PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		R
		095022	B. WING		12/16/2016
	ROVIDER OR SUPPLIER	CAPITOL CITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
, i. i. j.	A revisit survey wa and 16, 2016 as a fundicator Survey (Q conducted October deficiencies are bas reviews and staff in residents.  The following is a diacronyms that may  Abbreviations  AMS - Altered g-tube- Gastro EKG - 12 lea NP - Nurs BID - Twice EMS - emergen HVAC - Heating Neuro - Neurol B/P - Blood CRF - Common CNA- Certified DMH - Depart Peg tube - Percutar NP - Nurs L - Liter DI - deciliter	s conducted on December 15 collow-up to the annual Quality IS) recertification survey 25, 2016. The following sed on observations, record terviews for 30 sampled december of abbreviations and/or be utilized in the report:  Mental Status stomy tube d Electrocardiogram e Practitioner - a-day cy medical services (911) prentilation/Air conditioning	{F 000}	Transitions Healthcare Canitol City is	s filing with is not es
	MAR - Medica MD- Medica MDS - Minimu	ds (unit of mass) tion Administration Record cal Doctor im Data Set ams (metric system unit of			
				TITLE 1	(X6) DATE/

LABORATORY DIREC

Any deficiency statement ending with an asterisk (\*) denotes deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient profection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of sorvey whether or not a pian 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.

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

Event ID: 3QFH12

Facility ID: WASHNURS

If continuation sheet Page 1 of 8

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	COMPLETED
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		095022	B. WING _		12/16/2016
NAME OF PE	ROVIDER OR SUPPLIER	<del>-</del>		STREET ADDRESS, CITY, STATE, ZIP CODE	
TOANGIT	IONS HEALTHCARE C	APITOL CITY		2425 25TH STREET SE	
IKMNOIII	IONO REALITOANE			WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	BE COMPLETION
(F 000)	Continued From page mL - millilli volume) mg/dl - milligram mm/Hg - millimete POS - physic Prn - As not Pt - Pat TAR - Treatm PASRR - Preadmi Review ARD - assessi IDT - interdigit ID - Intelli QIS - Quality D.C District D/C - discontinue Rp, R/P - responsible PO-By Mouth  483.20(k)(3)(i) SER PROFESSIONAL STATE This REQUIREMENT This REQUIREMENT Based on observation of the facility 's mesheets, it was determent professional state of the quality control o	ge 1 ters (metric system measure of s per deciliter rs of mercury cian 's order sheet eeded tient ment Administration Record ssion screen and Resident ment reference date sciplinary team ectual disability y Indicator Survey to of Columbia ele party  EVICES PROVIDED MEET STANDARDS  led or arranged by the facility onal standards of quality.  NT is not met as evidenced by: tion, staff interview and a review dical device (Glucometer) log rmined that facility staff failed to standards of quality as evidenced on of a false [inaccurate] account of high and low glucose control	F 2	483.20(k)(3)(i) Services Provide Professional Standards  1. The nurses involved were sulto disciplinary action per the perspolicies of the facility.  2. All of the remaining 13 Gluco I ogs were reviewed immediately	ed Meet  Djected onnel 12/28/16  meter and no ence of 12/16/16  ity cometer ometer ometer lances, d a e and the s on a 12/28/16  ometer ometer on a 12/28/16
	The findings includ	bers for one (1) Glucometer		for their review. Such a review has added as a permanent agenda itel Safety Committee where all Depar Heads and the Administrator sit as	been hor the the threat threat 12/28/16

Facility ID: WASHNURS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
				R		
	095022	B. WING _		12/16/2016		
NAME OF PROVIDER OR SUPPLIER		Ì	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 25TH STREET SE			
TRANSITIONS HEALTHCARE	CAPITOL CITY	WASHINGTON, DC 20020				
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 281 Continued From pa  " Corrections, ame paper records show single line through the not to obliterate the error", " mistake the incorrect text as organizational policic correction above the available or adding signing and dating correct information adjacent to the ack information " (Burl 499-500).  Glucometer - a mediapproximate concervity the quality determine if they are amount of glucoses place of a drop of the meter should match strips used with the the range listed on problem with either http://www.mayoclites/expert-blog/bloo094453  A review of the fact Glucometer Quality	Indments and addendums in lid be performed by placing a the incorrect entry, being careful inaccurate information; writing en entry ", or "omit" next to a determined by the y; providing the rational for the e inaccurate entry if room is it to the margin of the document; the entry; and entering the in the next available space or nowledged inaccurate ingame, et al., 2015, pp.  dical device for determining the intration of glucose in the blood.  cometer Quality Control check is of the meter and test strips to be working properly.  Dution [low and high] is a liquid all vial and contains a known. The glucose solution is used in a range listed on the vial of test emeter. If the result is outside of the meter or the test strips" inic.org/diseases-conditions/diable od-glucose-control-solution/bgp-2 lility 's December 2016 y Control (QC) Log revealed the	:	81 483.20(k)(3)(i) Services Pro Professional Standards (co	ovided Meet ontinued)		
December 14, 201	6 [night shift, no time	:		İ		
		1	· ·	· ·		

