STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 000	INITIAL COMMENTS The unannounced Annual Licensure Survey was conducted at Health and Rehab at Thomas Circle from May 23 through May 30, 2019. Survey activities consisted of a review of 21 sampled residents. 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 CFU Colony Forming Unit 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 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team	F 000	The Residences at Thomas Circle files this Plan of Correction for the purpose of regulatory compliance. The facility submits this document to comply with applicable law and not as an admission or statement of agreement of deficient practices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/15/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 000	Continued From page 1 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 OD: Right eye OS: Left eye PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rap, R/P - Responsible party SCSA Significant change status assessment Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	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	F 558	Reasonable Accomodations Needs/ Preferences CFR(s): 483.10(e)(3) 1. Resident #127 was placed on 1:1 Monitoring until the receipt and installation of the EZ Call system.	5/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 558	Continued From page 2 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews for one (1) of 22 sampled Residents, facility staff failed to provide Resident #127 with a call light that was suitable to accommodate her need to call for staff assistance when necessary. Findings included... A review of the admission records showed that Resident #127 was admitted to the facility on May 22, 2019, for Sub-Acute Rehabilitation with diagnoses that included Type 2 Diabetes, Hyperlipidemia, Deep Vein Thrombosis (DVT), Anemia, Hypertension and Quadriplegia Occupational Therapist plan of care dated May 22, 2019, showed "Minimal movement in all extremities ..." A review of the Physician's Order Sheet initiated on May 23, 2019, at approximately 12:19 AM, included a telephone order that directed the following: "Please do bed check of the resident every hour Q (every) shift, as she cannot use a call light and cannot reposition her arms, hand, and legs every shift." A review of the Nursing Progress Notes dated May 23, 2019, at 06:00 AM stated "S/p [status post] new admitted... resident needs frequent check due to upper extremity weakness resident	F 558	Reasonable Accomodations Needs/ Preferences (continued) CRF(s): 483.10 (e)(3) 2. All other current in-house residents were able to use the call system provided in the room and needed no further accommodations. 3. The direct care staff will be in-serviced by the Director of Nurses and/or designee by 7/19/19 that for all new admission the staff must show the resident how to use the call system. The Charge Nurse will monitor the new admissions weekly and current residents to ensure their ability to use the call system provided in the room. Should other accommodations be necessary, the Administrator will ensure the installation of an EZ Call system or similar device. 4. These monitoring efforts will be forwarded to the Director of Nurses for her review. The Director of Nurses will present the results of these monitoring efforts along with any action plans to the Quality Assurance and Performance Improvement Committee at least quarterly and is chaired by the Administrator.	5/27/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 558	Continued From page 3 unable to use call light..." On May 23, 2019, at 3:18 PM during an interview with Resident #127 concerning the use of the call light the resident stated, "I cannot use the call light my hands cannot lift to touch the call light. My hand fell and I could not use my hand to touch the call light, the staff was in the hallway but they could not hear me calling them." On May 24, 2019, at 12:00 PM an observation made in the presence of Employee #11(Occupational Therapist) during resident's the rehabilitation treatment showed that both of the resident's hands were swollen, that she was not able to make a fist or pick up objects but was able to lift her hands. During this time, the Employee #11 stated, "I am working on her fine motor skill to allow her to use an E-Z touch call light system [a nurse call switch touchpad call switch enables clients with limited movement to summon help easily]." A face-to-face interview was conducted on May 24, 2019, at approximately 2:00 PM with Employee #3 (Assist Director of Nursing) concerning the resident's call light. She stated, "We are aware that the resident is unable to use her call light due to her swollen and weak hands. The staff is to frequently monitor the resident's room." A review of the Treatment Administration Record for May 2019, revealed that the staff was signing off that the resident was being monitored every shift from May 22, 2019, to May 24, 2019. Through observations, resident and staff interviews, it was determined that Resident #127	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 558	Continued From page 4 could not operate the call light provided for her use. Also, there was no evidence that facility staff made available an appropriate call light to accommodate the resident's need to call for staff assistance when necessary. Another face-to-face interview was conducted on May 24, 2019, at approximately 7:00 PM with the Employee#1(Administrator) and Employee #3 concerning the resident's call light. The findings were acknowledged by both employees who provided information that Resident #127 will be placed on one to one monitoring until the E-Z call was available, functioning and is actively being used by the resident at the bedside.	F 558		
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	F 575	Required Postings CFR(s): 483.10(g)(5)(i)(ii) 1. No specific residents were identified. 2. A revised posting was completed and and displayed upon discovery. The revised posting was also displayed on the Assisted Living Unit. A notice was also placed with all pertinent information indicating to residents that they may file a complaint with the State Survey Agency as desired. 3. The Administrator will review the public postings monthly to ensure their accuracy. Prior to posting for public viewing, the Administrator will review any received document from a State Agency or Advocacy group to ensure that it is legible and accurate. 4. The accuracy of the posting will be presented to the members of the Quality Assurance and Performance Improvement Committee at least quarterly for review and any further recommendations.	