	VASHINGTON, DC 20002		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From pag	ge 71	F	514			
		I to accurately document scribed wound treatment onto t sheets.			Refer to page 70 for response F514		
	PM directed, " D/C 2% Muprocin TX (tre treatment secondary Right heel wound- C Solution], Pat dry the	der dated June 17, 2014 at 5:01 (Discontinue) previous Santyl + eatment) for [right] heel wound / to non-covered by insurance. Cleanse with [Normal Saline en apply Santyl ointment with ery day) and prn (as needed). "					
	July 14, 2014 at app time the State Agen	observation was conducted on proximately 9:45 AM. At this cy Reprehensive observed ng applied to right heel.					
	Note " sheets from revealed, " Location unstageable, Treatm	ound and Skin Care Progress June 18, 2014 to July 9, 2014 n: Right heel; Stage/ Etiology- nent: Continue Santyl + 2% ment) as per order. "					
	Employee #24 on Ju 12:15 PM regarding He/she stated, "We as Santyl and 2% M the resident was rec one informed us (wo	iew was conducted with uly 15, 2014 at approximately the aforementioned findings. continued to write the treatment upirocin because we thought reiving the same treatment. No bund team) that the treatment clinical record was reviewed on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 72 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

	<u>S FUR MEDICARE (</u>	& MEDICAID SERVICES			l		. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			07/	18/2014
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			0 CONST. AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	 #42 's prescribed w and skin care progree 2. Facility staff failed resident 's bath and Resident #95. During a resident int 2014 at approximate Do you choose whe bed bath? He/she refurther stated; "I su Tuesday and Friday consistent. " A review of the resident 's and Fridays on 3PM February to July 201 baths on designated A face-to-face interv Employee #5 on July 11:45 AM. He/she a aforementioned find When a bed bath wa been documentation if resident refused. " reviewed on July 14 There was no evided documented the resilog sheet. 	 accurately document Resident ound treatment onto the wound ess notes. a to consistently document a showers on log sheet for bety 11:58 AM, when queried, " ther you take a shower, tub, or esponded, " No. " He/she uppose to get a shower on s on evening shift, but it is not beth 's " bath/shower log " shower days were Tuesdays -11PM shift. However, from 4 the resident received bed a shower days. beth was conducted with y 14, 2014 at approximately cknowledged the ings. He/she further stated, " as given, there should have that a shower was offered and The clinical record was 	F 5	514	Refer to page 70 for response F514		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 73 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

	S FOR MEDICARE	& MEDICAID SERVICES	r				. 0938-039		
AND PLAN OF CORRECTION		. ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED				
		095027	B. WING _			07/	18/2014		
NAME OF PROVIDER OR SUPPLIER CAPITOL HILL NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONST. AVE. NE					
				WA	SHINGTON, DC 20002				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE		
F 514	The "History and Ph revealed that Reside " Left hemiplegia, Cl Bilateral Pulmonary Hemorrhage and Hy A physician's interim directed, " Lovenox	nto the Medication ord (MAR) for Resident #127. hysical "dated January 24, 2014 ent #127 ' s diagnoses included: hronic Respiratory Failure, Embolism, Intracranial	F	514	Refer to page 70 for response F514				
	Administration recort to administer Lovence onto the MAR.	uary 2014 Medication d lacked evidence that the order ox 30 mg SQ was transcribed view was conducted with							
	Employees #5 and # approximately 2:30 acknowledged the a clinical record was r Facility staff failed to	#6 on July 16, 2014 at PM. Both employees forementioned findings. The eviewed on July 16, 2014. transcribe a physician 's order e Medication Administration							
	discontinue nutrition 2014 and July 2014 Records for Resider The History and Phy	vsical dated February 9, 2014 Included the following diagnoses:							

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 74 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO 0938-0391

