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 _____	11/12/2020

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 An unannounced Recertification Survey was conducted at Health Rehabilitation Center at Thomas Circle November 9, 2020, through November 12, 2020, and consisted of a review of six (6) resident clinical records. Based on observations, record reviews, and staff interviews, an analysis of the findings determined the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census on the first day of survey was five (5). 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 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)	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: Administrator | (X6) DATE: 12/11/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641	Accuracy of Assessments CFR(s): 483.20(g) 1. The MDS for resident #7 was corrected upon discovery	11/12/20

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F 641	Continued From page 2 his REQUIREMENT is not met as evidenced by: Based on record review and interview, facility staff failed to ensure an annual Minimum Data Set (MDS) included accurate information for one (1) of five (5) sampled residents. Resident #7. Findings included... Review of Resident #7's current clinical record showed that the resident was admitted to the facility on 10/02/19 with multiple diagnoses including Type 2 Diabetes Mellitus (DM) with Hyperglycemia (high blood sugar levels). Review of the physician's order dated 12/23/19 showed: "Levemir (Insulin) FlexTouch Solution Pen-injector 100 UNIT/ML (milliters) inject 40 units subcutaneously one time a day for DM". Review of the October 2020, Medication Administration Record (MAR) revealed that the resident refused the Levemir injections three (3) times on dates 10/2/20, 10/6/20, and 10/8/20. Review of Resident #7's annual MDS dated 10/11/20, showed that Section E0800 (Rejection of Care-Presence & Frequency) was coded as "0" indicating that Resident #7 did not exhibit behavior of rejecting (refusing) medications. Facility staff failed to ensure Resident #7's annual MDS included accurate information. During a face-to-face interview conducted on 11/12/2020, at 11:30 AM, Employee #2 acknowledged the findings.	F641	2. All charts were reviewed and no other corrections were required. 3.The last of the residents have been transferred off of the unit; and the skilled unit has been closed. 4. The skilled unit has been closed.	11/12/20 11/20/20 1/13/21 1/13/21

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of five (5) sampled residents, facility staff failed to update the care plan to address; two (2) residents being discharged to another facility pending facility closure; and failed to update the code status for two (2) residents. Residents' #2, #3, and #7	F 657	Care Plan Timing and Revision CFR(s) 483.21(b)(2)(i)-(iii) 1A. Resident #2 1. The Care Plan was amended to include the resident and son's acknowledgement of being notified of the skilled unit's closing. 2. All remaining charts were audited to ensure each one contained the resident and family's acknowledgement of the unit's closing. Correction were made wherever necessary. 3.The last of the residents have been transferred off of the skilled unit; and the skilled unit has been closed. 4. The skilled unit has been closed.	11/12/20 11/12/20 11/20/20 1/13/21 1/13/21

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F 657	Continued From page 4 Findings included ... 1A. Facility staff failed to update the care plan to address the resident being transferred to another facility pending facility closure. Resident #2 was admitted to the facility on 2/6/2020, with diagnoses that included Anemia, Hypertension, Hyperlipidemia and Cerebrovascular Accident (CVA). Review of the progress notes showed: "10/29/2020 at 15:33 (3:33 PM) "Discharge Care Plan Meeting Conference Call held with the resident's son ... [Resident's name] approved clinically.. pending the status of ...Patient Liability ..." "10/19/2020 at 16:08 (4:08 PM), Discharge Care Plan Meeting Conference Call held in which [Resident's name] and his son were made aware of and acknowledged the facility would be closing." Further review of the care plan with a revision date of 8/20/2020, showed in one focus area, "[Resident's name] wishes to return home." There is no evidence that facility staff updated Resident #2's care plan to address the resident being transferred to another facility pending facility closure. During a face-to-face interview conducted on 11/12/2020, at 9:42 AM, Employee #2 acknowledged the findings.	F 657		

