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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

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F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at Transitions Healthcare Capitol City from January 25, 2018 through February 2, 2018. Survey activities consisted of a review of 70 sampled residents. The following deficiencies are based on observation, record review and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CPR- Cardiopulmonary Resuscitation CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center	F 000	Transitional Healthcare Capitol City is filing this Plan of Correction in accordance with State and Federal requirements. Submission of this Plan of Correction is not an admission of any of the deficiencies identified are correct. This Plan of Correction is to serve as the facility's credible allegation of compliance with all the requirements of the Medicare/Medicaid programs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3/9/18

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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F 000	Continued From page 1 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would	F558	Reasonable Accommodations Needs/ Preferences CFR(s): 483.10(e)(3) 1. Resident #12 1. The call light was re-positioned upon discovery. 2. All other call lights were reviewed and Corrections made whenever necessary. 3. Nursing staff were inserviced on the need to have the call light always visible and within reach. The Nursing Quality Improvement Team will monitor call light	1/29/18 1/29/18 3/10/18

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F 558	Continued From page 2 endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews of two (2) of 70 sampled residents, the facility staff failed to ensure that one (1) resident's call system was connected, functioning, and within reach, and failed to respond to one (1) resident's call light to provide him with necessary assistance. Residents' #12 and #193. Findings included... 1. Facility staff failed to ensure that Resident #12's call system was connected, functioning and within reach. On January 29, 2018, at approximately 2:00 PM during a face-to-face interview with Resident #12, the call bell was not visible or within reach. When Employee #8 was asked about the location of the resident's call light, she looked around the room and found the call light behind the privacy curtains in the roommate's area. The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, showed the following: Under Section I-Active Diagnoses included Heart Failure, Hypertension, Pneumonia, Diabetes Mellitus, Hyperlipidemia, Depression, and Asthma. Under Section G, Functional Status - the resident		F558 Continued Improvement Team will monitor call light placement, visibility and response time on a monthly basis and report their findings to the Director of Nurses. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator. 2. Resident #193 1. The resident was assisted immediately upon discovery. 2. There were no other issues with call light response time noted. 3. Nursing staff will be inserviced regarding quick response to call lights from residents. The Nursing Quality Improvement Improvement Team will monitor call light placement, visibility and response time on a monthly basis and report their findings to the Director of Nurses. 4. The Director of Nurses will present his findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	3/16/18 1/29/18 1/29/18 3/10/18 3/16/18

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F 558	Continued From page 3 required extensive assistance with bed mobility, transfer, and was totally dependent on staff for toilet use. During a face-to-face interview with Employee #8 on January 29, 2018, at approximately 2:10 PM, she acknowledged the findings. 2. Facility staff failed to respond to Resident #193's call light to provide assistance. On January 26, 2018, at 1:45 PM, Resident #193 was observed lying in the bed watching television and pressing the call light. Someone answered the call light from the nursing station.The resident stated, "I need help to use the bathroom." The Staff, at the nursing station, replied, "I will let your nurse know." It was 30 minutes later as the surveyor was leaving the resident's room the Certified Nurse Aide (CNA) came to assist the resident. The CNA stated to the resident, "I am sorry, I was with another resident." The resident's Quarterly Minimum Data Set (MDS) dated October 11, 2017, revealed the following: Under Section I - Active Diagnoses included Hypertension, Diabetes Mellitus, Seizure Disorder, Anxiety Disorder, and Depression. Under Section G, Functional Status - the resident required extensive assistance with bed mobility, transfer, and was totally dependent on staff for toilet use. During a face-to-face interview conducted on	F 558		

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F 558	Continued From page 4 January 26, 2018, at 2:00 PM with Employee #6, he acknowledged the findings.			
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview for three (3) of 70 sampled residents, the facility failed to post the State Survey Agency and other advocacy groups [State Ombudsman, Adult Protective Services and Medicaid Fraud Control Unit] contact information in a format and height that is accessible and understandable to residents in wheelchairs. Residents' #58, #71 and	F 575	Required Postings CFR(s): 483.10(g)(5)(i)(ii) 1. The 3 postings noted to be at an improper height were lowered upon discovery. 2. The remaining 4 postings were at an acceptable height. 3. Maintenance will ensure that the postings remain at an acceptable height and report any discrepancies to the Director of Facilities immediately upon discovery. 4. The Director of Facilities will report any findings to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	1/30/18 1/30/18 3/10/18 3/16/18

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F 575	Continued From page 5 #196. Findings included... On January 30, 2018, at approximately 2:30 PM, a Resident Council Meeting was held in the presence of surveyors. One of the concerns expressed during the meeting by Residents #58, #71 and #196 was the state agency's contact information is posted at a height and location that is not accessible and readable for residents in wheelchairs to see and read. Resident #196 stated, "Some residents know where the postings are but the prints are so small, you could barely read it. Residents in wheelchairs cannot even make out what it says." A facility tour on January 31, 2018, at approximately 11:30AM showed that (3) three out of six (6) nurse's stations on 1S (South), 2N (North) and 3S (South) posted the State Agency and advocacy groups contact information by the unit elevators on the far right top section of the wall adjacent to the announcement poster board. The posting is not easily accessible and readable to residents in wheelchairs. Employee #2 acknowledged the findings during a face-to-face interview on January 31, 2018, at approximately 5:00 PM.	F 575		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and	F 576	Right to Forms of Communication w/Privacy CFR(s): 483.10(g)(6)-(9) 1. The facility has never received mail delivery on Saturday. Employee #26 is new to the facility and unfortunately did not give the survey team the correct answer. Mail is delivered Monday – Friday to the facility and subsequently delivered to the residents promptly upon receipt by the Activities Department.	1/31/18