5/24/19 7/13/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 575	Continued From page 5 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 observation, document review staff interview and residents interview, the facility failed to ensure the contact information to include the names, mailing and email addresses for all pertinent State agencies and advocacy groups were posted and failed to ensure the posting included a statement that the resident may file a complaint with the State Survey Agency. The resident census was 24 on the first day of survey. Findings included ... During tour of the facility on May 24, 2019 at 1:00 PM, the "State Survey and Certification Agency/State Licensure form was observed posted inside the wall cabinet beside the 2nd floor elevator door. The "State and Certification Agency/State Licensure form" contained a list of names of all pertinent State agencies and advocacy groups, adult protective services and the Office of the State Long-Term Care Ombudsman and the Medicaid Fraud Control. However, the signage failed to display the names, accurate phone numbers, mailing or email address for aforementioned organizations. In addition, the posting did not include 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.	F 575		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 575	Continued From page 6 During a face-to-face interview on May 24, 2019, at 2:00 PM, Employee #1 Administrator was shown the required posting of contact information. Employee #1 acknowledged the finding at the time of the review.	F 575		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility staff failed to post notice	F 577	Right to Survey Results/Advocate Agency Info CFR(s):483.10(g)(10)(11) 1. No specific residents were identified. 5/24/19 2..A sign was posted directing any interested party to the location of the survey results 5/24/19 A clearer copy of the survey was placed in the binder. 3. The Administrator will be responsible for keeping up both the posting of where the survey book is located as well as the contents of the book itself. 7/13/19 The Administrator will be responsible in ensuring that the copy of survey results is clear and readable prior to posting in the book. 4.The Administrator will report to the Quality Assurance and Performance Improvement Committee at least quarterly that the survey book and the posting of its location is in compliance. 7/22/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 577	Continued From page 7 of the availability of survey results and to display the results in a manner understandable to residents and resident representatives. The resident census was 24. Findings included... During tour of the facility on May 24, 2019 at 11:00 AM, there were no signs to indicate the availability of survey results in places readily accessible to residents, family members or resident representatives. The survey results were discovered on a table in the dining area in a white binder labeled "SNF (Skilled Nursing Facility) Survey Book." Review of the survey results (CMS-2567) with a completion date of 8/15/18 showed print which was difficult to read. Residents were asked if they were able to read the survey results the residents responded "it's too blurry", "I can't read this even with my glasses", this would be tiring to read, I can't see this, can you." During a face-to-face interview with Employee #1 on 5/24/19 at 2:00 after being shown the survey results the Employee stated " yes this is not a good copy, I will print out another copy and post the signage for the survey results, thank you. During a face-to-face interview on 5/24/19 at 2:00 PM Employee #1 acknowledged the findings	F 577		
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	F 578	Request/Refuse/Discontinue Treatment; Formulate Advance Directive CFR(s) 483.10 (c)(6)(8)(g)(12)(i)-(v) 1.The MOST form was discussed with the family member of resident #3 and it was completed entirely soon after.	5/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 578	Continued From page 8 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 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.	F 578	Request/Refuse/Discontinue Treatment; Formulate Advance Directive CFR(s) 483.10 (c)(6)(8)(g)(12)(i)-(v) (continued) 2. All of the current in-house resident's charts were reviewed by the Social Worker to ensure the presence of an Advance Directive or a note indicating that the Resident and/or responsible party had been offered information on the topic. 3. An in-service was completed by the Administrator by 7/19/19 with the Social Worker for the skilled unit in which policies and regulations were reviewed regarding a resident's Request/Refusal/ Discontinuation Treatment and to Formulate an Advance Directive. This process is included in the Admission process and will be updated routinely at each IDT meeting. 4. The Social Work Consultant will audit a minimum of 5 charts and admissions packets each month to ensure compliance in this area. The results of this audit will be sent to the Administrator and reviewed with the Social Worker. The Administrator will present the results of this audit and any action plans to the Quality Assurance and Performance Improvement Committee at least quarterly.	7/22/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 578	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview facility staff failed to complete a facility document (used to guide treatment) based on the residents medical condition that contained resident pertinent information and resident signature. Resident #3. Findings included... Review of the admission record on 5/28/19 at 11:30 AM showed the following diagnoses Hyperlipidemia, Essential (Primary) Hypertension, Aphasia following Cerebral Aphasia, Cerebral Infarction and Dysphagia following Cerebral Infarction. Further review showed "resident is listed as self- responsible party; sister is listed as the emergency contact #2". Review of the Comprehensive Minimum Data Set [MDS] dated 2/20/19 showed Section C [Cognition] Brief Interview for Mental Status [BIMS] is scored as "99" which indicates resident was unable to complete the interview. Review of the DC Medical Orders for Scope of Treatment (MOST) dated 3/29/19 showed the date of birth was left blank, medical conditions/patients goals were left blank and the form was not signed by the resident or a resident representative. A further review of the form indicates "signature and date is required for the form to be considered valid." During an interview on 5/28/19 at 12:40 PM, Employee #3 stated "I have the doctor on the phone and the doctor would like to talk with you (writer) about the form."	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 578	Continued From page 10 Employee #10, doctor stated "we have a new process in place of using the MOST form, it was explained to the doctor that the form must be complete and accurate, the doctor acknowledged the finding. During a face-to-face interview on 5/28/19 at 12:40 PM, Employee #3 acknowledged the finding.	F 578	Medicaid/Medicare Coverage/Liability Notice CFR(s) 483.10(g)(17)(18)(i)-(v) 1. Resident #17 was discharged from this skilled facility therefore, there is no opportunity to have the Notice of Non Coverage signed. 2. With the hiring of a new Social Worker in mid-May 2019, delivering a Notice of Non-Coverage at least 48 hours pre-discharge has become a priority. 3. Planned discharges are discussed and reviewed at the morning meeting by the Inter Disciplinary Team at which time it is validated that Non-Coverage notice was given within the regulatory timeframe. The Social Worker has been in-serviced by the Administrator by 7/19 regarding the policies, practices, and regulations Regarding the Medicare Notice of Non Coverage and the resident's right to appeal. Each signed noticed will be placed as part of the resident's hard copy medical record. 4. At a minimum a quarterly audit by the Social Work Consultant will be done on the timeliness of the delivery of the notices. The results of the audit will be given to the Administrator and Social Worker for review. The Administrator will present the results of this audit along with any action plans for improvement to the QAPI Committee at least quarterly.	5/15/19 7/22/19 7/22/19 7/22/19