Event ID: 3QFH12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		R	
		095022	B. WING		12/16/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				2425 25TH STREET SE		
TRANSIT	IONS HEALTHCARE	CAPITOL CITY		WASHINGTON, DC 20020		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY	ID PREFIX	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION	N SHOULD BE COMPLETION	
PREFIX TAG	OR LSC II	DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE DATE	
F 281	Continued From page	ane 3	F 28	483.20(k)(3)(i) Services Pi		
, 20,	· ·	essment "high control level "		Professional Standards (	continuea)	
	Indicated GC asse	d by manufacturer; when the	:			
		ccurately, the "high" results	:	1		
		nis range] was recorded as 172		•	i	
	mg/dl [milligrams p	per deciliter]. The pre-established			•	
	range [indicative th	nat the device was functioning as	: :			
	intended) was 184	-248 mg/dl. There was no				
	evidence that facili	ty staff implemented measures to			1	
	ensure the Glucon	neter was functioning properly	:			
	when it was detern	nined the high control level was				
	identified outside of	of the pre-determined range.	:			
	: - ====================================	2040 Inight shift no time		:		
	The December 15	, 2016 [night shift, no time			:	
	indicated the QC	assessment "high control level " 76 mg/dl. The pre-established				
	was recorded as 1	/dl. No action was taken when				
	the reading was or				: :	
	the reading was or	or range.			•	
	There was no evid	lence that when the quality control	!			
	values were out of	range, facility staff implemented				
	" troubleshooting"	measures to verify the accuracy	:			
	of the glucometer			II.	:	
	:			:	:	
	On December 16,	2016 at approximately 11:45 AM,				
	in the presence of	Employee #2, further review of		•	•	
	the December 201	6 Glucometer Control Logs were				
	conducted. Discre	pancies were identified between	ļ			
	the Glucometer lo	g copies that were provided to				
	survey team on De	ecember 15, 2016 as compared to ginals] maintained in in the facility				
	oc an active recor	d. In response to a query	!			
	regarding the disc	repancy, Employee # 2 stated, the	:			
	Glucometer Qualit	repartey, Employee in 2 states, the cy Control Log was likely altered.			!!	
	A face-to-face inte	erview was conducted with				
	Employee #4 [lice	nsed nurse] on December 16,				
	2016 at approxima	ately 1:00 PM. Employee#4				
		·	:	:		
			į.		:	

Facility ID: WASHNURS

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095022	B. WING				6/2016
	ONS HEALTHCARE	CAPITOL CITY		24	REET ADDRESS, CITY, STATE, ZIP CODE 25 25TH STREET SE ASHINGTON, DC 20020		, e
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From pa	ge 4 e created a new sheet when	. F	281			
	[he/she] identified to	hat "lot numbers were different name the sheet [original], I	:				
	December 2016 GI that differed from the State Agency Repr 2016. There was no corrections or ame	nittedly) rewrote/recreated a new ucometer Quality Control Log ne original log(s) presented to the esentative on December 15, o evidence that he/she made andments to the Quality Control with accepted standards of	***************************************		483.70(c)(2) Essential Equipmen Operating Condition	t, Safe	
•	effects to residents	ras no evidence of untoward who received insulin coverage gement. The records were er 16, 2016.			The nurses involved were subject to disciplinary action per the perso policies of the facility.     All of the remaining 13 Glucom	nnel	12/28/16
	M.J., Spruce, L., S	B., Denholm, B., Link, T., Ogg, pry, C., Van Wicklin, S. and he guidelines for preoperative enver, CO: AORN.	i		Logs were reviewed immediately and no other out of range results or evidence of any kind of altering was found.  3. All licensed nursing staff were inserviced on the Glucometer Quality	and no nce of y	12/16/16
{F 456} SS=D	483.70(c)(2) ESSE OPERATING CON	NTIAL EQUIPMENT, SAFE	{F	456}	Control policy, a review of the Glucor User Manual, a review of the Glucor Quality Control Log which included documentation, out-of-range variance	meter	
The facility must maintain all essential mechani electrical, and patient care equipment in safe operating condition.		ent care equipment in safe			correction of erroneous entries, and demonstration and competency. The Clinical Managers will review the Glucometer Logs on a weekly basis a	a nd the	
	This REQUIREME	NT is not met as evidenced by:			DON/designee will review all the logs monthly basis to ensure compliance.  4. The DON will present the Gluco	meter	12/28/16
	of the facility 's me	ation, staff interview and a review edical device (Glucometer) log ermined that facility staff failed to nality of			Logs to the Safety Committee each for their review. Such a review has a added as a permanent agenda item Safety Committee where all Departi Heads and the Administrator sit as	been for the ment	12/28/16

