Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|-------------------------------|--------------------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: _ | A. BUILDING: | | PLETED |
| HFD02-0004 | | B. WING | | 09/22/2017 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | RESS, CITY, STA | ATE, ZIP CODE | 1 03/2 | 2/2017 |
| | | | NECTICUT A | • | | |
| FOREST | HILLS OF DC | | TON, DC 20 | • | | |
| (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 | (X5) COMPLETE DATE |
| L 000 | Initial Comments | | L 000 | | | |
| L 000 | An annual Licensure September 20, 2017 at Forest Hills of DC on observation, reconstruction interviews for 22 sare. The following is a discronyms that may be a constructed and acronyms that may be a constructed an | mental Status ment Reference Date a-day I Pressure centimeters eters for Medicare and Medicaid d Nurse Aide of Columbia of Columbia Municipal | L 000 | | | |
| | mass) mL - millilit | ers (metric system measure of | | | | |
| | | | | | | |

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

TITLE Administrator (X6) DATE

October 21, 2017

LG8411

If continuation sheet 1 of 5

PRINTED: 10/13/2017 FORM APPROVED

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-------------------------------|--|
| | HFD02-0004 | B. WING | 09/22/2017 | |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4901 CONNECTICUT AVENUE, NW

| (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) COMPLETE DATE |
|--------------------------|--|---------------------|--|--------------------------|
| L 000 | Continued From page 1 volume) | L 000 | | |
| | mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review PO- by mouth POS - physician 's order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P- Responsible party Sol- Solution S/P- Status Post TAR - Treatment Administration Record Tx- Upper Extremity | | | |
| L 051 | 3210.4 Nursing Facilities A charge nurse shall be responsible for the | L 051 | | |
| | following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; | | | |

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Health Regulation & Licensing Administration STATE FORM

If continuation sheet 2 of 5 LG8411

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------------|--|--|
| | HFD02-0004 | B. WING | 09/22/2017 | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |

4901 CONNECTICUT AVENUE, NW

| FOREST HILLS OF DC | | NNECTICUT AVENUE, NW GTON, DC 20008 | | |
|--------------------------|---|--|---|--------------------------|
| (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) COMPLETE DATE |
| L 051 | Continued From page 2 | L 051 | L099 – Soiled Equipment | |
| | (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; | | Corrective Action for Deficient Practice: Equipment was cleaned thoroughly on September 21, 2017. | 9/21/17 |
| | (e)Supervising and evaluating each nursing employee on the unit; and | | 2. Residents Affected by Deficient Practice: There has been no indication to date that residents were affected by the deficient | 9/21/17 |
| | (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents This Statute is not met as evidenced by: | | practice. 3. Systemic Changes to Ensure Deficient Practice Does Not Recur: | |
| | This diatate is not met as evidenced by. | | a) All Production and Utility staff were trained on the proper cleaning of equipment.b) The Master cleaning schedule was revised to increase weekly cleanings to bi-weekly for all | 9/29/17 |
| L 099 | 3219.1 Nursing Facilities | L 099 | kitchen equipment. 4. Performance Monitoring to Ensure | |
| | Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal | | Sustainability: The Executive Chef will monitor compliance with the schedule and report findings quarterly to the QAPI Committee. | 10/26/17 |
| | Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: | | Soiled Floor 1. Corrective Action for Deficient Practice: | |
| | Based on observations made on September 20, 2017 at approximately 8:30 AM, the facility failed to serve foods under sanitary conditions as | | Entire kitchen floor was deck scrubbed immediately. 2. Residents Affected by Deficient Practice. | 9/21/17 |
| | evidenced by one (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove that were soiled throughout and the | | No resident was affected by deficient practice. 3. Systemic Changes to Ensure Deficient Practice Does Not Recur. | 9/21/17 |
| | kitchen floor soiled with debris. | | Floor cleaning policy was reviewed with all utility staff. Assignment sheet was revised to | 9/23/17 |
| | The findings include: | | include name of employee responsible for sweeping & mopping floor each shift to ensure | |
| | 1. One (1) of one (1) food warmer, one (1) of one (1) convection oven, and one (1) of one (1) stove located in the main kitchen soiled. | | accountability. 4. Performance Monitoring to Ensure Sustainability The Divine Services Manager on duty will | |
| | 2. The entire kitchen floor soiled with debris. | | The Dining Services Manager on duty will monitor the cleanness of the floor daily by checking out each utility person after the shift. | 10/26/17 |
| | The observations made in the presence of Employee #13 were acknowledged. | | Findings will be reported to the Director of Dining services weekly and reported at the Quarterly QAPI meeting. | |

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PRINTED: 10/13/2017 FORM APPROVED

9/20/17

9/27/17

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| Health R | Regulation & Licensing | Administration | | | | |
|---|------------------------|---|---|---|-------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
| | | HFD02-0004 | B. WING | | 09/2 | 2/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | , | | |
| FOREST | HILLS OF DC | | INECTICUT A STON, DC 20 | · · | | |
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| L 214 | Continued From page 3 | | L 214 | L 214 – Portable Heater in Resident's | Room | |
| L 214 | 3234.1 Nursing Fac | e designed, constructed, | L 214 | Corrective Action for Deficient Pra heater was immediately removed from respectively. | oom. | 9/20/17 |
| | | and maintained to provide a | | 2. Residents Affected by Deficient Pra | actice: | |

The findings include:

and the visiting public.