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 582	Continued From page 11 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on a clinical record review and staff interview, the facility failed to provide a resident with the Notice of Medicare Non-Coverage within 48 hours/no later than two (2) days before the discontinuation of rehabilitation services for one (1) of three (3) residents. Resident #17. Findings included ...	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 582	Continued From page 12 "The Notice of Medicare Non-Coverage form stipulates that every Medicare resident in a facility has the right to appeal the decision of non-coverage to the Quality Improvement Organization. The Quality Improvement Organization will notify you of its decision as soon as possible, generally no later than two days after the effective date of the notice if you are in Original Medicare" Resident #17 was admitted to the facility on April 15, 2019 with diagnoses that included Generalized Muscle Weakness, Altered Mental Status Unspecified, Dehydration, Unspecified Dementia without Behavioral Disturbance, Delusional Disorders and Major Depressive Disorder, Single Episode and Chronic Pain Syndrome. According to the Beneficiary Protection Notification Review form, the resident's last day of coverage for Part A Services was May 14, 2019 and the date the form was sent to the POA on May 13, 2019 which was less than the 48 hours required for the notification. A review of the resident's Beneficiary Protection Notification Review lacked a signature to verify that the resident or her Power of Attorney (POA) received the form within 48 hours of the end of scheduled Skilled Services. The timeliness of this notification allows the resident to determine if she will protest the facility's decision or if she will pay	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 582	Continued From page 13 for additional treatment/s. During a face-to- face interview with Employee #1 on May 30, 2019 at approximately 10:00 AM, she acknowledged that the facility did not receive the signed copy of the Notice of Medicare Non-Coverage and acknowledged the finding.	F 582	Grievances CFR(s): 483.10(j)(1)-(4) 1.No specific residents were identified.	5/24/19
			2. The most recent Grievances discussed at Resident Council Meeting have been transferred to the facility's Grievance Form and addressed per policy.	7/22/19
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585	3. The monthly Resident Council Meeting grievances will be processed through the Grievance Procedure by the Social Worker who will staff the Council Meeting and be the designated Grievance Official. The Social Worker has received an In-service on the Grievance Process, Policies, and Regulations by the Administrator by 7/19. Grievances will be archived in the Grievance Book for a period of three years. All Department Managers will be re-inserviced by the Administrator by 7/19 on the correct process for noting, receiving and addressing resident concerns/ grievances."	7/22/19
			4. The Grievance Forms will be audited each month by the Administrator to ensure that any grievances brought up at the Resident Council Meeting are processed through the Grievance Procedure. The Administrator will present the results of this audit to the QAPI Committee along with any action plans for improvement. This Committee meets at least quarterly.	7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 585	Continued From page 14 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 585	Continued From page 15 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to act promptly upon the grievances of the Resident Council concerning issues related to resident care and life in the facility and to maintain results of grievances for a minimum of three years. The resident census was 24 on the first day of the survey. Findings included ... Grievance Policy Last revised 8/8/18 "The facility goal is to resolve resident and family	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 585	Continued From page 16 concerns on a timely basis utilizing resources within the facility and through interdisciplinary approach." Review of the resident council meeting minutes on 5/24/19 at 3:00 PM, from December 2018-March 2019 conveyed the following concerns surrounding areas such as the "laundry not returning their clothing; food and beverage- meat is tough, what is on the menu is never available, running out of food choices, would like a hydration station; nursing: waiting long periods of time for assistance especially at night, speaking too loudly at the nurses station." Grievance official or department directors failed to address the resident concerns expressed at Resident Council meetings over the span of four months. During a interview on 5/24/19 Employee #3 was asked for the results of grievances over the past three years, Employee #3 states this is all we have. Facility staff failed to provide results of grievances over the past three years and to address the concerns of residents conveyed at the resident council meetings. During a face-to-face interview on 5/24/19 at 5:00 PM with Employees #1, it was stated "I intend to make resident concerns and grievances a priority." Employee #1 acknowledged the finding.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641	Accuracy of Assessment CFR(s): 483.20(g) 1.Resident #4, the MDS coordinator made the modification to the MDS to accurately reflect behavioral condition of the resident.	