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION  NG	<u></u>	(X3) DATE SURVEY COMPLETED		
		095022	B. WING			112	2/16/2016	
	ROVIDER OR SUPPLIER	CAPITOL CITY		STREET ADDRESS, CI 2425 25TH STREET WASHINGTON, D	SE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG	X (EACH CO	DER'S PLAN OF CORRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 456}	one (1) of twelve ( units Team I & Tea act when a quality	age 5 12) glucometers [two meters/6 am II] as evidenced by failing to control check value was less ed parameters on two (2)	{F 4	! !56}				
	The findings includ	de:		4				
	Control last updat	d Glucose Monitors- Quality ed November 2001 stipulated, " ntrol testing will be performed on the facility, daily.						
	the quality control the calibration (ba requires it 's use, test strip bottle. test must enter re identifying informa Record for the Glarequires a separa include: c. name of mistrument serial glucose tips, lot# 12. Enter the date appropriate column daily on each unit will on each u	e 11-7 nurse will be responsible for testing of monitors. 5. Make sure in code) strip, if the monitor matches the code number on the 10. The person who performs the sults on the record. Enter all ation on the Quality Control ucose meter. Each monitor the record. 11. Information must of person submitting results all number, and manufacturer of [number] and expiration date and the control results in the nn. Two level of controls must be glucose meter. The 11-7 nurse documents on the control record, the actual numerical values of the time a results falls outside the (below the minimum or above the appropriate correction action must be unmented in the appropriate column. 18. Corrective action should be						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDIN		R
		095022	B. WING _		12/16/2016
NAME OF PE	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				2425 25TH STREET SE	
TRANSITIONS HEALTHCARE CAPITOL CITY			WASHINGTON, DC 20020	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 456}	Continued From pag	ge 6	{F 45	56}	
	control solution and	or test strips as needed,			
	recalibrate the mete	r and retest. Document all step		:	
	taken and the result	s in the appropriate column.			;
	The nurse must not	fy administration if the monitor			
	cannot be calibrated	d WNL (within normal limits). "		i	
				i i	
	Glucometer - a med approximate concer	lical device for determining the ntration of glucose in the blood.	:   	: •	
	Dumage of the Clise	cometer Quality Control check is		1	
	to verify the quality	of the meter and test strips to			
	determine if they are				:
	determine in they are	o nonning property.	:		
	[used to test the 'qu comes in a small via of glucose. The gluc	lution [low and high] is a liquid ality' of the Glucometer] that al and contains a known amount cose solution is used in place			
	meter [Glucometer] the vial of test strips	of blood and the results on the should match a range listed on a used with the meter. If the	:	1	:
	vial, this indicates a the test strips"	he range listed on the test strip problem with either the meter or			!
	http://www.mayoclir	nic.org/diseases-conditions/diabe	:		:
	tes/expert-blog/bloc 0094453	od-glucose-control-solution/bgp-2		1	
	0094455				!
					!
	A review of the faci	ity 's December 2016	:		
	devices revealed th	Control Log for Glucometer at facility staff determined that test value for one (1) device felled parameters	!		
	201011 PIO OCIGIONO	·= 1- ···· ·			
	i : :		I		
	On December 14, 2	2016 [night shift, no time	İ		
					•

