Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0014	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT	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) COMPLETE DATE
L 000	Initial Comments	L 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 practice.	
L 002	3201.1 Nursing Facilities An Administrator shall be present forty (40) hours per week during regular business hours, and shall be responsible for the operation of the facility twenty-four (24) hours per day, seven (7) days a week. This Statute is not met as evidenced by: Based on record review and interview, facility staff failed to provide 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 ... 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 on November 10, 2020. In a face-to-face interview on November 10, 2020, at approximately 9:45 AM, Employee #4 provided documentation to show that a contracting company had conducted a walkthrough of the facility and collected water samples totest for Legionella on August 21, 2020. The results of the tests (3) were all "none detected". Employee #4 said that the contracting company was hired to develop a water management plan for the facility and he was told that the plan was ready, however, he had not yet	L 002	3201.1 Nursing Facilities. Water Management Plan 1. The facility was under contract with a water management company by the name of Apex who proceeded to inspect the building and draw samples of water to test in the early fall of 2019. Concurrently, Apex was to write and implement the water management plan. The Director of Plant Operations contacted them several times to secure the facility's copy of the water management plan but it was never received until November of this year. 2. No other contract is waiting to be received by the facility and the Water Management Plan has been fully executed. 3. The Water Management Plan is fully executed and being overseen by the Director of Plant Operations for on-going compliance Any discrepancies will be addressed immediately with Apex.	11/12/20 11/12/20 11/12/20 11/12/20

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/11/20

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L 002	Continued From page 1 received a copy of the plan. On November 11, 2020, at 2:26 PM, District of Columbia Health received a copy of the water management plan through e-mail. The plan, completed by the contracting company and dated September 25, 2020, was reviewed and it was confirmed that all requirements pertaining to a water management program to reduce the risk of Legionella in healthcare facilities were met. However, since the facility was cited in May 2019, because it did not have a water management plan, and its compliance date to correct that deficiency was July 22, 2019, the water management plan should have been available for review on November 10, 2020. Employee #4 confirmed the findings during a face-to-face interview conducted on November 10, 2020, at approximately 9:55 AM.	L 002	4. The Director of Plant Operations will report his findings to the Executive Director of the Community. 3210.4 Nursing Facilities Resident #2 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 care plan contained the resident and family's acknowledgement of the unit's closing. Corrections were made upon discovery. 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.	12/31/20 11/12/20 11/12/20 11/20/20 1/13/21 1/13/21
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;	L 051		

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L 051	Continued From page 2	L 051		

(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;

(e)Supervising and evaluating each nursing employee on the unit; and

(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:

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

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

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L 051	Continued From page 3 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. 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	L 051	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.	11/12/20 11/12/20 11/20/20 1/13/21 1/13/21

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L 051	Continued From page 4 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 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'	L 051	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 11/20/20 11/20/20 1/13/21 1/13/21

b

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L 051	Continued From page 5 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 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,	L 051	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.	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

4. The skilled unit has been closed. 1/13/21

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L 051	Continued From page 6 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 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.	L 051		

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L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating	L 052	3211.1 Nursing Facilities 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. 2. No other expired medications were found. 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 11/9/20 11/20/20 1/13/21 1/13/21

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L 052	Continued From page 8 independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute 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 Tazicef (ceftazidime for injection, USP Injection 1 gram, expiration dated 9/2020 in four (4) of four (4) observations Vancomycin Hydrochloride Injection 1 gram, 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	L 052		

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L 052	Continued From page 9 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.	L 052		
L 104	3219.6 Nursing Facilities Each food service employee shall wear either a hair net or other head covering. This Statute is not met as evidenced by: Based on observations and interview, it was vvdetermined 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	L 104	3219.6 Nursing Facilities 1. The scoops, bottom shelf of the reach-in refrigerator, and the baffles were cleaned soon after discovery. 2. No other sanitation issues were revealed after a thorough a audit of the kitchen was completed. 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. 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.	11/9/20 11/9/20 11/14/20 12/31/20 1/13/21

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L 104	Continued From page 10 residue. During a face-to-face interview on November 9, 2020, at approximately 1:45 PM, Employee #5 confirmed the findings.	L 104		
L 106	3219.8 Nursing Facilities Food waste shall be disposed in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced. This Statute is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to dispose of food waste in an efficient manner as evidenced by food items such as veggie burgers that were discarded in one (1) of one (1) trash can in the dishwashing machine area. Findings included... During a walkthrough of dietary services on November 9, 2020, at approximately 1:45 PM, several veggie burgers were discarded in one (1) of one (1) trashcan located in the dishwashing machine area. This practice violates District of Columbia Municipal Regulations Nursing Facilities which states "Food waste shall be disposed of in a garbage disposal system or garbage grinder which is conveniently located near each activity and which has adequate capacity to dispose of all readily grindable food waste (garbage) produced." During a face-to-face interview on November 9,	L 106	3219.8 Nursing Facilities 1. The improper disposal of food waste was addressed with the staff upon discovery. 2. No other improper waste disposal practice was noted. 3. All Dietary employees has been retrained on the proper method to when discarding food products using the garbage disposal. The Food & Beverage Director and/or his designee will monitor the disposal of food waste on a daily basis. 4. The Director of Food & Beverage will report the findings of this monitoring efforts to the Executive Director of the community.	11/9/20 11/9/20 11/12/20 11/12/20 12/31/20

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L 106	Continued From page 11 2020, at approximately 1:45 PM, Employee #5 confirmed the findings.	L 106		
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to ensure that a drain pipe from a food storage equipment was appropriately installed as evidenced by a drain pipe from one (1) of one (1) ice cream freezer that extended into the drain in the main kitchen. Findings included... During a walkthrough of the main kitchen on November 9, 2020, at approximately 1:35 PM, the drain pipe from one (1) of one (1) ice cream freezer was observed inside the floor drain and provided no air gap. This deficient practice is in violation of the 2012 District of Columbia Food Code, which states: 2403 DESIGN, CONSTRUCTION, AND INSTALLATION? BACKFLOW PREVENTION, AIR GAP 2403.1 An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than twenty-five millimeters (25 mm) or one inch (1 in).	L 359 11/9/20	3250.1 Nursing Facilities 1. The air gap on the drain for the ice cream freezer was fixed upon discovery. 2. No other drains in the kitchen which require an air gap. 3. Leadership in Food & Beverage were retrained by the Director of Plant Operations on the need to maintain the air gap on the drain for the ice cream freezer. It is checked daily by the Director of Plant Operations to ensure on-going compliance. 4. The Director of Plant Operations will notify the Director of Food & Beverage daily of his findings on the status of the air gap being maintained.	11/9/20 11/9/20 11/10/20 11/10/20 12/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0014	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT	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) COMPLETE DATE
L 359	Continued From page 12 Employee #5 acknowledged the above findings during a face-to-face interview on November 9, 2020, at approximately 1:45 PM.	L 359		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observation and 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.	L 426	3257.3 Nursing Facilities 1. The insect was removed upon discovery and reported to the pest control company for directed extermination. 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 11/9/20 11/20/20 1/13/21 1/13/21