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F 657	Continued From page 5 1B. Facility staff failed to update the care plan to address Resident #2 not being a full code. Review of the physician's order dated 2/7/2020, showed, "Resident is a DNR (do not resuscitate). Review of the document entitled, "District of Columbia Medical Orders for Scope of Treatment (MOST) signed on 2/7/2020, showed that, "Do Not Attempt Resuscitation (DNAR)/Allow Natural Death (AND)" was checked off. Review of the care plan with the initiation date of 3/26/2020, showed, "[Resident's name] wishes to be a Full Code". There is no evidence that facility staff updated Resident #2's care plan to indicate that the resident is a DNR. During a face-to-face interview conducted on 11/12/2020, at 9:42 AM, Employee #2 acknowledged the findings. 2. The facility staff updated Resident #3's care plan to address the resident being transferred to another facility pending facility closure. Resident #3 was admitted to the facility on 4/27/2018, with diagnoses that included Major Depressive Disorder, Primary Osteoarthritis, Chronic Kidney Disease and Hypertension. Review of the progress notes showed: "10/19/2020 at 14:57 (2:47 PM), "Discharge Care Plan meeting held ... The discharge meeting was	F 657	1B. Resident #2 1. The Care Plan was updated immediately upon discovery of the resident's code status. 2. All other charts were audited to ensure the correct code status was documented in the Care Plan. Corrections were made upon discovery. 3.The last of the residents were transferred off of the unit; and, the skilled unit has been closed. 4.The skilled unit has been closed. 2. Resident #3 1. The Care Plan was amended to include the resident acknowledgement of being notified of the skilled unit's closing. 2. All remaining charts were audited to ensure each care plan contained the resident's acknowledgement of the unit's closing. Corrections were made upon discovery. 3. The last of the residents were transferred off of the unit; and the skilled unit has been closed. 4. The skilled unit has been closed.	11/12/20 11/12/20 11/20/20 1/13/21 1/13/21 11/12/20 11/20/20 11/20/20 1/13/21 1/13/21

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F 657	Continued From page 6 due to the closing of the [Skilled] Nursing Sub-Acute Care Unit ..." "10/20/2020 at 12:22 [PM] Social worker met with the resident, per the guardian request and informed the resident that the Sub-Acute Rehab Unit ... will be closing ..." "10/23/2020 at 8:42 [AM] Discharge Care Plan meeting conference call held with the resident Guardian ... The resident has been accepted for admissions ..." "10/30/2020 at 7:54 [AM] Discharge Care Plan meeting held via conference call with resident's Guardian ..." "11/04/2020 at 8:13 [AM] Discharge Care Plan meeting held via conference call with [Resident's name] Guardian ..." "11/11/2020 at 9:32 [AM] Discharge Care Plan meeting conference call held with the residents' Guardian ..." "11/18/2020 at 18:54 [6:54 PM] Resident transferred to [Facility Name] on 11/18/20 ..." Review of the care plan last updated on 10/02/2020 showed, "[Resident's name] discharge plan is to return home alone, with family/friend supports..." Facility staff failed to update Resident #3's care plan to address the resident being transferred to another facility pending facility closure. During a face-to-face interview conducted on 11/12/2020, at 9:42 AM, Employee #2	F 657		