5/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 641	Continued From page 17 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 22 sampled residents facility staff failed to accurately code the Minimum Data Set (MDS) for one resident with a behavioral indicator for psychosis. Resident# 4. Findings included... Resident# 4 was admitted to the facility on 9/12/18, with diagnoses which include: Generalized Anxiety Disorder, Unspecified Mood Affective Disorder, Glaucoma, Hypothyroidism, Unspecified Dementia without Behavioral Disturbance, Major Depressive Disorder, Recurrent. Review of the Nursing Home Quarterly Minimum Data Set [MDS] dated 3/20/19, showed Section C-Cognitive Patterns: Brief Interview for Mental Status resident was scored as "12" which indicate cognition is mildly impaired. Section D [0100]- Mood was coded a 1 to indicate resident's mood interview was conducted and there were no symptoms present. Section E [0100] Potential indicators of psychosis allocated box is marked X none of the above to indicate no behaviors of psychosis exist (hallucinations or delusions). Further review of the Nursing Home Quarterly Minimum Data Set showed Section E: Behavior [E0100. Potential for Psychosis], check all that apply A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli), B.	F 641	Accuracy of Assessment CFR(s): 483.20(g) (continued) 2. There were no other residents on the unit' at that time with similar documented behavioral disturbances. 3. The Social Worker has been In-serviced by the Administrator and MDS Coordinator by 7/19/19 on the proper coding of behavioral disturbances on the MDS. Residents presenting with behaviors will be discussed at the IDT meeting to ensure all team members are aware of the issues presenting. 4. The MDS nurse will complete 5 monthly audits specifically looking at the coding of behavioral disturbances. The results of those audit will be reviewed with the Social Worker and Administrator. The Administrator will present the findings of this audit along with any Action plans for improvement to the QAPI Committee at least quarterly for review.	5/29/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 641	Continued From page 18 Delusions (misconceptions or beliefs that are firmly held, contrary to reality). None of the above box was marked with an "X" to indicate the resident did not exhibit those behaviors. Review of the physicians orders on 5/29/19 showed Risperdal tablet 0.5 mg give 1 tablet by mouth for Dementia with psychosis. Review of the Behavioral Therapy Assessment notes showed the following: On 3/5/19 note reads: "Baseline foul language toward staff continues; mood/affect; irritable Psychosis: history of episodic suspicions and delusions relate to staff, offered reassurance, encouragement, redirection and reality checks." On 3/12/19 note reads: "Processed patient continue perception that she is being targeted, picked on and treated unfairly (paranoid delusions remain). Mood/affect: suspicions and delusions related to staff. On 3/19/19 note reads: Baseline foul language used towards others continues. Mood/affect: history of episodic suspicions and delusions related to staff." Further review of the behavioral therapist diagnoses include: Unspecified dementia with behavioral disturbance, Psychotic delusions due to known physiological condition and Major depressive disorder, single episode, unspecified. During an interview with Employee #8 on 5/29/19 at 1:00 PM, the employee was asked what	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 641	Continued From page 19 sources were used to complete the MDS. She acknowledged the finding and stated "yes, it is coded incorrectly I will make the change on the MDS and give you a copy. Facility staff failed to accurately code Resident # 4 for a potential indicator for psychosis.	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 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)-	F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21 (b)(1) 1. A care plan for Resident's # 76 use of a foley catheter was added. 5/29/19 2. Current residents in-house who use a foley catheter were reviewed for the presence of a care plan. No additional corrections were necessary. 7/19/19 3. Licensed nurses were in-serviced by the Director of Nursing by 7/19 ensuring they understand the requirement of a care plan for a foley catheter. During the morning meeting new admissions will be reviewed to determine if a foley catheter is present and if so validate that the appropriate care plan is in place. 7/22/19 4. The MDS nurse will audit all charts monthly for residents with foley catheters to ensure the presence of a care plan. The results of her audit will be forwarded to the Director of Nurses. The Director of Nurses will present the results of this audit along with any action plans/facility interventions for improvement to the QAPI Committee at least quarterly. 7/22/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 656	Continued From page 20 (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 record review and staff interview for one (1) of 21 sampled residents, facility staff failed to develop a comprehensive person-centered care plan with goals and interventions for for one resident's use of a Foley catheter. Resident #76. Findings included . . . Facility staff failed to develop and implement a comprehensive care plan with goals and interventions for Resident #76's use of a Foley catheter. Resident #76 was admitted to the facility on May 17, 2019 with diagnoses which included Malignant Neoplasm of Rectum, Chronic Kidney Disease (CKD), Hypertension, Chronic Obstructive Pulmonary Disease (COPD) Urinary Tract Infection and colostomy.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 656	Continued From page 21 During a face-to-face interview with the resident on May 29, 2019 at approximately 3:00 PM the resident told this writer that he is anxious to return home but he needs to be able to urinate normally before he goes home. (Referring to his Foley catheter.) Review of the facility's Matrix presented by the facility showed the resident classified as having a Foley catheter. Review of the care plans on May 29, 2019 failed to show a care plan for the resident's use of the Foley catheter. Employee #3 reviewed the care plans and acknowledged that the facility failed to develop and implement a comprehensive care plan for Resident #76's use of a Foley catheter during a face-to-face interview at 10:30 AM on May 30, 2019.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by a surge	F 689	Free of Accidents Hazards/Supervision/ Devices CFR(s):483.25(d)(1)(2) 1.The surge protector and lamp were removed immediately from resident rm. #216. 2. All rooms were checked for surge protectors and/or defective lamps and none were found. 3. The Maintenance techs will be in-serviced by the Director of Plant Operations by 7/19 on how to do monthly checks in each room to ensure safety compliance. Information will be given to the social worker by 7/19 to distribute to new admissions specific to maintenance processes for the skilled unit to include the use of power strips and extension cords. .	5/23/19 5/24/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 689	Continued From page 22 protector that was stored in use, on the floor of one (1) of nine (9) resident's rooms, and exposed electrical wires from an unplugged table lamp in one (1) of nine (9) resident's rooms. Findings included ... During an environmental walkthrough of the facility on May 23, 2019, at approximately 2:30 PM: 1. A surge protector was observed in use, in a corner, on the floor of resident room # 216, one (1) of nine (9) resident's rooms surveyed. 2. Electrical wires from an unplugged table lamp with a broken light socket were exposed and accessible in one (1) of nine (9) resident room (# 216). Employee #6 acknowledged the above findings during a face-to-face interview on May 23, 2019 at approximately 3:00 PM.	F 689	4. Spot checks will be done by the Maintenance Supervisor 1x/week x4 and then 2x/month x 3 months. Results of these room checks audits will be given to the Director of Plant Operations. The Director of Plant Operations will present his findings and any action plans for facility interventions and/or improvements to the QAPI Committee at least quarterly	7/22/19