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F 576	Continued From page 6 use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on residents and staff interviews for two (2) of 70 sampled residents, the facility staff failed ensure that residents received mail delivery on Saturdays. Residents' #32 and 163.	F 576	Right to Forms of Communication w/Privacy CFR(s): 483.10(g)(6)-(9) – continued 2. There were no other issues with mail delivery. 1/31/18 3. The employees of the Activities Department were inserviced regarding their role in and the timeliness of mail delivery to the residents. 3/16/18 The Activities Director will monitor the mail delivery to the residents routinely to ensure compliance. 3/16/18 4. The Director of Activities will report any findings of her monitoring to the Quality Assurance/Quality Improvement Committee which meets monthly and is chaired by the Administrator. 3/16/18	

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F 576	Continued From page 7 Findings included... During the Resident Council Meeting held on January 30, 2018, at approximately 3:00 PM, Residents' #32 and 163 stated, "They [facility staff] do not deliver our mail on Saturdays." During a face-to-face interview with Employee #25, Activities Specialist, on January 31, 2018, at 10:45 AM, she was asked to explain the process of mail delivery. Employee #25 stated, "We deliver mail daily except during the weekend because Business Office is not here to sort out the mail. At times, mail doesn't get delivered to us [by the U.S. Postal Service] until 5:30 PM so we have to wait the next day to deliver the mail." During a face-to-face interview on January 31, 2018, with Employee #26, Activities Director, at 11:15 AM, Employee #26 stated, "There is no mail on Saturdays. We wait until Monday to deliver the mail received on Fridays." Employees' #25 and #26 acknowledged the findings at the time of the interview.	F 576		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578	Request/Refuse/Dscntnue Trmnt; Formite Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) 1.-3. Residents #131, #180, #273 1. Residents cited at the time of the survey regarding their right to execute an Advanced Directive either at the time of admission or at the first Care Plan Meeting were reviewed immediately by the Social Work staff and corrections made and	3/8/18

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F 578	Continued From page 8 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for three (3) of 70 sampled residents, facility staff failed to inform the resident or their representative of their right to establish an advance directive on admission and at the first care plan meeting for	F 578	Request/Refuse/Dscntnue Trmnt; Formite Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) Continued 1. (continued) documented. 2. An audit was conducted on all residents to ensure compliance with their right to be informed of and to formulate an Advanced Directive. 3. Social Work staff was inserviced on the residents' right to formulate an Advanced Directive. The Social Work Quality Improvement Team will audit on a monthly basis to ensure on-going compliance. The results of their audits will be given to the Director of Social Work for his analysis. 4. The Director of Social Work will present these audit findings and any action plans for improvement to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	3/9/18 3/16/18 3/16/18

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one (1) resident and failed to initiate an advance directive for two (2) residents on Admission. Residents' #131, 180, and 273.

Finding included ...

"Title CLIN-130 Advanced Directive and Advanced Care Planning (end of life), revision date 6/5/17 - Policy and intent of the Facility to inquire, obtain, or provide, the completion of advanced directives for the purpose of prospectively identifying a healthcare decision maker, clarifying treatment preferences and developing individualized goals of care near the end of life.

Procedure: The facility will periodically assess the resident for decision-making capacity and invoke the Resident Representative if the resident is determined not to have decision-making capacity; ...Identify, clarify, and periodically review, as a part of the comprehensive care planning process, the existing plan of care instructions and whether the resident wishes to change or continue these instructions; Review the resident's condition and existing choices and continue or modify approaches, as appropriate."

1. Facility staff failed to inform the resident and or their representative of their right to establish an advance directive on admission and at the first care plan meeting for Resident #131.

Resident #131 was admitted to the facility on May

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F 578	Continued From page 10 30, 2017, with diagnoses of Dementia, Congestive Heart Failure, Cerebral Vascular Accident/Stroke, Diabetes, Hypertension, Chronic Kidney Disease. A review of the Physician's order with at date of October 5, 2017, stipulated, "CPR [Cardiopulmonary Resuscitation] (Full Code)". A review of the resident's clinical record lacked evidence that an advance directive form was completed to support the facility discussed and established an advance directive. Review of the Minimum Data Set revealed that assessments were conducted on June 6, 2017 (Admission MDS), August 15, 2017 (quarterly MDS) and November 14, 2017 (quarterly MDS). Further review of the clinical record reflects that on admission and at the first quarterly MDS review, the resident's advance directive status was not addressed as part of the comprehensive care planning process. There was no evidence that facility staff informed the resident or their representative of their right to establish and advance directive. During a face-to-face interview on January 29, 2018, at 11:05 AM Employee # 21 acknowledged the findings. 2. Facility staff failed to inform the resident and or their representative of their right to establish an advance directive on admission [August 24, 2007] for Resident # 180.	F 578		