Facility ID: WASHNURS

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DATE SURVEY COMPLETED			
		095022	B. WING_		·	12/16/2016			
	ROVIDER OR SUPPLIER	CAPITOL CITY		2425 2	T ADDRESS, CITY, STATE, ZIP CODE 25TH STREET SE HINGTON, DC 20020				
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{F 456}	Continued From pa	ge 7	{F 4	56}					
	established by man functions accurately	gh control level " [Range lufacturer; when the device y, the " high " results should fall as recorded as 172 mg/dl				:			
	[milligrams per decindicative that the dintended was 184-2	iliter]. The pre-established range levice was functioning as 248 mg/dl. There was no y staff implemented measures to							
	ensure the Glucom when it was determ	eter was functioning properly nined the high control level was f the pre-determined range.		:					
	indicated] the "high as 176 mg/dl. The that the device was	2016 [night shift, no time gh control level " was recorded pre-established range indicative s functioning as intended was				!			
	184-248 mg/dl. No reading was out of	o action was taken when the range.		i		:			
	values were out of troubleshooting"	ence that when the quality control range, facility staff implemented measures to verify the accuracy the glucometer devices.	:	;					
	Employees #1, 2, 3 approximately 2:30 aforementioned glu	rview was conducted with 3 and 4 December 16, 2016 at 3 PM, regarding the acometer log concerns. It was							
	measures to recalil stipulated in the fac	staff should have taken brate the device and retest as cility policy/protocol. The wed on December 16, 2016.							
				:					
				:					

Event ID: 3QFH12

Health Re	egulation & Licensing	<u>Administration</u>				·	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATIO			PLE CONSTRUCTION G:	(X3) DATE S COMI	URVEY PLETED
						,   F	<u> </u>
		HFD02-0020	)	B. WING			6/2016
NAME OF DE	ROVIDER OR SUPPLIER	l l	STREET ADD	RESS, CITY.	STATE, ZIP CODE		
				STREET			ļ
TRANSIT	ONS HEALTHCARE C	CAPITOL CITY	WASHING	TON, DC			The state of the s
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENC BE PRECEDED BY FUL NTIFYING INFORMATION	L REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
{L 000}	Initial Comments	And the state of t		{L 000}			:
(- 339)	A follow up to the ar October 25, 2016) v and 16, 2016. The f on observations, rec for 30 sampled resid	vas conducted on ollowing deficienc cord reviews and s	December 15 ies are based		Transitions Healthcare Capitol City this Plan of Correction in accordance State and Federal requirements. Submission of this Plan of Correction an admission of any of the deficient identified are correct. This Plan of Correction is to serve as the facility credible allegation of compliance with the requirements of the Medicare/Medicar	ce with on is not cies 's ith all	
	The following is a d acronyms that may	irectory of abbrevi be utilized in the r	ations and/or eport:		Programs		
·	g-tube- Gastro EKG - 12 lea NP - Nurs BID - Twice	Mental Status estomy tube d Electrocardiogra e Practitioner - a-day cy medical service					
	Neuro - Neurol B/P - Blood	y ventilation/Air co ogical d Pressure munity Residentia	·				:
	CNA- Certified DMH - Depart Peg tube - Percutar	Nurse Aide ment of Mental He neous Endoscopic	ealth	:			:
	L - Liter DI - deciliter CMS - Center	se Practitioner s for Medicare and	d Medicaid	The second secon			!
	MAR - Medica MD- Medi	ds (unit of mass) ation Administratio cal Doctor	n Record				:
	Mg - milligr mass)	ım Data Set rams (metric syste iters (metric syste			•		
	volume)	, ,					:
Health Regul	 ation & Licensing Adminis DIRECTOR'S OR PROVIDE	tration	TATHVE'S STGNATUR	RE	A TITLE . /		(X6) DATE