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 1.The labeling of the tubing and validation that the oxygen was being delivered at 3L/minute for Resident #275 was completed when identified. 2. Any other residents in-house requiring oxygen were reviewed to ensure the proper amount was being delivered per MD orders and that the tubing was labelled. There were no other issues were noted.	5/30/19 5/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 695	Continued From page 23 Based on observation, record review and staff interviews for one (1) of sampled 22 residents facility staff failed to maintain oxygen therapy and to label oxygen tubing according to physicians order in accordance with professional standards of care. Resident# 275 Findings included... Resident #275 was admitted to the facility on 5/1/19 with diagnoses to include Hypokalemia, Obstructive Sleep Apnea, Essential (Primary) Hypertension, Unspecified Asthma. Review of the Comprehensive Minimum Data Set [MDS] dated 5/8/19 showed Section C [Cognition] Brief Interview for Mental Status [BIMS] is scored as "15" which indicates cognitively intact. Section O [Special Treatments, Procedures, and Programs] showed under respiratory treatments "oxygen therapy" was selected to indicate resident uses oxygen therapy. Review of the physicians order dated 5/1/19 showed "continuous O2 (oxygen) 3L (liters)/minute via nasal cannula." Further review of the physicians order showed "change oxygen tubing one time a day every Wednesday for infection control." Review of the nurse's progress note dated 5/2/19 showed "no shortness of breath or distress notes, denied pain oxygen 3 liters/minute continues." Further review of the nurse's progress note dated 5/23/19 showed "remains on O2 at 3L via nasal cannula." Review of the care plan showed "focus: the	F 695	3. Licensed nurses were in-serviced by the Director of Nursing by 7/19 regarding the policy involving the proper delivery of oxygen and the labelling of tubing. When a MD order for oxygen is received, the staff nurse signing off the order will be responsible for placing this order into Point Click Care into the eMAR/eTAR. Correct transcription to include the about of O2 to be delivered and the day/shift of the week for tubing to be changed. The licensed nurse will be further responsible for notifying the MD and DON if the resident is refusing/manipulating O2 delivery and document notification in a progress note. 4. The night charge nurse will audit the delivery of oxygen per MD orders and tubing labelling weekly x4, then monthly. The results of these audits will be given to the Director of Nurses. The Director of Nurses will present the findings of these audits along with any action plans and/or disciplinary action for continued staff non-compliance, to the QAPI Committee meeting at least monthly x3 then quarterly.	7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 695	Continued From page 24 resident has oxygen therapy related to (SOB) shortness of breath." Interventions: Oxygen settings: O2 via nasal cannula @ 3L [3L/minutes]." Observation on 5/30/19 at 10:00 AM showed Resident #275 sitting in his room with oxygen therapy via nasal cannula, oxygen parameters observed at 2L and the tubing was not labeled. During an interview in the resident's room on 5/30/19 at 10:00 AM Employee #9 stated "yes, I see the oxygen is as 2L and it should be at 3L and the tubing is not labeled we change it every week for infection control. Resident #275 denied shortness of breath. During an interview on 5/30/19 at 10:30 AM Employee #3 stated "he always manipulates the oxygen and changes it to 2L, and he takes the labels off, we tell him but he still does it. Review of the nurses notes and care plan failed to show resident changes the setting of the oxygen and or removes the label from the tubing. The facility staff failed to maintain oxygen therapy in accordance with physicians order and professional standards of practice. During an interview on 5/30/19 at 10:30 AM Employees #3 and #9 acknowledged the findings.	F 695		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791	Routine/Emergency Dental Services In NFs CFR(s): 483.55(b)(1)-(5) 1. Both Resident #3 and #19 have been seen by a dentist.	7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 791	Continued From page 25 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F 791	Routine/Emergency Dental Services In NFs CFR(s): 483.55(b)(1)-(5) (continued) 2. Current residents in-house requiring dental care have been addressed by their family dentist. The facility assisted with escorts and transportation. 3. The licensed staff and Social Worker will be in-serviced by the Director of Nursing by 7/19 on the policy/requirements for providing dental services in an emergency on upon request. The facility has secured a dental contract with Regional Mobile Dental to address such issues and concerns in a timely manner. 4. The night charge nurse will audit the medical records on a monthly basis to ensure all orders for dental services have been addressed. The results of those audits will be given to the Director of Nurses. The Director of Nurses will present findings of the audit to the QAPI Committee least monthly for further actions/recommendations as indicated.	5/24/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 791	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 22 sampled residents facility staff failed to schedule routine dental services for one (1) resident and to reschedule a dental appointment for one (1) resident who requested to see a dentist. Resident# 3 and #19. Findings included... 1. Facility staff failed to schedule routine dental services for Resident# 3. Review of the admission record on 5/24/19 at 9:30 AM showed the following diagnoses Hyperlipidemia, Essential (Primary) Hypertension, Aphasia following Cerebral Aphasia, Cerebral Infarction and Dysphagia following Cerebral Infarction. Review of the Comprehensive Minimum Data Set [MDS] dated 2/20/19 showed Section C [Cognition] Brief Interview for Mental Status [BIMS] is scored as "99" which indicates resident was unable to complete the interview. Section L [Oral/Dental Status] showed the section was left blank. Observation on 5/24/19 at 10:30 AM showed Resident #3 sitting in the dining area and it was observed that the resident has missing upper and lower teeth. Resident was asked does the facility help you with appointments to the dentist. Resident stated "I have not had a dental exam." Review of the medical record showed an Interim Order form dated 1/24/19; doctors order "Dental Consult, hx (history) of gingivitis, decay of teeth."	