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F 578	Continued From page 11 On January 26, 2018, a review of Resident #180's medical admission record showed the following diagnoses: Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation, Hyperlipidemia, and Hypokalemia. A further review of the medical record showed an Interdisciplinary Care Conference Form with a date of December 5, 2017. The medical record lacked evidence of an Interdisciplinary Team Care Conference note (meeting was confirmed by Employee # 7 and Employee#31) and any evidence that written information was provided to Resident#180, Responsible Party (RP) concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. During a face-to-face interview with Employee #31 on January 26, 2018, at approximately 11:30 AM, the Employee stated, "No, I don't see the advance directive on the chart." There was no evidence that facility staff informed the resident and or their representative of their right to establish an advance directive. Employee #31 acknowledged the findings at the time of the observation. 3. Facility staff failed to inform the resident and or their representative of their right to establish an advance directive on admission [May 12, 2016] for Resident # 273.	F 578		

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F 578	Continued From page 12 On January 26, 2018, a review of Resident # 273's, medical admission record showed diagnoses that included Multiple sclerosis, Constipation, Insomnia, and hypertension. On January 26, 2018 a review of the medial record lacked evidence of an advance directive form. A further review of the medical record showed an Interdisciplinary Care Conference form with dates of October 3, 2017 and January 2, 2018. The medical record lacked evidence of an Interdisciplinary Team Conference note for October 3, 2017, and January 2, 2018 (meeting confirmed by Employee# 7 and Employee# 31) and any evidence that written information was provided to Resident# 273, Responsible Party (RP) concerning the right to accept or refuse medical or surgical treatment and the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. During a face-to-face interview with Employee #31 on January 26, 2018, at approximately 11:45 AM, he #31, stated, "The sister is the responsible party, I don't see an advance directive on the chart but I just started six months ago." There was no evidence that facility staff informed the resident and or their representative of their right to establish and advance directive. Employee# 31 acknowledged the findings at the time of the observation.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 1. Water Temperatures	

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	095022	A. BUILDING _____ B. WING _____	02/02/2018

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F 584	Continued From page 13 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. -- continued 1. Water Temperatures A-F 1. Maintenance staff returned to the areas cited as having temperatures out of range and allowed the water to run for however long it took for the temperature to read between 95-110 degrees. All areas were found in compliance.	2/1/18
			2. Temperatures throughout the facility were checked and recorded to ensure the range of 95-110 degrees reached every resident room.	2/1/18
			3. The facility's long standing vendor, Capitol Boilers, installed a new digital mixing valve which allows for more consistent temperatures to reach the resident rooms in a quicker period of time. The Maintenance staff was inserviced on domestic hot water temperatures and continue to monitor them in resident rooms every day. Results of their monitoring efforts are brought to the Director of Facilities for his review.	3/7/18
			4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	3/16/18
			2. Exhaust Vents 1. Exhaust fans cited at the time of the survey as soiled with dust were cleaned immediately upon discovery.	1/31/18
			2. All exhaust fans throughout the facility were inspected to ensure their cleanliness. Corrections were made whenever necessary.	2/6/18

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F 584	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on January 31, 2018, between 11:45 AM and 4:00 PM and on February 1, 2018, between 9:20 AM and 11:30 AM, the facility failed to maintain a sanitary, orderly and comfortable interior as evidenced by water temperatures tested consistently below 95 degrees Fahrenheit in six (6) of six (6) resident care units; exhaust vents soiled with dust in ten (10) of 53 resident rooms; shower room floors soiled in two (2) of six (6) resident shower rooms; the floors in resident restrooms located in the hallways of the C-wing, the G-wing and the A-wing soiled; walls in eight (8) of 53 resident rooms marred; marred doors in four (4) of 53 resident rooms; one (1) of one (1) Geri-chair with torn armrests; and two (2) of two (2) resident chairs soiled with numerous stains. Findings included... 1. Water temperatures tested consistently below 95 degrees Fahrenheit in six (6) of six (6) resident care units as follows: A. In the shower room on 3 South, on January 31, 2018, water was turned on at 12:36 PM and tested at 71.1 degrees Fahrenheit. Six (6) minutes later at 12:42 PM, the water temperature from one (1) of two (2) showerheads was 71.7 degrees Fahrenheit. B. In the shower room on 3 North, on January 31, 2018, water was turned on at 1:04 PM and tested at 88.9 degrees Fahrenheit. Seven (7) minutes	F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. – continued 3. Housekeeping staff were inserviced on the proper cleaning of exhaust vents. The Environmental Services Quality Improvement Team will monitor for cleanliness of the exhaust vents on a monthly basis and forward the results of their monitoring efforts to the Director of Facilities for his analysis. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator. 3-4. Shower Room and Resident Rest Room Floors 1. Floors found to be soiled at the time of the survey were corrected immediately upon discovery. 2. All shower room floors and resident restroom floors were inspected for cleanliness. Corrections were made whenever floor care was needed. 3. Housekeeping staff were inserviced on the proper floor care.. The Environmental Services Quality Improvement Team will monitor for cleanliness of the floors on a monthly basis and forward the results of their monitoring efforts to the Director of Facilities for his analysis. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	3/16/18 3/16/18 1/31/18 2/1/18 3/16/18 3/16/18