STATE FORM

Health Re	egulation & Licensing	Administration			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		TE SURVEY COMPLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		701111 22125
					R
		HFD02-0020	B. WING		2/16/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE, ZIP CODE	
		2425 25T	H STREET SE	<u>:</u>	
TRANSITI	ONS HEALTHCARE C	WASHIN	GTON, DC 2	0020	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{L 000}	Continued From pag	ge 1	{L 000}		
	mm/Hg - millimeter POS - physic Prn - As no Pt- Pa TAR - Treatm PASRR - Preadmin Review ARD - assessr IDT - interdis ID - Interdis D.C District D/C- discontinue Rp, R/P- responsibl PO-By Mouth	cian 's order sheet eeded tient lent Administration Record ssion screen and Resident ment reference date sciplinary team ectual disability / Indicator Survey of Columbia e party		3200.1 Nursing Facilities  1. The nurses involved were subjected to disciplinary action per the personnel	12/28/16
L 001	3200.1 Nursing Fac Each nursing facility these rules and the	ilities  shall comply with the Act, requirements of 42 CFR Part	L 001	policies of the facility.  2. All of the remaining 13 Glucometer Logs were reviewed immediately and nother out of range results or evidence of	
	483, Subpart B, Sec D, Sections 483.150 section 483.200 to constitute licensing the District of Colum	ctions 483.1 to 483.75; Subpart 0 to 483.158; and Subpart E, 483.206, all of which shall standards for nursing facilities i		any kind of altering was found. 3. All licensed nursing staff were inserviced on the Glucometer Quality Control policy, a review of the Glucometer User Manual, a review of the Glucometer Quality Control Log which included	12/16/16
	of the facility 's med sheets, it was deter meet professional s by the documentation of quality control a numbers for one (1)	on, staff interview and a review dical device (Glucometer) log mined that facility staff failed to tandards of quality as evidence on of a false [inaccurate] accoussessment results and lot Glucometer device. 42 CFR 3, Sections 483.20(k)(3) F281.	d nt	documentation, out-of-range variances, correction of erroneous entries, and a demonstration and competency. The Clinical Managers will review the Glucometer Logs on a weekly basis and the DON/designee will review all the logs on a monthly basis to ensure compliance.  4. The DON will present the Glucometer Logs to the Safety Committee each mont for their review. Such a review has been added as a permanent agenda item for the Safety Committee where all Department Heads and the Administrator sit as members.	12/28/16  n

Health Regula	ation & Licensing	Administration						
STATEMENT OF D AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIFICATION I		(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0020		B. WING			R 16/2016	
NAME OF PROVID	ER OR SUPPLIER		STREET ADDI	RESS, CITY, STATE	E, ZIP CODE			
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11041101110110			WASHING	TON, DC 2002				
(X4) ID PREFIX : (EA TAG	CH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	ES REGULATORY	: ID PREFIX TAG .	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
L 001 Cor	ntinued From pag	je 2		L 001				
pap sind not " er the org cor ava sig cor adj info 499 Glu app to v det "Gl tha am pla me strithe pro htt tes 00 A i Glu	per records should gle line through the to obliterate the tror", "mistake incorrect text as anizational policy rection above the ailable or adding the rect information in acent to the ackromation" (Burlia-5-500).  Incometer - a medion of the concern to the Glucometer of the Glucometer of the Glucometer of a drop of the comes in a small come of a drop of the comes in a small come of a drop of the comes in a small come of a drop of the comes in a small come of a drop of the comes in a small come of a drop of the comes in a small come of a drop of the comes in a small come of the come of the come of the come of the come of the come of the come of the come of the come of the come of the come of the facility of th	adments and addend be performed by periodic information of the entry of the entry; and enterior in the next available and device for detentration of glucose in the meter and test working properly. In the meter and test working properly. In the meter and test working properly. In the meter and test working properly. In the meter and test working properly. In the meter and the meter. If the result is a range listed on the meter. If the result is a range listed on the test strip vial, the meter or the test incorg/diseases-conded-glucose-control-strip in the meter of the test in the meter of t	placing a peing careful ion; writing it " next to ponal for the room is the document; ng the expace or te is, pp.  I mining the name the blood.  I is a liquid a known on is used in son the he vial of test it is outside of is indicates a set strips" nditions/diabe solution/bgp-2016 evealed the					

Health Re	<u>egulation &amp; Licensing</u>	Administration				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0020	B. WING		R 12/16/2016	
NAME OF PE	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	ATE, ZIP CODE		
		2425	25TH STREET SE			
TRANSIT	IONS HEALTHCARE C	CAPITOL CITY WAS	HINGTON, DC 2	0020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATOR NTIFYING INFORMATION)	Y ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
L 001	Continued From pag	ge 3	L 001			
	[Range established device functions acc should fall within this mg/dl [milligrams perange [indicative that intended] was 184-2 evidence that facility ensure the Glucome when it was determidentified outside of The December 15, 2 indicated] the QC as was recorded as 17 range 184-248 mg/d the reading was out There was no evide values were out of restriction to the glucometer deconducted. Discrep the Glucometer log survey team on December 2016 conducted. Discrep the Glucometer log survey team on December 2016.	ence that when the quality co range, facility staff implemen neasures to verify the accura	es to  as  es to  as  as  and  and  and  and  and  and			
	as an active record regarding the discreding the di	<ul> <li>In response to a query epancy, Employee # 2 stated Control Log was likely alter- view was conducted with</li> </ul>	d, the ed.		: : : :	
	2016 at approximat	sed nurse] on December 16 ely 1:00 PM. Employee#4 e created a new sheet wher			:	