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 791	Continued From page 27 During an interview with Employee #7 on 5/24/19 at 11:30 AM, Employee states "I am looking into it now to see if it was scheduled can you give me a minute." During an interview with Employee #3 on 5/27/19 at 10:00 AM, Employee states "he was not scheduled for the appointment here is the order that the appointment was scheduled." Facility staff failed to schedule and or arrange for dental services for Resident #3. During a face-to-face interview on 5/27/19 at 10:00 AM Employees #3 and #7 acknowledged the finding. 2. Facility staff failed to reschedule a dental appointment for one (1) resident who requested to see the dentist. Resident #19. A review of the admission records showed that Resident #19 was admitted to the facility January 13, 2019, with diagnoses, which include Hyperlipidemia, type 2 Diabetes Mellitus, Congestive Heart Failure, Anemia, Gastro-Esophageal Reflux Disease, Heart Failure, Major Depressive Disorder, Alcohol Dependency, and cancer of the Prostate. On May 24, 2019, at approximately 10:23 AM during an interview with Resident #19 he stated that "I have not seen the dentist my appointment was canceled I do not know if I am rescheduled."	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 791	Continued From page 28 A review of the Quarterly MDS (Minimum Data Set) dated April 26, 2019, showed, Section C Cognitive Patterns C0500 BIMS score "11" for moderate cognitive impairment indicative that resident is able to make his needs known. Section L [Oral/Dental] left Blank. On May 30, 2019, at approximately 9:00 AM another interview with the resident concerning the condition of his teeth. The resident stated, "I had an appointment with the dentist and he canceled me. I need to get another appointment with him, I am having some sensitive feelings with my teeth [pointing to the right side of his face] I might be having a cavity but I am not having any pain." There was no evidence to showed that facility staff rescheduled Resident #19 dental appointment. A face -to- face interview was conducted with Employee#3 on May 30, 2019, at 9:20 AM concerning a rescheduled dental appointment for the resident. Employee #3 acknowledged the findings.	F 791		
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	F 812	Food Procurement, Store/Prepare//Serve-Sanitary CFR(s): 483.60(i)(1)(2) Steam Tables/Sprinklers/Baffles/Fruit Cups 1. No specific residents were identified. 2..Sanitation issues, expired fruit cups and Repair issues found in the kitchen at the time of the survey were corrected immediately. All steam tables, sprinklers and adjoining pipes, fruit cups and baffles were examined and no further corrective action was necessary.	5/23/19 5/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 812	Continued From page 29 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (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 and interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by four (4) of four (4) steam table wells in the main kitchen that were soiled with food residue, four (4) of four (4) fire sprinklers that were soiled with grease, four (4) of eight (8) bent baffles from the kitchen hood system and nine (9) of nine (9) four-ounce fruit cup of diced pears, stored on the second floor food serving area, that were expired as of April 30, 2019. Findings included ... The following were observed during a walkthrough of dietary services on May 23, 2019, at approximately 9:02 AM: 1. Four (4) of four (4) steam table wells in the main kitchen were soiled with food residue. 2. Four (4) of four (4) fire sprinklers and adjoining piping located above the grease fryer, the oven and the grill were soiled with an oily sludge. 3. Four (4) of eight (8) baffles from the kitchen hood system were bent at the sides.	F 812	3. An In-service will be given to the kitchen Staff by the Director of Food Services by 7/19 about checking expiration dates on pre-packaged food, appropriate cleaning of equipment and reporting maintenance issues through the we-based portal known as the TELS system. The Kitchen Supervisor will monitor cleaning and maintenance compliance daily. The results of these monitoring efforts will be reported to the Director of Food Service. 4. The Kitchen Supervisor will monitor cleaning and maintenance compliance daily. The results of these monitoring audits will be reported to the Director of Dining. The Director of Dining will present the results of the monitoring audits along with any action plans and/or disciplinary action for continued staff non-compliance to the QAPI Committee at least quarterly.	7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 812	Continued From page 30 4. Nine (9) of nine (9) four-ounce fruit cup of diced pears, stored on the second floor food serving area were expired as of April 30, 2019. Employee #5 acknowledged the findings during a face-to-face interview on May 23, 2019, at approximately 9:15 AM and on May 24, 2019, at approximately 3:00 PM.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview facility staff failed to effectively use resources to efficiently attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident and to follow the plan of correction (compliance date 10/15/18) as evidenced by a continuation of concerns/grievances of residents at resident council meetings. Findings included ... Grievance Policy Last revised 8/8/18 "The facility goal is to resolve resident and family concerns on a timely basis utilizing resources within the facility and through interdisciplinary approach ...	F 835	Administration CFR(s): 483.70 1.No specific residents were identified. 2. The most recent Grievances discussed at Resident Council Meeting have been transferred to the facility's Grievance Form and addressed per policy. 3. The monthly Resident Council Meeting grievances will be processed through the Grievance Procedure by the Social Worker who will staff the Council Meeting and be the designated Grievance Official. The Social Worker has received an In-service on the Grievance Process, Policies, and Regulations by the Administrator by 7/19. Grievances will be archived in the Grievance Book for a period of three years. All Department Managers will be re-inserviced by the Administrator by 7/19 on the correct process for noting, receiving and addressing resident concerns/ grievances.	