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F 657	Continued From page 7 acknowledged the findings. 3A. The facility's staff failed to ensure Resident #7's care plan was updated to include the resident's current Do Not Resuscitate (DNR), Do Not Intubate (DNI), and Do Not Hospitalize (DNH) status. Review of Resident #7's current clinical record showed that the resident was admitted to the facility on 10/02/19, with multiple diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia, Malignant Neoplasm of Unspecified Site of Female Breast, Anemia and a recent diagnosis of COVID-19 on 06/29/20. Review of Resident #7's care plan intitiated on 3/26/2020, showed; "[Resident's name] and her Responsible party wishes her to be a Full Code." which indicates that all resuscitations procedures should be provided for Resident #7, if needed. Review of the physician's order dated 04/13/20, documented, "Patient is DNR, DNI, DNH if Cov:D [COVID-19] related." Review of Resident #7's care plan showed no evidence that facility staff updated it to include the aforementioned physician's order related to the residents wishes. During a face-to-face interview conducted on 11/12/2020, at approximately 11:00 AM, Employee #2 acknowledged the findings. 3B. Facility staff failed to ensure Resident #7's care plan was updated to include current	F 657	3A. Resident #7 1. The resident's care plan was updated upon discovery of his/her current code status per the physician order. 2. All remaining care plans were audited to ensure the care plan reflected the current code status per the physician order. Corrections were made upon discovery. 3.The remaining residents were transferred off of the unit; and, the skilled unit has been closed. 4.The skilled unit has been closed. 3B.Resident #7 1. The discharge planning goals were made part of the care plan immediately upon discovery. 2. All remaining charts' care plans were reviewed to ensure the residents' discharge planning goals were included. Corrections were made upon discovery. 3.The remaining residents were transferred off of the unit; and, the skilled unit has been closed. 4. The skilled unit has been closed.	11/12/20 11/12/20 11/20/20 1/13/21 1/13/21 11/12/20 11/12/20 1120/20 1/13/21 1/13/21

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F 657	Continued From page 8 discharge planning goals and approaches. Review of Resident #7's current clinical record showed that the resident was admitted to the facility on 10/02/19, with multiple diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia, Malignant Neoplasm of Unspecified Site of Female Breast, Anemia and a recent diagnosis of COVID-19 on 06/29/20. Review of the resident's current clinical record showed a Social Worker's note dated 10/19/20 at 14:41 (2:41 PM) that documented, "Discharge planning was discussed due to the Skilled Sub-Acute Unit Closing as of January 13, 2021 and the need for an alternative placement for [Resident's name]. Facility staff failed to revise Resident #7's care plan to include goals and approaches to address the resident's need for alternative placement. During a face-to-face interview conducted on 11/12/2020, at approximately 11:00 AM, Employee #2 acknowledged the findings.	F 657		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45©(1)(2)(4)(5) Resident #3 1. The lab tested was ordered upon discovery. 2. A review of the Pharmacist's monthly review on the remaining charts found everything to be in compliance.	11/12/ 20 11/12/20

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F 756	Continued From page 9 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of five (5) sampled residents, facility staff failed to act upon laboratory test requested by the pharmacist. Resident #3. Findings included ... Resident #3 was admitted to the facility on 4/27/2018, with diagnoses that included Major	F 756	3.The remaining residents were transferred off of the unit; and, the skilled nursing unit was closed. 4.The skilled nursing unit was closed	11/20/20 1/13/21 1/13/21

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F 756	Continued From page 10 Depressive Disorder, Primary Osteoarthritis, Chronic Kidney Disease and Hypertension. Review of the document entitled, "Consultant Pharmacist's Medication Regimen Review For Recommendations Created Between 10/1/2020 And 10/8/2020" showed in a note writtten to the physician, "[Resident's name] is ordered Lasix, Lisinopril, Magnesium Oxide, and Aspirin. No recent labs can be found. Please consider CMP (complete metabolic panel), CBC (complete blood count), and serum Magnesium Oxide level every 6 months." There is no evidence that facility staff acted on the laboratory test recommended by the pharmacist for Resident #3. During a face-to-face interview conducted on 11/12/2020, at approximately 10:45 AM, Employee #2 acknowledged the findings.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 1. All expired drugs were returned to the pharmacy upon discovery. The pharmacy's Quality Assurance nurse had done her review the previous week, identified the need to replace the expired medication. She had called for a pick up but but the pharmacy was tardy in completing that task.	11/9/20