A portable heater was plugged in and in use in resident room #140, one (1) of 21 resident's rooms surveyed.

This observation made in the presence of Employees #11 and #12 was acknowledged.

functional, healthful, safe, comfortable, and

This Statute is not met as evidenced by:

in use in one (1) of 21 resident's rooms.

Based on observations made on September 20,

2017 at approximately 10:00 AM, the facility failed

to maintain resident's environment free of accident

hazards as evidenced by a portable heater that was

supportive environment for each resident, employee

L 442 3258.13 Nursing Facilities

The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This Statute is not met as evidenced by:

Based on observations made on September 20, 2017 between 8:30 AM and 9:45 AM, the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of one (1) food warmer with no temperature control knob, one (1) of one (1) tilt skillet which failed to power up when turned on, and one (1) of one (1) dishwashing machine which failed to reach 180 degrees

L442 – Failure to Maintain Essential Equipment in Good Working Condition

No resident was affected by deficient practice.

a) Safety rounds Checklist has been updated to

include observation for portable heaters and

other equipment in resident rooms that may

b) Education was provided to all private duty

other safety measures to be maintained while caring for a resident. Emphasis included use

caregivers regarding equipment safety and

4. Performance Monitoring to Ensure Sustainability: Results of bi-weekly safety

rounds will be reported quarterly to QAPI

3. Systemic Changes to Ensure Deficient

Practice Does Not Recur:

pose safety hazards. .

of portable heaters.

Committee.

L 442

6899

A. Missing Temperature Control Knob

1. Corrective Action for Deficient Practice:
The Knob was found and placed back on the warmer.

2. Residents Affected by Deficient Practice:
No resident was affected by deficient practice.
3. Systemic Changes to Ensure Deficient
Practice Does Not Recur: The monthly Safety
and Sanitation Audit Checklist has been
updated to include checking the working
condition of all equipment.

4. Performance Monitoring to Ensure
Sustainability: The Assistant Dining Director and the Executive Chef will monitor results recorded on the Checklist. Concerns will be discussed with the Director at weekly Managers' meetings and presented to the QAPI Committee quarterly.

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Fahrenheit at final rinse.

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Health Regulation & Licensing Administration

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| L 442 | The findings include | : | L 442 | L442 – Failure to Maintain Essential Equipment in Good Working Conditi (cont'd) | ion | |
| | (1) food warmer was | tilt skillet failed to power up | | B. <u>Tilt Skillet Failed to Power Up</u> 1. Corrective Action for Deficient Pra Written notice placed on skillet stating to was not working. 2. Residents Affected by Deficient Pra No residents were affected. | that it | 9/20/17 |
| | | machine in the main kitchen | | No residents were affected. 3. Systemic Changes to Ensure Defici Practice Does Not Recur: | ent | 9/20/17 |
| | degrees Fahrenheit rinse cycles. The dis | al rinse temperature of 180 during several consecutive shwashing machine located in the Healthcare 1 Unit was used all dishes. | | Purchase of new tilt skillet has been app by Administrator. Upon arrival, tilt skil be added to Safety Rounds Checklist. 4. Performance Monitoring to Ensure Sustainability: Results from safety rou | let will | 9/26/17 |
| | The observations ma Employee #13 and E acknowledged. | ade in the presence of Employee #14 were | | will be reported quarterly to QAPI Com C. Dishwashing Machine Failed to 1 Final Temperature of 1800 | nmittee. | 10/26/17 |
| | | | | 1. Corrective Action for Deficient Pra Ecolab was called and responded immediately. Assessed dish machine a made recommendations regarding proof flow changes to prevent depletion of h water in booster heater before rinse cy- complete. | nd cess ot cle is | 9/20/17 |
| | | | | 2. Residents Affected by Deficient Properties No residents were affected. 3. Systemic Changes to Ensure Deficient Practice Does Not Recur: a) New portion | ent | 9/20/17 |
| | | | | that incorporates Ecolab's recommend was developed, and all utility staff wer in-serviced. | ations re | 9/23/17 |
| | | | | b) Purchase of new dish machine has be approved by Administrator. c) Upon a dish machine temperatures will be adde Safety Rounds Checklist. | rrival, ed to | 9/26/17 |
| | | | | 4. Performance Monitoring to Ensure Sustainability: Results from safety r will be reported quarterly to QAPI | | 10/26/17 |

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