5/24/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 835	Continued From page 31 Review of the resident council meeting minutes on 5/24/19 at 3:00 PM, from December 2018-March 2019 conveyed the following concerns surrounding areas such as the "laundry not returning their clothing; food and beverage- meat is tough, what is on the menu is never available, running out of food choice, would like a hydration station; nursing: waiting long periods of time for assistance at night, speaking too loudly at the nurses station, need staff diversity training..." Review of the plan of correction with a compliance date of 10/15/18 showed: 1."Activities manger or designees will document resident council grievances on the grievance form, provide original to Social Worker who will copy to the appropriate discipline for resolution. Social Worker will review progress of resolution weekly by the appropriate department manager with accompanying documentation during Grievance Performance Improvement Project meetings. Nursing Home Administrator designees will in-service all department managers as to the new process." 2. "Social Worker or designee will Audit and document findings relate to timely and appropriate resolution of reported grievances weekly x 4, then monthly x 3. This will be reported to the Quality Assurance Performance Improvement (QAPI) for review, evaluation and further recommendation as indicated." Facility staff was unable to provide evidence of the implementation of the process as outlined in the plan of correction.	F 835	4. The Grievance Forms will be audited each month by the Administrator to ensure that any grievances brought up at the Resident Council Meeting are processed through the Grievance Procedure. The Administrator will present the results of this audit to the QAPI Committee along with any action plans for improvement. This Committee meets at a minimum quarterly.	7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 835	Continued From page 32 During a face-to-face interview on 5/24/19 at 5:00 PM with Employees #1, it was stated "I intend to make resident concerns and grievances a priority." Employee #1 acknowledged the finding.	F 835	QAPI Program/Plan, Disclosure/Good Faith Attempt CFR(s): 483.74(a)(2)(h)(i) 1. No specific residents were identified.	7/15/19
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on resident interview and facility document review facility staff failed to develop and implement an effective, comprehensive, data-driven quality assurance performance program (QAPI) as evidenced by the failure to review and address the residents' concerns during resident council meetings. Findings included...	F 865	2. Grievances brought forward from the monthly Resident Council meeting will be processed through the Grievance Procedure format to include being addressed by the appropriate Department Manager. 3. Grievances from the Resident Council Meeting will be elected as a QAPI problem Focus area. The problem will be stated & validated, interventions indicated, responsible managers identified and expected date for resolution indicated. Pertinent documentation from the appropriate team member(s) responsible will accompany the monthly review. 4. The QAPI Committee will review monthly X4 the process involved in addressing Identified grievances. Review is to ensure all Issues reported properly, assigned to appropriate department manager, resolution obtained promptly and to the resident's satisfaction. Continuation of incorrect process, or unsatisfied residents will require further review by the NHA and DON.	7/22/19 7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 865	Continued From page 33 Review of the resident council meeting minutes on 5/24/19 at 3:00 PM, from December 2018-March 2019 conveyed the following concerns surrounding areas such as the "laundry not returning their clothing; food and beverage- meat is tough, what is on the menu is never available, running out of food choices, would like a hydration station; nursing: waiting long periods of time for assistance especially at night, speaking too loudly at the nurses station." Grievance official or department directors failed to address the resident concerns expressed at Resident Council meetings over the span of four months. Facility staff failed to provide evidence QAPI committee reviewed resident council grievances weekly as outlined in the plan of correction (compliance date 10/15/18). During a face-to-face interview on 5/24/19 at 5:00 PM with Employees #1, it was stated "I intend to make resident concerns and grievances a priority." Employee #1 acknowledged the finding.	F 865	Infection Prevention& Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 1. No specific residents were identified.	7/13/19 722/19
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	2..Policy manual for Infection Control had the annual review completed by 7/19 by the Clinical Team including the Medical Director. Policies identified during Survey as out of date have been reviewed and updated. 3. The Infection Preventionist will monitor the dates on all Infection Control policies to ensure that each is reviewed annually. The Infection Preventionist will be responsible for reviewing, updating, and educating staff on new policies, procedures and changes as indicated. 4. Annual review of the facility policy manuals will be completed as part of the QAPI program every July. The Administrator will be responsible for that process and it will be noted in the minutes of the QAPI Committee.	7/22/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 880	Continued From page 34 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 880	Continued From page 35 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to show evidence that the Infection Prevention Control policies and procedures were reviewed and revised annually to provide guidance for staff in the prevention, development and transmission of communicable diseases and infections to residents staff and visitors and failed to develop a water management plan to help prevent and reduce the risk of growth and spread of Legionella and other pathogens in the building's water system. Findings included . . . 1. During a meeting with the Infection Control Preventionist on May 30, 2019 at approximately 1:30 PM a review of the facility's Infection Prevention Control	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 880	Continued From page 36 Manual showed that no policies were reviewed for 2018. Below is a list of the policies contained in the manual and dates they were last revised. The manual was titled Infection Control Policy and Procedure. The Table of Contents had a revised date of August 2015. The page titled References was dated September, 2017. Influenza was dated August, 2014. Norovirus was dated October, 2011. Pneumonia was dated August, 2013. Isolation was dated June, 2010. PPE (Personal Protective Equipment). PPE (Masks) 2009. PPE (Gloves) 2010. Fever, 2016. UTI (Urinary Tract Infection) 2017. Pneumonia Vaccine, 2016. During a face-to-face interview on May 30, 2019 at approximately 1:30 PM, Employee #3	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 880	Continued From page 37 acknowledged that the facility failed to review/revise the Infection Prevention Control Policies annually. 