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F 584	Continued From page 15 later at 1:11 PM, the water temperature from one (1) of two (2) showerheads was 95.0 degrees Fahrenheit. C. In the shower room on 2 South, on February 1, 2018, four (4) separate water outlets were opened at 10:08 AM and water from one (1) of two (2) shower heads tested at 71.2 degrees Fahrenheit. Six (6) minutes later at 10:14 AM, the water temperature was 86.0 degrees Fahrenheit. D. In the tub room on 2 North, on February 1, 2018, water was turned on at 10:27 AM and tested at 10:31 AM. The temperature from one (1) of two (2) showerheads was 51.2 degrees Fahrenheit. E. In the shower room on 1 North, on February 1, 2018, four (4) separate water outlets were already open at 11:05 AM and water from one (1) of two (2) shower heads tested at 80.7 degrees Fahrenheit. Five (5) minutes later at 11:10 AM, the water temperature from one (1) of two (2) showerheads was 91.8 degrees Fahrenheit. F. In the tub room on 1 South, on February 1, 2018, water was turned on at 11:20 AM and tested at 11:22 AM. The temperature from one (1) of two (2) showerheads was 79.7 degrees Fahrenheit. 2. Exhaust vents soiled with dust in ten (10) of 53 resident rooms (Rooms #156, 158, 231, 305, 310, 323, 325, 331, 335, and 359). 3. Shower room floors soiled throughout on 3 South and 3 North, two (2) of six (6) resident shower rooms.	F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. – continued 5.- 6. Walls and Doors 1. Walls and doors noted to be marred at the time of the survey were evaluated and repaired.	2/16/18
			2. Walls and doors throughout the facility were assessed and scheduled for repair or repaired immediately to eliminate mars.	2/18/18
			3. Maintenance staff were inserviced on the proper wall and door care. The Environmental Services Quality Improvement Team will monitor for presentation of the walls and doors on a monthly basis and forward the results of their monitoring efforts to the Director of Facilities for his analysis.	3/16/18
			4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	3/16/18
			7.- 8. Geri-Chair, Lounge and Sofa Chairs 1. Chairs noted to have needed repairs or cleaning were addressed immediately at the time of discovery.	1/31/18
			2. All Geri-chairs, lounge chairs and sofa chairs were checked for needed repairs and/or cleaning and corrective actions taken as needed.	3/16/18
			3. Housekeeping and Maintenance staffs were inserviced on the care and repair of Geri-chairs and proper chair cleaning. The Environmental Services Quality Improvement Team will monitor for repair of Geri-Chairs and the cleanliness of lounge and sofa chairs on a monthly basis and forward the results of	3/16/18

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F 584	Continued From page 16 4. The floors in resident restrooms located in the hallways of the C-wing, the G-wing, and the A-wing soiled with numerous stains. 5. Walls in eight (8) of 53 resident rooms marred including Rooms #207, 231, 248, 249, 321, 325, 343, and 359. 6. Doors in four (4) of 53 resident rooms marred including Rooms #305, 323, 331, and 359. 7. One (1) of one (1) Geri-chair located on the C-wing lounge with two (2) torn armrests. 8. Two (2) of two (2) lounge chairs from the H-wing lounge and three (3) of three (3) sofa chairs from the A-wing lounge soiled with numerous stains. The observations made, in the presence of Employee #15, were acknowledged.	F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. – continued 3. their monitoring efforts to the Director of Facilities for his analysis. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Accuracy of Assessments CFR(s): 483.20(g) 1. Resident #180	3/16/18
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 70 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) to reflect the resident's current status. Resident #180. Findings included....	F 641	1. This resident's MDS was corrected Immediately upon discovery. 2. A review of all MDS records revealed no other areas of miscoding for ostomy. 3. MDS coordinators were inserviced to ensure that proper assessment and review is completed for each MDS. The MDS Quality Improvement Team will monitor this coding monthly and forward the results of this coding to the Director of Resident Assessment. 4. The Director of Resident Assessment will present the results of the audit to the Quality Assurance/Quality Improvement Committee which meets monthly and is chaired by the Administrator	2/1/18 2/1/18 3/16/18 3/16/18

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F 641	Continued From page 17 On February 1, 2018, a review of Resident #180's medical admission record showed the following diagnoses: Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation, Hyperlipidemia, and Hypokalemia. According to the annual MDS with a date of November 11, 2017,) H0100 Appliances, Ostomy (including urostomy, ileostomy, and colostomy) had a check to indicate the resident has an ostomy. During an interview on February 1, 2018, with Employee #7, Clinical Nurse Manager, stated, "No, the resident does not have an ostomy or colostomy, or anything." During an interview on February 1, 2018, at approximately 2:00 PM with Employee # 23, MDS Coordinator, she reviewed the annual MDS. She then stated, "That must be a computer glitch the resident does not have an ostomy, look at all the other MDS it's not checked on any on them." Employee #7 acknowledged the annual MDS was coded inaccurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) Resident #179, #494, #646 1. Care plans for sever anemia, continuous oxygen, and seizure were immediately completed upon discovery. 2. All care plans were reviewed and no other care plans were required to be developed.	2/1/18 2/1/18