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F 761	Continued From page 11 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview at approximately 3:00 PM on November 9, 2020, facility staff failed to store medications safely in accordance with State and Federal Laws as evidenced by storing medications, anticoagulatants and intravenous solutions beyond the expiration date. Findings included ... During a tour of the medication storage room conducted on November 9, 2020, at approximately 3:00 PM, the following was observed: Cefazolin Injection 1 gram/vial, expiration date 7/2020 Ertapenem Sodium IV(Intravenous)/IM (intramuscular) 1 gram, expiration date 6/2020 Gentamicin 80mg (milligram) per 2ml (milliliter) Injection, expiration date of 9/2020 in two (2) of two (2) observations Taxicef (ceftazidime for injection, USP Injection 1 gram, expiration dated 9/2020 in four (4) of four (4) observations Vancomycin Hydrochloride Injection 1 gram,	F 761	2. No other expired medications were found. 11/9/20 3. The remaining residents were transferred off of the unit; and the skilled unit has been closed. 11/20/20 1/13/21 4.The skilled unit has been closed. 1/13/21	

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(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 761	Continued From page 12 expiration date 10/2020 in four (4) of four (4) observations Heparin Lock Flush Solution, USP 5 ml in 12 ml syringe, expiration date 9/2020 in six (6) of six (6) observations Sodium Chloride 0.45% 1000 ml bag, expiration date of 9/2020 in one (1) of three (3) bags observations Facilty staff failed to store medications safely in accordance with State and Federal Laws. During a face-to-face interview condcuted on November 9, 2020, at approximately 3:00 PM, Employee #7 aknowledged the findings.	F 761	Food Procurement/Store/Prepare Serve-Sanitary CFR(s) 483.60(i)(1)(2)	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (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	F 812	1. The scoops, bottom shelf of the reach-in refrigerator, and the baffles were cleaned soon after discovery. 11/9/20 2. No other sanitation issues were revealed after a thorough a audit of the kitchen was completed. 11/9/20 3. Cleaning schedules were assigned as a daily task. The Director of Food & Beverage or his designee will monitor the cleanliness of the kitchen on a daily basis and provide inservice education if needed for on-going compliance. 11/14/20 4. The Director of Food & Beverage will review the findings of his monitoring efforts with the Executive Director of the Community The skilled unit has been closed. 12/31/20 1/13/21	

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 _____	11/12/2020

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F 812	Continued From page 13 by: Based on observations and interview, it was determined that facility staff failed to store and prepare foods in accordance with professional standards as evidenced by two (2) of three (3) measuring scoops that were stored on top of the food in two (2) of three (3) storage bins, one (1) of two (2) reach-in refrigerators that was soiled with spilled/defrosted liquid, and one (1) of five (5) baffles that was soiled with grease. Findings included ... 1. Two (2) of three (3) measuring scoops were improperly stored on top of the food in the storage bins. 2. One (1) of two (2) reach-in refrigerators was soiled at the bottom shelf with spilled or defrosted reddish liquid and needed to be cleaned. 3. One (1) of five (5) baffles, located above one (1) of one (1) grease fryer was soiled with grease residue. During a face-to-face interview on November 9, 2020, at approximately 1:45 PM, Employee #5 confirmed the findings.	F 812	Maintains Effective Pest Control Program CFR(s) 483.90(i)(4) 1. The insect was removed upon discovery and reported to the pest control company for directed extermination.	11/9/20
F 925 SS=D	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	F 925	2. No other insects were observed. 3. The remaining residents were transferred off of the unit; and, the skilled unit has been closed. 4.The skilled unit has been closed.	11/9/20 11/20/20 1/13/21 1/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 925	Continued From page 14 by: Based on observation and staff interview, it was determined that facility staff failed to maintain an effective pest control program, as evidenced by a crawling pest observed on the wall of resident room #204. Findings included ... A crawling pest was seen on the wall of resident room #204, on November 9, 2020, at 4:02 PM. During a face-to-face interview on November 9, 2020, at approximately 4:30 PM, Employee #6 was made aware of the finding and stated that the facility was not satisfied with its former pest control contractor and had just recently switched over pest control services with another contractor.	F 925		