Health Re	egulation & Licensing	Administration	T			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	***************************************	(X3) DATÉ SURVEY COMPLETED	
AND PLAN O	FURRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
					R	
		HFD02-0020	B. WING		12/16/2016	
NAME OF DE	OVER OR SHOPLED	STREET AN	DRESS, CITY, ST	ATE ZIP CODE		
NAME OF PR	OVIDER OR SUPPLIER		STREET SE			
TRANSITI	ONS HEALTHCARE C	ADITAL ATV	STON, DC 2		AND THE RESIDENCE OF THE PROPERTY OF THE PROPE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
L 001	Continued From pag	ge 4	L 001			
	[he/she] identified th whatever I saw on transferred to the ne	nat " lot numbers were different i the sheet [original], I ew sheet "				
	December 2016 Gluthat differed from the State Agency Repre 2016. There was no corrections or amen	ittedly) rewrote/recreated a new acometer Quality Control Log e original log(s) presented to the esentative on December 15, a evidence that he/she made adments to the Quality Control with accepted standards of			:	
:	effects to residents	as no evidence of untoward who received insulin coverage gement. The records were r 16, 2016.		3258.13 Nursing Facilities  1. The nurses involved were subjected to disciplinary action per the perso		
:	M.J., Spruce, L., Sp	B., Denholm, B., Link, T., Ogg, ory, C., Van Wicklin, S. and he guidelines for preoperative enver, CO: AORN.		policies of the facility.  2. All of the remaining 13 Glucom Logs were reviewed immediately a other out of range results or evider any kind of altering was found.  3. All licensed nursing staff were	neter :	
{L 442}	3258.13 Nursing Fa	acilities	{L 442}	inserviced on the Glucometer Qualit Control policy, a review of the Gluco User Manual, a review of the Glucor	meter	
	electrical, and patie operating condition. This Statute is not Based on observati of the facility 's mesheets, it was deter ensure the function glucometers [two mas evidenced by fai	met as evidenced by: on, staff interview and a review dical device (Glucometer) log mined that facility staff failed to ality of one (1) of twelve (12) neters/6 units Team I & Team II] ling to act when a quality control ss than pre-determined	Automotive and the community of the comm	Quality Control Log which included documentation, out-of-range variance correction of erroneous entries, and demonstration and competency. The Clinical Managers will review the Glucometer Logs on a weekly basis at DON/designee will review all the logs monthly basis to ensure compliance.  4. The DON will present the Gluco Logs to the Safety Committee each for their review. Such a review has added as a permanent agenda item	nd the on a 12/28/16 meter month been for the	
	parameters on two	(z) occasions.		Safety Committee where all Departr	ment 12/28/16	

Health R	equiation & Licensino	Administration				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0020	B. WING		R 12/16/2016	
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STAT	E, ZIP CODE		
		2425	5 25TH STREET SE			
TRANSIT	IONS HEALTHCARE C	CAPITOL CITY WAS	SHINGTON, DC 200	20		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATO NTIFYING INFORMATION)	ID DRY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
{L 442}	Continued From pag	ge 5	{L 442}			
	The findings include	2;				
	Control last updated Policy: Quality control all glucometers in the Procedure: 1. The 1 the quality control to	1-7 nurse will be responsibesting of monitors. 5. Make	l on			
	requires it 's use, m test strip bottle. 1 test must enter resu identifying informati	code) strip, if the monitor natches the code number or 0. The person who perform ilts on the record. Enter al on on the Quality Control	s the:		:	
	Record for the Gluc requires a separate include: c. name of instrument serial r glucose tips, lot# [n	ose meter. Each monitor record. 11. Information m person submitting results number, and manufacturer umber] and expiration date	of :			
	appropriate column run daily on each gl on each unit will do 13. Always enter the	and the control results in the . Two level of controls must lucose meter. The 11-7 nu cuments on the control reco e actual numerical values o	t be irse ord. If the			
	acceptable limits (b maximum range) ar be taken and docur	me a results falls outside the elow the minimum or above oppopriate correction action mented in the appropriate course corrective action should be appropriate or the corrective action should be action should be action.	e the       must   olumn	·	:	
	taken: replace contineeded, recalibrate Document all step t appropriate column	18.Corrective action shoul rol solution and/or test strip the meter and retest. taken and the results in the . The nurse must notify a monitor cannot be calibrat I limits).	s as			