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F 656	Continued From page 18 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews for three (3) of 70 sampled residents, the facility staff failed to develop care plans with appropriate goals and approaches to address care services for one (1)	F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) – continued 3. Nursing staff were inserviced on care plan development and implementation which reflects relevant resident diagnoses. The Nursing Quality Improvement Team will monitor the development and implementation of relevant care plans on a monthly basis and forward the results of their monitoring to the Director of Nurses. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator.	3/10/18 3/16/18

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F 656	Continued From page 19 resident with a diagnosis of Severe Anemia; for one (1) resident who receives oxygen therapy and for one (1) resident with a diagnosis of Seizure Disorder. Residents #179, 494 and 646 Findings included... 1. Facility staff failed to develop and implement a person-centered care plan to reflect a resident's current diagnosis of Severe Anemia. Resident #179. On February 1, 2018, a review of the Resident #179 medical admission record showed the following diagnoses: Squamous cell carcinoma of skin, Hypertension, Chronic pain, Chronic Obstructive Pulmonary Disease. On February 1, 2018, a review of the medical record laboratory data sheet with a date of December 13, 2017, showed a hemoglobin of 9.1 g/dL (Grams per Deciliter) [normal 13.5-17.5] and hematocrit of 28.7 g/dL (Grams per Deciliter) [normal 41.0-53.0]. A review of the medical record Interim Order Form with a date of January 7, 2018, stipulated, "Please arrange for transfusion to (hospital name) on Tuesday, January 9th Monday for transfusion of packed red blood cells (RBCs)." A further review of the medical record showed "(hospital name) discharge/transfer summary with a date of January 9, 2018, revealed the admitting and discharge diagnosis was Severe Anemia, [an abnormally low hemoglobin level and/or level of circulating red blood cells, decreases the blood's oxygen-carrying capacity within the body] s/p	F 656		

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F 656	Continued From page 20 (status-post) transfusion. Retrieved from: http://nursing.ceconnection.com/ovidfiles/00152193-201301000-00013.pdf. On February 1, 2018, a review of the resident's laboratory data form with a date of January 24, 2018 showed the "hemoglobin 8.7 g/dL and hematocrit 26.0 g/dL". A review of the resident's care plan on February 1, 2018, at approximately 10:00 AM did not show the facility staff initiated a person-centered care plan with goals and interventions to address the care and treatment for the resident's active diagnosis of Severe Anemia. During a face-to-face interview on February 1, 2018, at approximately 10:30 AM with Employee # 7, she stated, "Yes, the [Resident # 179] has Anemia and I should have created a care plan." Employee #7 acknowledged the findings. 2. Facility staff failed to develop a care plan with goals and approaches to address care needs for Resident #494 who receives continuous oxygen (O2). During an interview with Resident #494 on January 31, 2018, at 1:40 PM, the resident was observed receiving oxygen via nasal cannula. She stated, "I need longer oxygen tubing so I can move about my room without interrupting the flow of oxygen and lose my breath".	F 656		

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A review of the Resident #494's medical record showed an admission date of January 1, 2018, which include diagnoses: Human Immunodeficiency Disease Pneumoycstosis, Pneumonia, and Asthma.

A Physician's order signed and dated January 20, 2017, directed, Oxygen via nasal cannula at 2 liters titrate to keep oxygen saturations greater than or equal 95 percent every six (6) hours as needed for shortness of breath or wheezing.

A review of the care plan section of the clinical record revealed that there was no plan of care developed with goals and approaches to address the care needs of Resident #494 receiving oxygen therapy.

During a face-to-face interview with Employee #8 on January 31, 2018, at 11:00 AM, the employee acknowledged the findings after reviewing the resident's care plan.

3. Facility staff failed to initiate and implement a person-centered care plan with goals and interventions to address a resident's diagnosis of Seizure Disorder. Resident #646.

Resident #646 admitted to the facility on November 15, 2017, with diagnoses of Encephalopathy, Extrapyramidal Reaction, History of Cerebrovascular Accident (CVA), Hypertension and Seizure Disorder.

A review of the Physician's order with a dated of November 15, 2017, directed, Levetiracetam tablet 1000 mg - give one (1) tablet by mouth two

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F 656	Continued From page 22 (2) times a day for Seizure Disorder. Section I [Active Diagnoses] of the admission Minimum Data Set completed on December 8, 2017, included a diagnosis of Seizure Disorder. A review of Resident #646's clinical record lacked evidence that facility initiated a care plan to include goals and interventions to address the resident's active diagnosis of Seizure Disorder. During a face-to face-interview with Employee #9 on January 31, 2018, at 4:45 PM, the employee acknowledged the findings.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 70 sampled residents, the facility failed to provide resident-directed care in accordance with professional standards of practice as evidenced by failure: to follow the physician's order for the use of an assistive device (scoop plate) to serve one (1) resident all meals; to administer normal saline in accordance with the mid-line flushing protocol for one (1) resident; and to administer one (1) resident their	F 684	Quality of Care CFR(s): 483.25 1. Resident #180 1. Resident was re-evaluated for the need for a scoop plate. The order was discontinued because the resident requires full assistance from the staff for feeding. 2. A facility-wide audit was done for all residents ordered an assistive device and all were in compliance. 3. Nursing staff were inserviced to ensure that all orders for assistive devices are carried out. The Nursing Quality Improvement Team will monitor the use of and orders for assistive devices monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator.	2/1/18 2/2/18 3/10/18 3/16/18