	S FUR MEDICARE	& MEDICAID SERVICES					. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			07/	18/2014
	ROVIDER OR SUPPLIER	ER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONST. AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 514	Hemiplegia, Hyperte Apnea, Tracheostor A telephone order d D/C [discontinue] Be supplement] related [discontinue] Juven A review of the June 'Physician's Order F orders dated April 2 [gram] - 1.5G [gram liquid by mouth twic Beneprotein 7GM [g in liquid by mouth twic Beneprotein 7GM [g in liquid by mouth twic On July 14, 2014 at face-to-face intervie Employee #3 regard orders. He/she conf supplements were a Forms,' the resident supplements. The A Administration Recco indicated they were the following markin Resource Beneprote 2014 ". A review of the June that here were no mareas to indicate tha Facility staff failed to discontinue nutrition	ension, Obstructive Sleep ny, Peg Tube [feeding tube]. ated May 28, 2014 directed, " eneprotein [nutritional to wound healing, D/C [nutritional supplement]." e 2014 and July 2014 forms' revealed the following 8, 2014: "Juven 7G[gram]-7G] packet, 1 packet dissolved in e dailyand Resource gram] packet, 1 packet dissolved	F	514	Refer to page 70 for response F514		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 83C111

Facility ID: CAPITOLHILL

If continuation sheet Page 75 of 77

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,			COMPLETED	
	095027	B. WING	B. WING		07/18/2014	
NAME OF PROVIDER OR SUPPLIER CAPITOL HILL NURSING CENTER			70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONST. AVE. NE /ASHINGTON, DC 20002		
PREFIX (EACH DEFICIENCY MUST B	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY TIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
SS=F QUARTERLY/PLANS A facility must maintal assurance committee nursing services; a ph facility; and at least 3 staff. The quality assessme meets at least quarter respect to which qualit activities are necessa implements appropriatidentified quality defice. A State or the Secret of the records of such such disclosure is relacommittee with the re Good faith attempts b correct quality deficient basis for sanctions. This REQUIREMENT Based on record revinine (9) of 36 sampler supplemental residen facility 's Quality Assoc (QAA) Committee fail /or revise appropriate	in a quality assessment and consisting of the director of hysician designated by the other members of the facility's ent and assurance committee fly to identify issues with ity assessment and assurance try; and develops and the plans of action to correct ciencies. Tary may not require disclosure a committee except insofar as ated to the compliance of such quirements of this section. By the committee to identify and ncies will not be used as a the is not met as evidenced by: ew and staff interviews for d residents and eight (8) of 40 ts, it was determined that the essment and Assurance ed to develop, implement, and corrective actions for the actice as necessary. Residents	F	520	 483.75(o)(1) QAA COMMITTEE-MEMBERS/ QUARTERLY/PLANS MDSs for residents #38, #42, #48, #58, # #111, #134, S50, S65, S83, S119 will b corrected. Residents #55, #113, S123, S no longer resides in the facility, therefore further measures could be taken. MDS coordinator will audit residents' MD ensure V-section is complete. MDS coordinator or designee will audit M a monthly basis for completion. Quality Assurance Coordinator will in-service Qu Assurance Coordinator will in-service Qu Assurance Committee members as to the to address concerns to the committee MDS coordinator will document findings a present to the Quality Assurance Commi review, evaluation, and recommendation monthly for a period of three months. Qu Assurance Coordinator will prompt memb address any concerns during quality assu- committee monthly for a period of three r 	#95, e 16, S26 ; no Ss to IDSs on ality e need and ttee for s ality pers to urance	9.12.2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 76 of 77

PRINTED: 08/19/2014 FORM APPROVED OMB NO. 0938-0391

	S FUR MEDICARE	& MEDICAID SERVICES			(. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		095027	B. WING			07/	18/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAPITOL	HILL NURSING CENT	ER			00 CONST. AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	residents: S16, S26 S123. The findings include During the survey, the was identified: Facility staff failed to Sets were accurated Area Assessment. On July 17, 2014 at Interim Director of N regarding their QAA the concern listed at It was stated that the identified concerns is summary. Upon no system problem was There was no evide Committee identified measures to address	34, and eight (8) supplemental , S40, S50, S65, S83, S119, e: he following area of concern o ensure that the Minimum Data y coded under Section V, Care approximately 3:20 PM, the lursing was interviewed . Committee 's identification of		520	DEFICIENCY) Refer to page 76 for response F520		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: CAPITOLHILL

If continuation sheet Page 77 of 77