2. Facility staff failed to develop a water management plan to include a facility risk assessment, a water management program and testing protocols to identify where Legionella and other water borne pathogens could grow and spread in the facility water system was not available for review. Findings included.... A water management plan to include a facility risk assessment, a water management program and testing protocols to identify where Legionella and other water borne pathogens could grow and spread in the facility water system was not available for review Employee #6 confirmed the findings during a face-to-face interview on May 29, 2019, at approximately 11:10 AM.	F 880	Infection Prevention& Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) (continued) Water management plan 1. No specific residents were identified. 2. A consultant will be secured to revise and will assist the facility to update the Water Management Plan to ensure it is in compliance. 3. Additions were made to the current Water Management Program to include Risk assessment and a means of Accomplishing a baseline standard regarding measurement of disinfectant and protocols to identify water-borne pathogens. The Director of Plant Operations and Maintenance Supervisor attended a day-long seminar given by the Department of Health on Legionella and Water-Borne Pathogens on 6/25/19. 4. The Consultant will assist the facility in monitoring the effectiveness of the Water Management Plan and send the results of their monitoring activities to the Director of Plant Operations, the Administrator and the Executive Director. The results of this monitoring along with any action plans for improvement will be presented by the Director of Plant Operations to the QAPI Committee which meets at least quarterly.	7/22/19 7/22/19 7/22/19 7/22/19
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by four (4) of four (4) fire sprinklers from the Ansul fire suppression system in the main kitchen that were soiled with grease and four (4) of eight (8) baffles from the	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 908	Continued From page 38 kitchen hood system that were bent at the sides. Findings included ... During a walkthrough of the facility's dietary services on May 23, 2019, at approximately 9:02 AM: 1. Four (4) of four (4) fire sprinklers and adjoining piping located above the grease fryer, the oven and the grill were soiled with an oily sludge. 2. Four (4) of eight (8) baffles from the kitchen hood system were bent at the sides. Employee #6 acknowledged the above findings during a face-to-face interview on May 23, 2019 at approximately 3:00 PM.	F 908	Essential Equipment, Safe Operating Condition CFR(s): 483.90 (d)(2) 1. No specific residents were identified.	5/23/19
			2..Sanitation issues, expired fruit cups and Repair issues found in the kitchen at the time of the survey were corrected immediately. All steam tables, sprinklers and adjoining pipes, fruit cups and baffles were examined and no further corrective action was necessary.	5/23/19
			3. An In-service will be given to the kitchen Staff by the Director of Food Services by 7/19 about checking expiration dates on pre-packaged food, appropriate cleaning of equipment and reporting maintenance issues through the we-based portal known as the TELS system. The Kitchen Supervisor will monitor cleaning and maintenance compliance daily. The results of these monitoring efforts will be reported to the Director of Food Service.	7/22/19
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 by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in one (1) of nine (9) resident's rooms that failed to alarm when tested.	F 919	4. The Kitchen Supervisor will monitor cleaning and maintenance compliance daily. The results of these monitoring audits will be reported to the Director of Dining. The Director of Dining will present the results of the monitoring audits along with any action plans and/or disciplinary action for continued staff non-compliance to the QAPI Committee at least quarterly.	7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 919	Continued From page 39 Findings included... During an environmental walkthrough of the facility on May 23, 2019, at approximately 2:30 PM, the call bell in resident room # 202B did not alarm when activated, one (1) of nine (9) resident's rooms. This breakdown could prevent or delay care to the resident (s) in an emergency. Employee #6 acknowledged the above findings during a face-to-face interview on May 23, 2019, at approximately 3:00 PM.	F 919	Resident Call System CFR(s): 483.90(g)(2) 1. The call bell/beside remote for room 202-B was replaced immediately upon discovery. 2. All call bell/bedside remotes were tested and there were no other issues. 3. Maintenance Techs will be inserviced by the Director of Plant Operations by 7/19 on monitoring the operation of the call bells There will be a check of the call bell/bedside remote before each new admission by the maintenance team. 4. Will continue with monthly audits of all rooms on the skilled unit to ensure that each call bell/remote is functional. The Maintenance Supervisor will monitor these audits and send the results of them to the Director of Plant Operations. The Director of Plant Operations will present the findings of these monitoring efforts along with any action plans for improvement to the QAPI Committee which meets at least quarterly.	5/23/19 5/23/19 7/22/19 7/22/19
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to maintain an efficient pest control program as evidenced by flying pest that were observed in the kitchen area throughout the survey. Findings included ... Flying pests were seen in the kitchen area and around the walk-in refrigerator and the dry food storage area especially during and after food deliveries. Flying pest were observed entering the back door that connects the kitchen area to the back of the building freely and frequently between	F 925	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) 1. No specific residents were identified. 2. A new Pest Control contract with Ehrlichs Pest Control was put into place 6/20/19 in an effort to substantially improve The pest control services at this facility. 3. In-services were completed with all Departments by the Director of Housekeeping by 7/19 about the pest control processes now in place under the new contractor.	5/28/19 6/20/19 7/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING _____ B. WING _____	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

(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 925	Continued From page 40 May 23, 2019, and May 30, 2019. Employee #5 acknowledged the findings during a face-to-face interview on May 28, 2019, at approximately 11:55 AM.	F 925	Maintains Effective Pest Control Program CFR(s): 483.90l1)(4) continued 4. The Director of Housekeeping will be Monitoring the effectiveness of the new Pest control services weekly to ensure on-going compliance. The Director of Housekeeping will present the findings of her monitoring efforts along with any action plans for improvement to the QAPI Committee at least quarterly .	7/22/19