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	095022	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

(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) COMPLETION DATE
F 684	Continued From page 23 antihypertensive medications in accordance with the physician's orders. Residents' # 180, #331 and #648. Findings included... 1. Facility staff failed to follow doctor's order to use a scoop plate (a high rimmed adaptive plate used to promote independence while eating) to serve Resident #180 all of her meals. A review of the medical record showed an Interim Order Form dated January 19, 2018," OT (Occupational Therapist) clarification order: Pt. (patient) to be served all meals on a scoop plate with suction base to improve efficiency and indep (independence) during feeding. A further review of the medical record showed an Occupational Therapist Progress note dated January 31, 2018, "The patient is able to feed utilizing scoop dish for of meal requiring set up (assist for device retrieval or modification of environment while seated upright) [sic]. Observation on February 1, 2018, at approximately 12:45 PM showed, Employee #28 CNA, (Certified Nurse Assistant) feeding the resident lunch from a plate without a high rim and suction base. At the time of the observation, Employee #4, Registered Nurse, was asked to observe the resident eating. Employee# 44 stated, "Yes, she is my patient, and I don't know anything about a scoop plate, I see her eating from a regular plate." According to the annual Minimum Data Set	F 684	Quality of Care CFR(s): 483.25 - continued 2. Resident #331 1. This resident experienced no adverse effects as a result of this finding. 2. There were no other residents affected. The facility the batch orders were revised for IVs in the electronic health record, Point Click Care, to be reflective of the actual IV protocol used in the facility. 3. Licensed nurses were inserviced about the corrected IV protocol. The Nursing Quality Improvement Team will monitor the IV protocol monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator.	2/1/18 2/2/18 3/10/18 3/16/18

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F 684	Continued From page 24 (MDS) completed on November 21, 2017, Under Section G Functional Status the resident is coded as "independent with eating and required set up help from staff." During an interview on February 1, 2018, at approximately 1:30 PM with Employee #22, Occupational Therapist, she stated, "She can eat independently with a scoop plate I would take her breakfast off of the regular plate and put it on a scoop plate." Employee #7, Clinical Nurse Manager, stated, "I did not know anything about a scoop plate, if there is a new order they would come and tell me, I will send this down to the kitchen so she can get her scoop plate, I missed this order." Employee#7 and #22 acknowledged the finding at the time of the observation. 2. Facility staff failed to administer normal saline in accordance with the mid-line flushing protocol for Resident # 331. A review of the Mid-line Catheter Protocol dated October 16, 2017, stipulated the flushing protocol as: "Use SASH (Saline antibiotic saline and heparin) Technique Intermittent Meds ...5 ML NSS (Normal saline solution) before Med, 5 ML NSS After Med, then 5 ML 10 units/ML Heparin Flush." The Physician's order dated October 17, 2017, at 0000 [12:00 AM] directed, Normal saline flush solution 0.9 %, use 10 ml intravenously every six (6) hours for IV [intravenous] until 10/25/17. \	F 684	Quality of Care CFR(s): 483.25 - continued 3. Resident #648 1. This resident was not adversely effected by these findings. 2. A review of the Medicine Administration Records of all residents on anti-hypertensives with their stated parameters was done with no other corrections needed. 3. Licensed nurses were inserviced about anti-hypertensive parameters. The Nursing Quality improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	2/2/18 2/4/18 3/10/18 3/16/18

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F 684	Continued From page 25 According to the October 2017 Medication Administration Record, the facility staff administered 10 mls of normal saline every six (6) on October 17 at 12:00 AM, 6:00 PM, 12:00 PM, and 6:00 PM on October 18, at 12:00 AM. There was no evidence that facility staff administered 5mls of normal saline solution before and after administration of the antibiotic in accordance with the flushing protocol (SASH). During a face-to-face, interview with Employee #2 on February 2, 2018, at approximately 11:30 AM, he acknowledged the findings. 3. Facility staff failed to withhold an antihypertensive medication when blood pressure dropped below the parameters for administration outlined in the physician's orders for Resident #648. Physician's orders for January 2018, directed, Metoprolol Tartrate (anti-hypertensive) tablet 50mg- Give one (1) tablet by mouth two (2) times a day for tachycardia. Hold for systolic blood pressure less than 110 or diastolic blood pressure less than 60. Review of the MAR (Medication Administration Record) dated January 2018 showed: Metoprolol Tartrate 50mg- Give one (1) tablet by mouth two (2) times a day for tachycardia. Hold for systolic blood pressure less than 110 or diastolic blood pressure less than 60. Resident's blood pressure readings recorded on	F 684		