Health R	<u>legulation &amp; Licensing</u>	<u>Administration</u>		·		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
		IN NUMBER:	A. BUILDING: _	OOMFEETED		
						R
		HFD02-0020	1	B. WING		12/16/2016
		NLD02-0020	,			12.3 10/2.010
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
			2425 25Th	STREET SE		
TRANSIT	TONS HEALTHCARE C	CAPITOL CITY		TON, DC 20	020	
	1	****			PROVIDER'S PLAN OF CORRECTION	/۷6\
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	'ATEMENT OF DEFICIEN' TBE PRECEDED BY FUL ENTIFYING INFORMATIO	L REGULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{L 442}	Continued From page	ge 6		{L 442}		
				: ;		
	Glucometer - a med approximate concer	lical device for det ntration of glucose	termining the in the blood.	:		
	D		antral aboak is			
	Purpose of the Glucometer Quality Control check is to verify the quality of the meter and test strips to determine if they are working properly.		est strips to			
	determine it triey ar	e working property	,	1		
	"Glucose control so	lution (low and hig	jh] is a liquid	:		
	[used to test the 'quality' of the Glucometer] that comes in a small vial and contains a known amount of glucose. The glucose solution is used in place [instead] of a drop of blood and the results on the					
				!		
	meter [Glucometer]	should match a ra	ange listed on			
	the vial of test strips	s used with the me	eter. If the			
	result is outside of t	he range listed on	the test strip	:		
	vial, this indicates a	problem with eith	er the meter or	٠.		
	the test strips"		111	;		. :
	http://www.mayoclir	nic.org/diseases-c	onditions/diabe			
	tes/expert-blog/bloc	od-glucose-control	-solution/bgp-2	. \$		
	0094453					
				!		 
	A review of the faci	lity 's December 2	2016			! ! :
	Glucometer Quality	Control Log for G	lucometer	\$		
	devices revealed th	at facility staff det	ermined that	-		
	the Quality Control	test value for one	(1) device fell			
	below pre-establish	ned parameters.				
	0.5	2040 Imimbt abift a	a tima			
	On December 14, 2 indicated] the "high	zo to [night Shift, H	(Pange	•		
	established by man	yn control ievel Jufacturer: when th	r ango re device			· •
	functions accurately	v. the " high " rest	ilts should fall			!
	within this range] w	as recorded as 17	'2 mg/dl			
	[milligrams per dec	iliter]. The pre-est	ablished range			
	indicative that the c	levice was functio	ning as			
	intended was 184-2	248 mg/dl. There	was no			
				į	: 	
	•			}		

Health Regulation & Licensin	q Administration			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(3) DATE SURVEY COMPLETED	
THE PERMIT CONTINUES NO.		A. BUILDING:		_
	LIETAG DODO	B. WING		R
	HFD02-0020			12/16/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE,	ZIP CODE	
TRANSITIONS HEALTHCARE	CAPITOL CITY	H STREET SE		
	WASHING	TON, DC 2002		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
{L 442} Continued From pa	ige 7	{L 442}		
evidence that facilit	y staff implemented measures to	. :		
ensure the Glucom	eter was functioning properly	 		
	nined the high control level was			·
identified outside of	f the pre-determined range.	-		
On December 15, 2	2016 [night shift, no time			
indicated] the " hi	gh control level " was recorded	:		
	pre-established range indicative sfunctioning as intended was			:
	o action was taken when the			
reading was out of				
. There was no ovide	anno that when the quality contro	1		
values were out of	ence that when the quality contro range, facility staff implemented	1		:
" troubleshooting" r	measures to verify the accuracy	1		į
and functionality of	the glucometer devices.	:		
A face-to-face inter	view was conducted with			
	3 and 4 December 16, 2016 at			!
approximately 2:30	PM, regarding the			
aforementioned glu	ucometer log concerns. It was staff should have taken			
measures to recali	brate the device and retest as			
stipulated in the fac	cility policy/protocol. The			i
records were revie	wed on December 16, 2016.			
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