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F 684	Continued From page 26 the MAR were 102/60 mmHg on January 6, 2018, and 106/75 mmHg on January 25, 2018. On both dates, Resident #648 received the medications. The facility staff failed to withhold the medication when the systolic readings were less than the prescribed parameter for the systolic blood pressure of 110mmHg. During a face-to-face interview with Employee #8 on February 1, 2018, at approximately 4:15 PM, Employee #8 acknowledged both findings.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) 1. The dressing was changed immediately upon discovery. 1/25/18 2. An audit of all residents with g-tubes was performed and their g-tube dressings evaluated. All were in compliance. 2/16/18 3. Licensed nurses were inserviced about the following physician orders for treatments and subsequent documentation of completion. The Nursing Quality Improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 3/10/18 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator 3/16/18	

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F 693	Continued From page 27	F 693		

by:
Based on observation, record review, resident and staff interviews for one (1) of 70 sampled residents, facility staff failed to ensure that one (1) resident who had a gastrostomy tube received care to the ostomy site according to the physician's orders. Resident #175

Findings included...

Facility staff failed to perform gastrostomy tube (g-tube) care as per the physician's order for Resident #175.

During an interview on January 25, 2018, at 2:00 PM, Resident #175 insist on showing her Gastrostomy site to the surveyor. The observation of the site showed a soiled gauze dated January 22, 2018, and the initials "B.E" circled next to the date. Employee #8 immediately changed the dressing to the gastrostomy site, after the observation.

A review of Resident #175 ' s clinical record showed an "Interim Order Form " that included the following G-tube order initiated August 22, 2017, that directed:

"Every night shift cleanse site with soap and water unless otherwise prescribed. If drainage noted, may cover with Aviant drain sponge or similar."

Review of Resident #175's January 2018, Treatment Administration Record showed that on January 22, 23, and 24, 2018, the facility staff signed that treatment to the G-tube was completed.

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F 693	Continued From page 28 The observation provided evidence that facility staff failed to perform the treatment to Resident # 175's gastrostomy site as per the physician's order on two days. During a face-to-face interview on January 25, 2018, at approximately 2:30 PM with Employee #8, she acknowledged the findings.	F 693		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	Pharmacy Srvcs/Procedures/Pharmacist/ Records CFR(s): 483.45(a)(b)(1)-(3) 1. Resident #179 1. The narcotic book was signed immediately upon discovery. The involved nurse was given education on the correct protocol for signing for the administration of Controlled Substances. 2. A review of all of the Narcotic Books was performed and all were in compliance. 3. Licensed nurses were inserviced about The policy of signing off on Narcotic Logs The Nursing Quality Improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	1/29/18 1/29/18 3/10/18 3/16/18

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F 755	Continued From page 29 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations during medication administration, medication storage and staff interview for two (2) of 70 sampled residents, the facility staff failed to assure that services being provided meet professional standards of quality as evidenced by failure to reconcile controlled medications for one (1) resident and failed to obtain one (1) resident ' s blood pressure in accordance with accepted standards of practice. Residents' #179 and #251. Findings included... 1.Facility failed to reconcile the control substance medication record for Resident # 179. On January 29, 2018, a review of Resident #179's, clinical record showed diagnoses to include Squamous cell Carcinoma of the skin, Hypertension, Chronic Pain, and Chronic Obstructive Pulmonary Disease. Medication reconciliation process observation on January 29, 2018, at approximately 3:30 PM with Employee #7, Clinical Nurse Manager, showed a discrepancy with the narcotic count for Resident #179. At the time of the observation, Resident #179's individual controlled substance record showed a pill count of 19 for Oxycodone/APAP/ Tab 5/325 mg (milligrams) [RX #24417636]. However, the blister pack containing the	F 755	Pharmacy Srvcs/Procedures/Pharmacist/ Records CFR(s): 483.45(a)(b)(1)-(3) 2. Resident #251 1. The licensed nurse was corrected immediately and the facility blood pressure machine was used to obtain the blood pressure of this resident. Staff was counseled regarding the use of personal blood pressure equipment and to not bring it to the facility again. 2. No other staff member was found to possess or be using a personal blood pressure cuff. 3. Nursing staff were inserviced about only facility equipment being used to obtain vital signs. The Nursing Quality Improvement Team will monitor for compliance monthly. The results their monitoring efforts will be forwarded to the Director of Nurses for his analysis. 4. The Director of Nurses will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	1/26/18 1/26/18 3/16/18 3/16/18

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F 755	Continued From page 30 medication Oxycodone/APAP/ Tab 5/325 mg showed a pill count of 18. During an interview with Employee #24, Registered Nurse, stated, "I did not sign for the medication can I sign it out now, I gave it already, I forgot to sign." Employee #24, Clinical Nurse Manager, stated, "You were supposed to sign it before now." Facility staff failed to document the administration of a controlled drug after administering the medication to Resident#179, in accordance with acceptable standards of clincal practice. Employees #7 and #24 acknowledged the finding at the time of the observation. 2. Facility staff failed to obtain one (1) resident's Blood Pressure and Pulse in accordance with accepted standards of practice. Resident #251. According to the CDC, "Application of the cuff: 1. Use the cuff size from column 1 associated with the arm circumference in column 4. (Example: If the arm circumference at the midpoint is 36 cm, use the large adult cuff.) 2. Position the rubber bladder over the brachial artery at least 1" above the crease of the elbow. For long thin arms, the cuff should be placed in the middle of the arm. Place the marker on the inner part of the cuff directly over the brachial artery. 3. Wrap the cuff in a circular manner in such a way that the wrapped cuff is smooth, snug, and no more than 2 fingers can be fit under the cuff. 4. Check the fit of the cuff to ensure that it is secure but not tight." www.cdc.gov/nchs/data/nhanes/nhanes_09_10/bp.pdf	F 755		

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F 755	Continued From page 31 During an observation of medication administration on January 26, 2018, at approximately 9:22 AM, Employee #27 was observed obtaining Resident #251 ' s blood pressure and pulse with an automated blood pressure monitor. The employee wrapped the blood pressure cuff around the resident's forearm, and obtained the blood pressure of 145/88 mmHg[millimeters of mercury] and pulse 88 beats per minute. At the time of the observation, a face-to-face interview occurred with Employee #27 concerning the placement of the blood pressure cuff on the resident's forearm. In response to the concerns, she stated, "The blood pressure cuff on the resident's forearm was inaccurately placed." There was no evidence that facility staff obtained the resident ' s blood pressure and pulse in accordance with accepted standards of practice.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812	Food Procurement/Store/Prepare/Serve-Sanitary CFR(s):483.60(i)(1)(2) 1. The plastic debris inside the ice scoop holder and the grease found on the outside of the fryer were taken care of immediately upon discovery. 2. All other areas of the kitchen were in compliance. 3. These cited areas were added to the cooks' walk through protocol to ensure on-going compliance. Any areas of concern are forwarded to the Director of Dining Services for his analysis. 4. The Director of Dining Services will present his analysis of these monitoring efforts with any action plans for improvement to the Quality Assurance/Quality Improvement Committee which meet monthly and is chaired by the Administrator	1/25/18 1/25/18 2/15/18 3/16/18

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F 812	Continued From page 32 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations made in the kitchen on January 25, 2018, at approximately 9:30 AM, the facility failed to prepare and distribute foods under sanitary conditions as evidenced by plastic debris inside the ice scoop holder and two (2) of two (2) soiled grease fryers. Findings included... 1. A piece of plastic debris observed inside the ice scoop holder. 2. Two (2) of two (2) grease fryers soiled on the outside with grease stains. The observations made in the presence of Employee #11 were acknowledged.	F 812	Resident Call System CFR(s): 483.90(g)(2) 1. Maintenance staff repaired the cited call bells immediately upon discovery. 2. Call bells throughout the facility were checked and repairs provided if necessary. All call bells were in compliance. 3. The Maintenance staff was inserviced on the repair and upkeep of the call bells. and continue to monitor them in resident rooms every day. Results of their monitoring efforts are brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/1/18 2/2/18 2/16/18 3/16/18
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced			

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F 919	Continued From page 33 by: Based on observations, the facility failed to maintain resident call system in good working condition as evidenced by the three (3) of six (6) call bells alarms that did not alarm when tested. Findings included ... Observations on January 31, 2018, between 11:45 AM and 4:00 PM and February 1, 2018, between 9:20 AM and 11:30 AM, showed three (3) call bells failed to alarm when activated as follows: A. Two (2) resident room call lights in Rooms #212A and 359A B. One (1) of four (4) call bells in the 3 North shower room The observations made, in the presence of Employee #15, were acknowledged.	F 919	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) 1. Surge Protector 1. The noted surge protector was secured immediately upon discovery. 2. All other surge protectors were properly secured. 3. The Maintenance staff was inserviced on the securing of surge protectors. The Maintenance Quality Improvement Team will inspect/monitor the surge protectors monthly. The results of these monitoring efforts will be brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/1/18 2/1/18 2/16/18 3/16/18
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations made during an environmental tour of the facility on , facility failed to provide an environment that is free from accident hazards. Findings included ...	F 921		

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	095022	A. BUILDING _____ B. WING _____	02/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS HEALTHCARE CAPITOL CITY	2425 25TH STREET SE WASHINGTON, DC 20020

(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) COMPLETION DATE
F 921	Continued From page 34 Observations on January 31, 2018, between 11:45 AM and 4:00 PM and on February 1, 2018, between 9:20 AM and 11:30 AM showed potential accident hazards as follows: 1. A surge protector in use, unsecured, on the floor and under the bed of one (1) resident in one (1) of 53 resident rooms. 2. Call bells cords frayed in two (2) of 53 resident rooms including Rooms #121 (Beds A and B) and 132 (Bed A). The observations made in the presence of Employee #15 were acknowledged.	F 921	2. Call bell cords 1. The noted call bell cords were replaced immediately upon discovery. 2. All other call bell cords were inspected and all were in compliance. 3. The Maintenance staff was inserviced on the inspection and replacement of call bell cords. The Maintenance Quality Improvement Team will inspect the call bell cords monthly. The results of these monitoring efforts will be brought to the Director of Facilities for his review. 4. The Director of Facilities will present his findings and any action plans for improvements to the Quality Assurance/ Quality Improvement Committee which meets monthly and is chaired by the Administrator.	2/1/18 2/1/18 2/16/18 3/16/18